

**AN INVESTIGATION INTO THE SAUDI ARABIAN CULTURAL KNOWLEDGE  
AMONG NON-MUSLIM NURSES WORKING IN THE OBSTETRIC UNITS**

by

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## DECLARATION

I declare that **AN INVESTIGATION INTO THE SAUDI ARABIAN CULTURAL KNOWLEDGE AMONG NON-MUSLIM NURSES WORKING IN THE OBSTETRIC UNITS** is my own work and that all the sources that used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE

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DATE .....

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## ABSTRACT

REWRITE???????

The study was conducted with the aim of assessing the Saudi Arabian cultural knowledge among the non-Muslim nurses. These nurses work in the obstetric units at the King Faisal Specialist Hospital and Research Centre, Jeddah and come from different cultural groups and are caring for the Saudi Arabian Muslim women. In order for care to be congruent, comprehensive and of a high quality, the patients' needs should be met at the best attainable level.

Nurses in all health care settings are expected to demonstrate knowledge of the culture that they serve in order to eliminate barriers.

Data analysis was facilitated with the use of the SPSS 11.5 computer program. The study findings may suggest the development of educational guidelines, which will direct the activities of an educational intervention.

## KEY CONCEPTS

Childbearing women; cultural competence; health care providers; non-Muslim; Muslim; obstetric practices; Saudi Arabia; transcultural nursing.

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The Lord has and is great for He has and constantly is providing me with gifts and opportunities beyond my comprehension. The strength and wisdom that I possess is all from Him. I am truly grateful for His presence in my life.

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## *Dedication*

*“The learning process is endless, we must read, we must observe we must assimilate and we must ponder that to which we expose our minds. I believe in the evolution of the mind, the heart and the soul of humanity. I believe in their improvement. I believe in growth. There is nothing quite as invigorating as being able to evaluate and then solve a difficult problem, to grapple with something that seems almost unsolvable and then find a resolution”*

*GB Hinkly: Standing for something: (2000:62)*

*I dedicate this work to my two sons who remained loving and caring throughout this stressful and challenging period:*

*Fitz-Gerald Kagisho Sidumo*

*and*

*Gregory Letlhogonolo Sidumo*

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# CHAPTER 1

## Orientation to the study

### 1.1 INTRODUCTION

Health care policies mandate that nurses acknowledge the uniqueness of the culture that they serve and that nurses should identify cultural barriers to health care delivery (Roberts 2002:222). According to Tjale and De Villiers (2004:31), culture comprises a “system of shared ideas, concepts, rules and meaning that shapes people’s way of life”. Furthermore, culture stipulates guidelines to the members of a society on how they should experience and view the world and how to behave in relation to other people.

It is important to note that cultural practices may change from one generation to the next, as time and the environment influence the individuals’ lives and the people with whom they interact. According to Helman (2002:3), individual, educational, socio-economic and environmental factors influence the culture, health beliefs and behaviours of individuals.

Cultural knowledge is the process through which one seeks to obtain sound educational foundations concerning the various worldviews of different cultures (Tjale & De Villiers 2004:9). Cultural knowledge may lead the nurse towards providing culturally competent health care to the patient. Andrews and Boyle (2003:15) define cultural competence as a “complex integration of knowledge, attitude and skills”. This process may lead to developing and sharpening one’s cultural knowledge and of being able to work effectively within the cultural context of individuals, families or communities with diverse cultural backgrounds. The development of cultural competence requires cultural learning, and understanding cultural concepts and their effects on the individual’s way of life (Tjale & De Villiers 2004:32-38). In addition, Callister (2001:209) states that cultural competence “involves moving beyond the biophysical to a more holistic approach and seeking to increase cultural knowledge, change attitudes and hone clinical skills”. In a holistic approach, illness and healing cannot be dealt with without taking into account the cultural and religious context within which they occur. Tjale and De Villiers (2004:4)

point out that the traditional health care system is “more holistic in nature” because religion and culture are significant in the healing process. The focus of the traditional health care system is on the individual and meeting his/her physical and spiritual needs. In contrast to traditional health care, the Western or scientific health care system is dependent on documented, researched, shared scientific knowledge based on rationality. The focus is on the disease or condition, and not on the religious and/or cultural needs of the individual (Tjale & De Villiers 2004:5).

Saudi Arabian patients follow a traditional health care system because of their cultural and religious way of life (Leininger & McFarland 2002:307). One of the Saudi Arabian cultural practices with significant influence on the health outcome of infants is the practice of consanguinity, defined as the custom of marrying one’s cousin (Panter-Brick 1991:1295). Panter-Brick (1991:1295) explains this as the Saudi Arabian belief that, “when you have beauty, intelligence and money, why marry outside of the family”. They believe that such marriages strengthen family ties. If an infant born out of such a marriage is healthy at birth, then suddenly becomes ill, the illness is attributed to the “evil eye”. Within the Saudi Arabian culture, it is believed that a wicked, jealous or envious female or family member who wants to harm the baby usually casts the “evil eye”. This is a cultural belief in the causes of illness. In Western society, scientific evidence suggests that consanguinity is the cause of the high incidence of Saudi Arabian genetic disorders (Panter-Brick 1991:1297-1299).

## **1.2 STATEMENT OF THE RESEARCH PROBLEM**

Childbearing women in Saudi Arabia, who belong to the Muslim faith, are required to adhere strictly to cultural expectations during pregnancy and childbirth as well as during the postpartum period and while breastfeeding. Many foreign non-Muslim nurses work in the obstetric units in these countries. This study wished to assess whether or not foreign non-Muslim nurses possess sufficient cultural knowledge to provide culturally competent care to the childbearing women in the obstetric units of the King Faisal Specialist Hospital and Research Centre, Jeddah, in Saudi Arabia.

### **1.2.1 Background to the research problem**

Saudi Arabia is one of the countries that attract nurses from all over the world and from different cultural backgrounds. Most of the nurses working in Saudi Arabia are expatriates (Luna 1998:9). They might have some knowledge of the Islamic faith and culture. Saudi Arabia is a country that, despite modernisation and industrialisation, remains strongly rooted in its religious and cultural traditions. The population reflects a diversity varying from the desert-dwelling Bedouin to the members of the royal family (Luna 1998:8). The Saudi Arabian government encourages young people to continue their studies in the Western world. Some of these youngsters may return to their country with different perceptions of the world and their cultural values might be influenced by Western society. However, in Saudi Arabia there are still those who are culturally deeply rooted, like the Bedouins, whose traditional and cultural needs should be considered and accommodated by health care providers. Culture is a complex and dynamic process (Tjale & De Villiers 2004:31-32) and therefore single dimensions thereof should not be viewed in isolation.

Some of the cultural practices of the group under investigation may have changed or may not be known to the new generation, who tend to adopt Western cultures. Culture is shaped and influenced by factors such as religion, race, economic status, level of education and the environment (Helman 2002:3). There is a thin line between the Saudi Arabian culture and their Islamic religious practices. Religion shapes the culture of the Saudi Arabian population and therefore, some of the rituals, taboos and health care practices may stem from religious origins and influences (Al-Shahri 2002:133). The Saudi Arabian religion and culture are thus discussed together because of the close link between these two concepts.

### **1.2.2 Significance of the study**

Cultural beliefs and values associated with childbearing touch all aspects of the social life in any given culture (Callister 1995:327). The author adds that, "sharing the women's perceptions of the meaning of childbearing may improve the nurse-patient relationship as this may enhance culturally congruent care, that stems from cultural competence". Andrews and Boyle (2003:6) state that cultural congruent care is "the care that is beneficial and meaningful to the people being served".

Nursing interventions during pregnancy and childbearing should be culturally sensitive to promote positive outcomes. Nurses thus need culture specific knowledge and skills to care for women and newborns from culturally diverse backgrounds. In this technologically complex and bureaucratic world of health care delivery, cultural considerations in the provision of care are often overlooked and neglected. Cultural competence includes knowledge, awareness, being sensitive to and understanding the dimensions of the culture served (Tjale & De Villiers 2004:32).

The Saudi Arabian patients' definition of a caring nurse is congruent with the views of Nahas (1997:22) who states that caring includes good "interpersonal skills, supportiveness, sensitivity, competence, cultural awareness and sensitivity". Nahas (1997:22) emphasises that the establishment of a good client-nurse relationship is especially important to the patients in defining the quality of care rendered to them.

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

Among the nurses in the obstetric units of King Faisal Specialist Hospital and Research Centre, Jeddah are non-Muslim foreigners, who care for patients from the Saudi Arabian culture. The nurses need cultural knowledge and skills to optimally care for their patients.

The overall purpose of this study was to conduct a needs assessment of obstetric non-Muslim nurses' knowledge of Saudi Arabian cultural knowledge and to plan the content and activities of an educational intervention based on the identified needs.

The study wished to build on the obstetric nurses' Saudi Arabian cultural knowledge and, by promoting sharing of ideas and experiences, to render culturally competent care when interacting with the patients in obstetric units.

### **1.3.1 Research questions**

The study wished to answer the following research questions:

- Does the non-Muslim nurse understand the cultural practices associated with pregnancy, labour, the postpartum period and breastfeeding of the Saudi Arabian childbearing woman?
- Does the non-Muslim nurse have knowledge of the cultural taboos, rituals, and health beliefs practised by the Saudi Arabian childbearing patient?
- What are the educational needs of non-Muslim nurses who work in the obstetric units of King Faisal Specialist hospital and Research Centre, Jeddah in Saudi Arabia?

### **1.3.2 Research objectives**

The research objectives in this study were to

- investigate non-Muslim nurses' understanding of the cultural practices associated with pregnancy, labour, the postpartum period and breastfeeding of the Saudi Arabian childbearing woman
- investigate the non-Muslim nurses' understanding and knowledge of the cultural taboos, rituals, and health beliefs practised by the Saudi Arabian childbearing patient
- to provide guidelines on what educational aspects need to be provided to non-Muslim nurses working with Saudi Arabian women

In this study, the researcher attempted to describe the cultural and religious practices of Saudi Arabian childbearing women and then determine whether non-Saudi nurses possess the cultural knowledge required.

## **1.4 DEFINITIONS OF KEY CONCEPTS**

For the purposes of this study, the following terms are used as defined below:

### **1.4.1 Childbearing**

“Child bearing is the process, (in a woman’s life span), of being pregnant and of giving birth to children” (*Longman Dictionary of Contemporary English* 2005:256). Andrews and Boyle (2003:96) describe childbearing as “a time of transition and social celebration; it signals a realignment of existing cultural roles and responsibilities, psychological and biological state and social relationships”. Childbirth thus depends on the cultural consensus about health, medical care and the status of women.

In this study, childbearing refers to the stage of pregnancy and giving birth of women belonging to the Islamic faith as patients at the King Faisal Specialist Hospital and Research Centre Jeddah, Saudi-Arabia.

### **1.4.2 Culture**

Hahn (1995:66) defines culture as “a coherent set of values, concepts, beliefs and rules that guide and rationalise people’s behaviour in society”. Helman (2002:2) defines culture as “that complex whole which includes knowledge, beliefs, art, morals, law, customs and habits acquired by man as a member of society”. Andrews and Boyle (2003:33) add that culture is “an integrated pattern of human behaviour that includes thoughts, communication, actions, customs, beliefs, values, racial, religious or social issues”. In addition, culture facilitates the development of a harmonious attitudes and behaviour among a group.

For the purpose of this study, culture is defined as the practices and beliefs that influence the childbearing Saudi Arabian Muslim women’s health care behaviour as shaped by the Islamic religion.

### **1.4.3 Cultural competence**

Cultural competence is a “complex integration process of knowledge, attitudes and skills that enhance cross-cultural communication, appropriate and effective interaction with others” (Andrews & Boyle 2003:15).

In this study, cultural competence is the non-Muslim nurse's ability to demonstrate knowledge of the Saudi Arabian cultural practices. It includes respecting and being sensitive to these cultural practices and incorporating them in the planned care for the childbearing women.

#### **1.4.4 Cultural practices and health care practices**

Cultural practice is "the way that people often do certain actions regularly in order to live their lives according to religious or set rules" (*Longman Dictionary of Contemporary English* 2005:1283).

Health is "a state of being free from illness; a person's mental or physical well-being" (*Oxford Dictionary* 2004:414). Care is "the process of doing things to keep the body in good condition and working correctly" (*Longman English Dictionary* 2005:223).

In this study, cultural practices are those actions that childbearing Muslim women have inherited and that are shaped by the Islamic religion. The health care practices in this study are defined as those actions that the Muslim women engage in to achieve physical well-being. The Muslim childbearing women's cultural practices influence their health care practices.

#### **1.4.5 Muslim**

The term Islam means "submission to the will of Allah (God)" and "one who is a follower of the Islamic faith is called a Muslim" (Tjale & De Villiers 2004:95).

In this study, the childbearing women referred to are from Saudi Arabia, Jeddah; are of the Islamic faith, and are referred to as Saudi Arabian Muslims throughout the study.

#### **1.4.6 Saudi Arabian**

According to Andrews and Boyle (2003:477), a Saudi-Arabian is a person who resides in Saudi Arabia and who practises the Islamic faith. Saudi Arabia is a Middle Eastern country geographically located in the Gulf region of the Asian continent. Various sects of

the Islamic faith include Muslims from Lebanon, Jordan, Iran, Iraq, Yemen, Afghanistan and Saudi Arabia.

In this study, Saudi-Arabian refers to childbearing women who are pregnant or in labour, or lactating women who are of the Islamic faith. The focus is on the childbearing women of the Muslim faith living in Saudi Arabia. The study was conducted at the King Faisal Specialist Hospital and Research Centre, Jeddah in Saudi Arabia (see figure 1.1).



**Figure 1.1**

**Map of Saudi Arabia**

(www.far2.com: 2007)

## **1.5 RESEARCH DESIGN AND METHODOLOGY**

This section discusses the research design and methodology followed in order to achieve the objectives of the study.

### **1.5.1 Selecting a research design**

The research design is a “blue print” or plan of the study. As a blueprint, the design is a broad pattern that guides and is applied to different studies. As a plan, the design is

implemented in order to achieve the intended goal (Burns & Grove 2001:223).

The researcher followed a descriptive and explorative study design. The descriptive study design provides an accurate explanation of the characteristics of a particular individual, situation or group (Burns & Grove 2007:25). The basic assumption in this design is that there is a literature base for the study and that this information can be used in the current study. The type of data-collection instrument is in the form of questionnaires and the measurement is quantitative. When questionnaires are used, usually face and content validity are used. This design is used when study variables have not been defined (Brink & Wood 2001:105-110). Taylor, Kermode and Roberts (2006:173) add that descriptive studies increase the knowledge on a topic as the researcher explores the research question.

This study described the cultural practices of Muslim childbearing women and explored and non-Muslim nurses' Saudi Arabian cultural knowledge.

### **1.5.2 Research methodology**

According to Burns and Grove (2001:26), the research method includes the scientific procedures used to generate knowledge. Burns and Grove (2001:26) explain that the research methodologies may be quantitative and/or qualitative and include outcomes and intervention research, which are relatively new to the clinical practice. Polit and Beck (2004:44) point out that quantitative methods are highly structured. These methods are formal, objective and systematic and numbers are used to obtain information about the world. The quantitative research method is used to describe or determine relationships between variables (Burns & Grove 2001:26).

The research method in this study was quantitative and followed a descriptive and explorative design. The study described the qualities and processes associated with obtaining cultural knowledge and developing cultural competence.

### **1.5.2.1 Population**

Burns and Grove (2001:806) define the population in a study as “all elements of individuals, objects, events, or substances that meet the sample criteria for inclusion in a study”. A population is also sometimes referred to as a target population. According to Polit and Beck (2004:727), the population is seen as the entire set of individuals sharing common characteristics.

In this study, the population comprised all the non-Muslim nurses working at the King Faisal Specialist Hospital and Research Centre, Jeddah who rendered care to childbearing Saudi Arabian women.

### **1.5.2.2 Sample and sampling technique**

#### **Sample**

The sample is a subset of the population that is selected for the study. The sample should be able to provide data that will answer the study questions (Burns & Grove 2007:554). According to Polit and Beck (2004:731), the sample comprises the study participants selected from the identified population.

The researcher conveniently selected a sample of 52 non-Muslim nurses from a population of 67 nurses. The convenience sample comprised the nurses working in the obstetrical units of the King Faisal Specialist Hospital and Research Centre, Jeddah, at the time of data collection during November-December 2007.

#### **Sampling technique**

A sampling technique is a process or method of selecting a portion from the population that will participate in the study and thus represent that population (Polit & Beck 2004:291).

All the non-Muslim nurses working in the obstetric units were targeted and selected, using the convenience sampling technique. Nurses from both day and night duty were targeted.

## **Inclusion criteria**

To be included in this study, the respondents had to meet the following inclusion criteria:

- Nurses from the obstetric (antenatal, postnatal, labour and delivery) units who were not Saudi Arabian and not of the Islamic faith. These included nurses from the Philippines, South Africa and Ireland.
- Categories included: staff nurse (SN I), which is equivalent to the professional nurse category, staff nurse (SN II) that is equivalent to the enrolled nurse and staff nurse (SN III) equivalent to an enrolled nurse assistant in South Africa.

## **Exclusion criteria**

- Nurses from Jordan, Saudi Arabia and Egypt and those of Islamic faith were not included in the study because the researcher assumed that they had the cultural and religious knowledge under investigation.
- The non-Muslim nurses on vacation during the data-collection phase could not be included in the data collection due to their unavailability.

### **1.5.2.3 Data-collection method**

According to Burns and Grove (2007:41), the data collection method should be precise and systematic, and the information gathered should be relevant to the purpose and objectives of the study. Data collection and measurement are related and in quantitative research, the measurement requires quantification by the use of standardised procedures for converting the data collected into numerical scores to facilitate analysis (Stommel & Wills 2004:244).

In this study, a structured questionnaire enabled the researcher to analyse the data quantitatively. The focus of the questionnaire was on assessing the cultural knowledge of non-Muslim obstetric nurses regarding the taboos, rituals, health care and cultural practices and beliefs of Saudi Arabian Muslim childbearing women, during pregnancy, the intrapartum period, during anaesthesia and in the postpartum period. Some of the questions were general and some were specific to Saudi Arabian Muslim childbearing women.

#### **1.5.2.4 Reliability and validity**

Measures taken to enhance the reliability and validity of the study are described briefly below (see chapter 3 for full discussion).

##### **Reliability**

Assessing the reliability of the research instrument means to establish consistency and accuracy with multiple measures (Gerrish & Lacey 2006:376). There are three ways of testing reliability (Rossouw 2003:122):

- **Stability reliability**, which is the test retest method. The instrument should yield the same results every time that it is used in the same situation.
- **Representative reliability** is tested when the instrument produces the same results when applied to different populations.
- **Equivalence reliability** is used during item analysis to determine if all respondents interpret the responses to each item in the same way.

The researcher tested the questionnaire by giving it to colleagues in order to determine if all interpreted the items similarly. These colleagues were not part of the study, but served as critics of the questionnaire.

##### **Validity**

Validity of the measuring instrument means that it measures what it is supposed to measure. In most studies, the measuring instrument is valid for the aim for which it was designed (Gerrish & Lacey 2006:375).

Rossouw (2003:123) describes different types of validity:

- **Content validity**, which ensures that the content of the definition is represented in the measuring instrument.

The questions in the questionnaire used in this study did not include all the aspects of the Saudi Arabian cultural practices. Only a limited number of aspects were covered to assess the need for an educational intervention to enhance nurses' cultural competent care.

- **Construct validity** is often tested by item analysis. The feedback is based on the independent clinical experts' assessment of the tool to enhance its validity.

The researcher made use of Muslim colleagues to validate the information obtained from the literature in order to structure and formulate the questions.

- **Face validity** is obtained when the researcher asks experts in a particular field to judge the measuring tool and their opinions about the relevance of each item to the studied phenomenon. According to Polit and Beck (2004:26), face validity of an instrument is met when the tool appears to be measuring the appropriate constructs.

The researcher gave the measuring instrument to colleagues to proofread and determine whether the questions were well phrased. The instrument was subjected to multiple revisions, based on peer review, for face, content and constructs validity.

#### **1.5.2.5 Method of data analysis**

Data in quantitative studies rely on statistical analysis. Data analysis involves two steps, namely **summary** of the results and **interpreting** the patterns found in the data (Stommel & Wills 2004:27).

Data analysis of the surveyed items was numerated and the data entered using the Statistical Package for the Social Sciences (SPSS Version 11.5) program. The

researcher used the guidance and service of a qualified statistician at the King Faisal Specialist Hospital and Research Centre, Jeddah for data entry and analysis.

## 1.6 ETHICAL CONSIDERATIONS

The rights of the participants should be protected to the fullest by researchers (Brink & Wood 2001:199; Burns & Grove 2007:203-4). Before conducting research at the King Faisal Specialist Hospital, it is mandatory for all researchers to complete an online course and be certified in **Human Participants Protection Education for Research Teams**, sponsored by the National Institutes of Health (NIH 2007) (see Annexure A). Accordingly, the researcher did this.

The researcher needed approval from the King Faisal Specialist Hospital and Research Centre, Jeddah Institutional Review Board (IRB) before conducting the study (see Annexures B and C).

- **Scientific honesty:** Burns and Grove (2001:191) state that in order to maintain high standards of research, “the conduct of nursing research not only requires expertise and diligence, but also honesty and integrity”.

The study was directed by scientific information from publications such as books, articles, the Internet and not on opinions formed without scientific validation. The comments were based on clinical experience and observation.

- **Right to self-determination:** Right to self-determination implies that the researcher treats the participants as autonomous agents by giving them the freedom to choose, after providing information of the study, and allowing them to give informed consent (Burns & Grove 2007:204).

The participants in the study were given the necessary information and allowed to decide whether or not to participate. No written consent was required, thereby ensuring the respondents' anonymity. The questionnaire outlined the rights of the participants, explained the research methodology and addressed consent issues.

- **Rights of privacy:** Names and any means of identifying the participants were not needed for this study. The designation, nationality and number of years that each participant had worked in the obstetric department in Saudi Arabia were required (Burns & Grove 2007:209).
- **The right to anonymity and confidentiality:** In this study, the participants' identity would not be linked to their responses because this information was not required on the questionnaire. To ensure confidentiality, no individual results but group scores were analysed and shared with the staff working in the obstetric units and the managers during dissemination of the findings (Burns & Grove 2007:212). The researcher presented the analysis of the data using statistics without mentioning any names.
- **Compensation.** No monetary compensation was offered. The purpose of the study was to develop and share knowledge to enhance cultural competent care rendered to obstetric patients in Saudi Arabia (Burns & Grove 2001:207).

## 1.7 LIMITATIONS OF THE STUDY

The study had the following limitations:

- Generalisation of the study findings was not possible because the study was conducted only at the King Faisal Specialist Hospital and Research Centre, Jeddah. Polit and Beck (2004:718) define generalisability as the "degree to which research findings are true for a broader group than the study participants".
- The study was only conducted in the obstetric units of this hospital.
- The sample size was small and limited only to one hospital in Saudi Arabia.

## 1.8 GUIDELINES FOR AN EDUCATION INTERVENTION

The result of the needs assessment would direct and shape the framework for the education intervention.

The structure of the education intervention took the form of:

- Content based on literature search.
- Planning and timing of the education activities.
- Selecting theories to guide the knowledge development.
- Classroom presentations and discussions.
- Identifying strategies in the literature search that will motivate nurses to develop their Saudi Arabian cultural knowledge in order to render a culturally competent and congruent care to the childbearing women in Saudi Arabia.

## **1.9 OUTLINE OF THE STUDY**

Chapter 1 introduced the topic and discussed the purpose of the study.

Chapter 2 discusses the literature review conducted to understand Saudi Arabian cultural issues.

Chapter 3 describes the research design and methodology, including data collection and analysis, population and sampling, validity and reliability, scope and limitations, and ethical considerations.

Chapter 4 deals with the data analysis and research findings. The statistical procedures and methods, validity and reliability are also discussed.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for cultural competence development among healthcare providers and for further research.

## **1.10 CONCLUSION**

This chapter discussed the background to the study and the research problem. Providing culturally sensitive and competent care is a challenge to health care providers who care for patients who come from different cultural backgrounds. The study was

significant to the health care providers because Saudi Arabian childbearing women come from a rich cultural background and expect non-Muslim nurses to understand and respect their culture.

Chapter 2 discusses the literature review.

## CHAPTER 2

### Literature review

#### 2.1 INTRODUCTION

Terre Blanche and Durrheim (2004:480) define a literature review as the “identification and analysis or review of the literature and information related to what is intended to be studied”. A literature review entails seeking relevant, scientifically researched information on the topic. The literature includes books, journals, electronic material and the Internet and research articles. “This process includes identifying potentially relevant sources, an initial assessment of these sources, thorough analysis of the selected sources and the construction of an account integrating and explaining the relevant sources” (Terre Blanche & Durrheim 2004:17). Babbie (1998:A17) adds that it is important to note that every research report should be placed within the context of the general body of scientific knowledge and be based on the general agreement or disagreement of the previous researchers.

Babbie (1998:112) lists the following four questions that a researcher needs to ask when reviewing the literature:

- What have others said about the topic?
- What theories address the topic?
- Is there consistency in the findings or do past studies disagree?
- Are there flaws in the body of existing research that need remedies?

According to De Vos (2001:179), “the prospective researcher can only hope to undertake meaningful research if he is fully up to date with existing knowledge on his prospective subject”. Burns and Grove (2007:31) add that the researcher must be knowledgeable about the world and this knowledge is obtained from clinical and other personal experiences and the conducting of a literature review

The purpose of a literature search or review, according to De Vos (2001:180), is to familiarise the researcher with the topic and to determine whether the information is relevant and actually exists, and what kind of information is available from the sources.

Terre Blanche and Durrheim (2004:18-20) list the following purposes of a literature review:

- Puts the research project into perspective, identifies the knowledge gaps and provides information that will help refine the research by providing up to date and current information on the topic.
- Identifies the theoretical framework that serves as an orientation for gathering facts and specifies the type of facts to be observed.
- Identifies the issues and variables related to the research topic.
- Assists in the development of a working bibliography by compiling notes as relevant material is gathered.
- Identifies conceptual and operational definitions and the research methodologies.

In this chapter, a comprehensive literature overview is provided on the importance of cultural knowledge as applied to non-Muslim nurses providing health care to Saudi Arabian childbearing women.

## **2.2 CULTURAL KNOWLEDGE DEVELOPMENT**

Health care providers care for patients from different cultural groups. "Diversity" is a word often associated with cultural differences and is derived from the Latin word meaning; "being different or having differences" (*Longman Dictionary of Contemporary English* 2005:456). According to Andrews and Boyle (2003:7), cultural diversity refers to the differences among people, the extent that they are compared to their race, ethnicity, religion, age, and social and economic status. Boyle (2007:22S) points out that the application of cultural competence to practice requires being sensitive to the cultural diversities of people throughout the world. Pacquiao (2007:34S) states that cultural competence removes health disparities and outcomes challenges associated with cultural diversity. Nursing should aim at professional commitment in building a global

community that is inclusive, respectful and dedicated to global health care for all (Kulwicki 2006:396).

Jones, Cason and Bond (2004:290) investigated the cultural attitudes, knowledge, and skills of the healthcare providers and found that cultural knowledge and educational preparation of nurses influence cultural skills. In addition, Jones et al (2004:290) emphasise that knowledge of cultural concepts make nurses more confident to care for patients in a more culturally sensitive way. Although educational interventions may enhance nurses' knowledge, it is questionable whether such enhancement of knowledge yields conclusive evidence of improved patient care outcomes.

Narayanasamy (2003:194) found that health care providers should deliver a service that is culturally sensitive and appropriate. Among other things, Narayanasamy (2003:194) discovered that patients listed their needs as special diets, communication, care for the dying, time for prayer and respect for religious and cultural practices. Furthermore, a significant number of health care providers suggested that health care providers required further education to meet the cultural needs of the patients. Masson (2005:95) maintains that health care providers should make time to communicate with the patients with the aim of understanding their cultural preferences and practices.

Chenowethm, Jeon, Goff and Burke (2006:35) point out that cultural competence and knowledge assessment has been researched and studied in Australia, Canada and the United States of America (USA). In these countries, cultural competence was assessed among nurses who care for patients from different cultural groups. Luna (1998:8) states that nurses from all over the world care for the patient in his/her own country and the nurse is the outsider and is entering a culture different from her/his own.

According to Crigger and Holcomb (2007:70), health care providers may not understand or be aware of patients' cultural practices and this may lead to "misunderstandings" which could have dire consequences Eshleman and Davidhizar (2006:180) emphasise that much of the existing literature encourages health care providers to become "culturally competent" by participating in educational activities like story-telling, literature reviews and international symposia. Crigger and Holcomb (2007:74), however, warn against the belief of gaining "instant cultural competence" resulting in "oversimplifying the complexities" of that culture. Cultural competence is a process the health care

provider needs to develop continuously by aiming at acquiring cultural knowledge of others on a daily basis (Tjale & De Villiers 2004:33). Pacquiao (2007:29S) adds that health care providers' educational interactions will improve their knowledge, attitudes, skills in cultural competence and thus influence patient satisfaction.

Flowers (2004:48) is of the opinion that nurses in the 21<sup>st</sup> century need to be culturally competent because of the multicultural society that they serve. The nurse needs to be aware that there is a relationship between the patient's culture and his/her health. Thus Flowers (2004:51) views culture as a variable, which influences the health care beliefs and practices of nursing care. From this comment it could be deduced that knowledge of the culture may lead to effective interaction and appropriate responses to patients' needs.

De Sandre (2000:82) are of the opinion that midwives are ideal health care promoters of the woman's health throughout her lifespan. Their focus is wellness and health education of the mother and child. Foley and Wurmser (2004:122) are of opinion that nurses should pay closer attention to the patient's cultural needs for better health care outcomes. With this knowledge base, health care providers should be able to develop care plans based on cultural considerations of the patients (Wells 2000:199). As a predominantly female group, midwives are an excellent source of qualified providers for childbearing women (De Sandre 2000:82).

Cultural knowledge, according to Leininger and McFarland (2002:276), may reduce stress, conflict and practices that prevent cultural problems and offensive acts. Nurses have to study a culture's religious beliefs, values and ways of life in advance and/or monitor the actions of a culture in question (Leininger & McFarland 2002:276).

### **2.3 THE NURSE-PATIENT RELATIONSHIP AND CULTURE**

According to Boyle (2007:29S), cultural competence "enables individuals to care effectively for diverse cultures, groups and communities". Pacquiao (2007:28S) maintains that "bias, prejudices, stereotypes, time pressure" influence clinical decision making and care provision. Thus cultural competence is important in providing patient-centred care and to establish a constructive therapeutic relationship with patients and their family.

The nurse is expected to demonstrate effective communication skills, especially when there are barriers to language and literacy (Masson 2005:98). Boyle (2007:29S) emphasises that “cultural and linguistically congruent services improve care delivery”.

Baldacchino (2006:886) identifies the following nursing competencies for patients’ spiritual care:

- Providing care on a physical, mental, social and spiritual level
- Developing the therapeutic nurse-patient relationship
- Communication with patients
- Identifying the patients’ needs
- Developing a nursing care plan through the nursing process

The nurses’ availability and actual presence is highly appreciated by the patients (Baldacchino 2006:887). Baldacchino (2006:887) found that nurses tend to associate spiritual care with religion. This could be because of lack of knowledge about the definition of spirituality and spiritual care. However, the nurses considered themselves incapable of meeting patients’ spiritual needs (Baldacchino 2006:887). Consequently, nurses recommended further continuing education to ameliorate their nursing care by integrating the spiritual dimensions in care. These educational programmes should also include achieving spiritual care competence (Baldacchino 2006:896). Nurses should take the initiative in increasing their knowledge about spiritual care and give priority to reflection in and on their clinical practice to enhance patient care (Baldacchino 2006:896). Supporting this statement is Al-Shahri’s (2002:135) view that the expression of spiritual healing by health care providers “may establish a good nurse patient relationship”.

Bau (2007:5S) recommends that health care providers establish a constructive therapeutic relationship with patients in a single encounter or over an extended period of hospitalisation. Nurses who understand patients’ conditions can respond with the appropriate care giving skills. According to Betancourt (2007:27S), educators should take on the challenge of teaching and evaluating the knowledge and skill demonstrating cultural competence among health care providers. Nursing school faculties and nurse preceptors and mentors can use these recommendations to ensure that the nursing students and trainees are equipped with appropriate skills to be effective, more

culturally sensitive and competent nurses (Bau 2007:6S). Flaskerud (2007:122) concurs, stating that cultural sensitivity includes “valuing and respecting the beliefs, norms practices of the people served”. Interacting with and responding to individuals’ needs in the health care service is essential in order to achieve cultural competence” (Flaskerud 2007:123).

Patients and families bring different worldviews and life experiences and beliefs about their health to the clinical environment. The nurse is thus expected to observe, listen, ask and work with the patient to understand and heal (Masson 2005:97). Due to the cultural diversity existing in the health care environment, Bau (2007:5S) advises health care professionals to continue increasing their cultural awareness, knowledge, experience and skills. Furthermore, Bau (2007:5S) explains that the objectives of the current health care institutions are to integrate cultural competency in the education and training of health care providers. Betancourt (2007:25S-27S) supports this view.

Willis (1999:48) investigated the culturally competent nursing care during the prenatal period, and identifies the following steps in the cultural competence framework:

- Knowledge of one's own cultural affiliation: beliefs, values, and life ways
- Knowledge of others’ cultural beliefs, values, and life ways
- Non-threatening/non-fear provoking interaction with different cultures
- Tolerance
- Inclusion
- Appreciation/acceptance and respecting others’ culture
- Cultural competence development

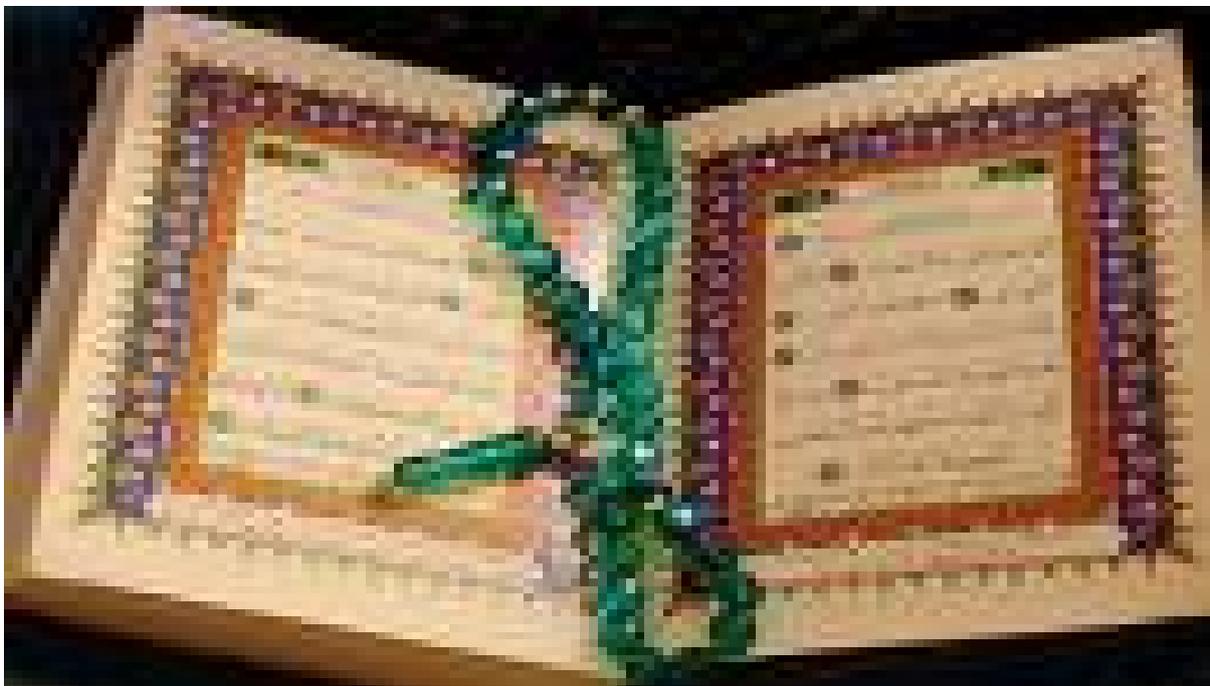
In support of Willis’ steps, Schim, Doorenbos, Benkert and Miller (2007:105), developed a puzzle for health care providers, which contains the following pieces:

- cultural diversity
- cultural awareness
- cultural sensitivity and
- cultural competence

Although the midwives may come from a different cultural group, they are required to render culturally competent care to the mothers and their newborn babies (Callister 2001:209). Moreover, according to Callister (2001:210), “in the technologically complex and bureaucratic world of health care delivery, cultural considerations in the provision of care are often overlooked and neglected”. Schim et al (2007:109) point out that cultural competence changes over time and the individual has the opportunity to “gain awareness and sensitivity, learn skills and expand abilities”. Although people come from different cultural groups, they have the potential to change their perceptions and attitudes through accommodation and adaptation to cultural practices different from their own (Schim et al (2007:109).

## **2.4 FOUNDATION OF THE ISLAM FAITH**

Islam is an Arabic word meaning the act of “total submission to the Will of Allah God” (Andrews & Boyle 2003:476; Al-Shahri 2002:134). The Muslim is a believer in the Islam faith and lives according to the teachings of the Qur’an, which is the Holy Book of Islam (Andrews & Boyle 2003:477; Al-Shahri 2002:134).



***Figure 2.1***

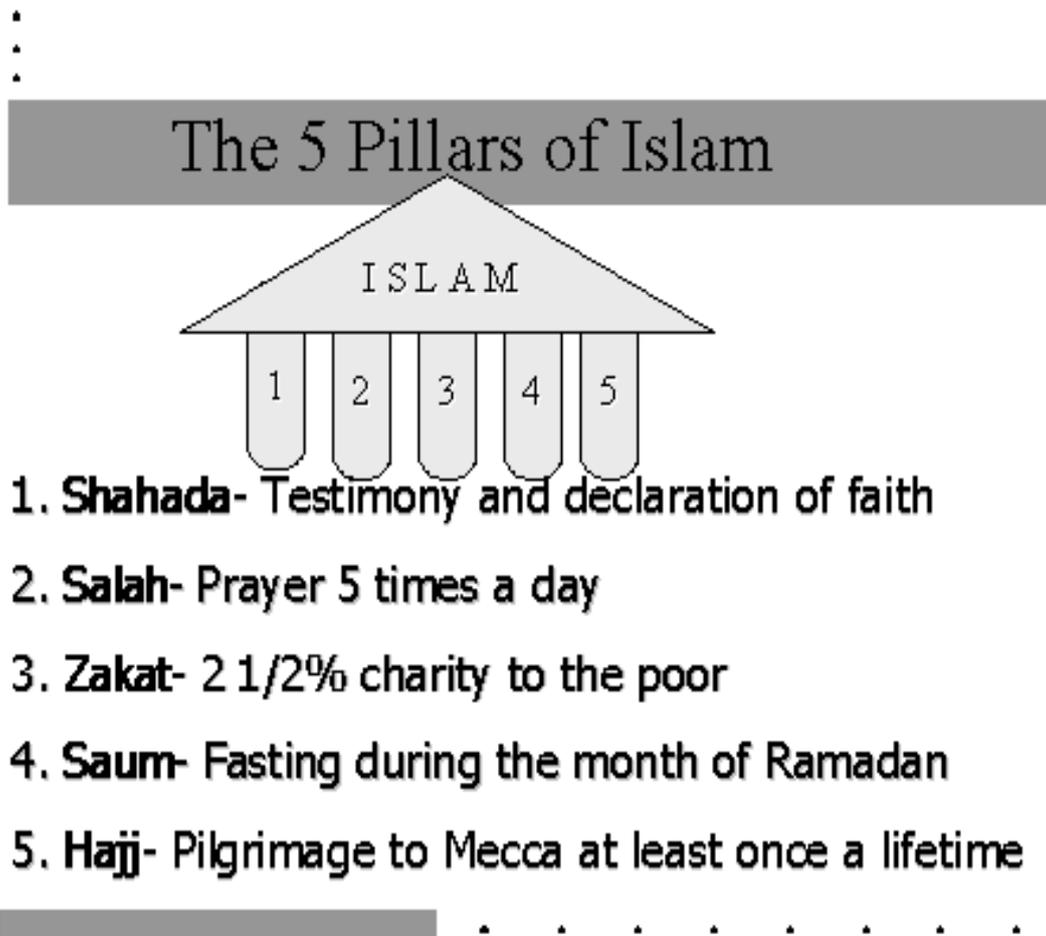
***The Qur'an***

Source: Far2.static.flicker (2007)

According to Leininger and McFarland (2002:303), nothing should be placed on the Qur'an, other than religious items, for it is regarded as taboo to do so (figure 2.1).

Islam is founded on five pillars, which form the basis of the Muslim's faith (Andrews & Boyle 2003:476-477; Leininger & McFarland 2002:302; Tjale & De Villiers 2004:97-98).

Figure 2.2 is a schematic presentation of the pillars.



**Figure 2.2**

***The five pillars of Islam***

Source: media4islam (2008)

Leininger and McFarland (2002:304-306) explain the five Pillars as follows:

- **Confession of faith**, which is uttered on a number of occasions at birth or death: *lā ilāha illa Allāh* (“there is no God but God”) and Muhammed is the prophet of God.
- **Prayer** is the second duty of a Muslim and is performed at special hours, five times each day. Prayer is obligatory to a Muslim (figure 2.2).



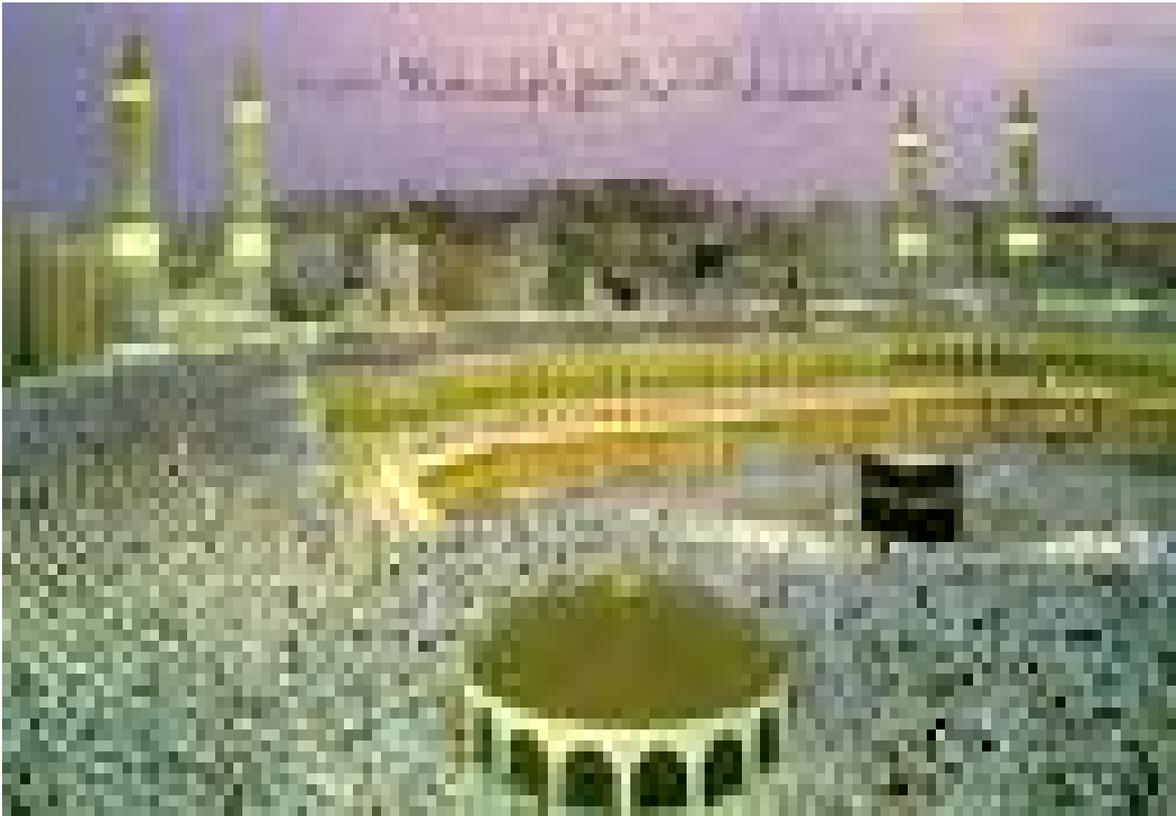
**Figure 2.3**

***Prayer inside the Mosque***

Source: media4islam (2008)

A Muslim would carry out the purification rituals of prayer by washing of the feet up to the ankles, the arms up to the elbows, the face and the inside of the ears. A part of the worship ritual includes removing the shoes and facing Mecca. Prayer maintains health and well being. Prayer beads are common symbols used by both males and females to recall the ninety-nine attributes of Allah listed in the Qur'an. Beads are a reminder to Muslims of the nearness of God.

- **Obligation of almsgiving** or giving to the needy. The Qur'an stipulates that "one should share with the less fortunate the blessings of wealth that God gave".
- The duty required of Muslim is **fasting** during the month of Ramadan. No food or drink is taken during daylight hours in Ramadan. Many Muslim patients extend this duty to oral medication. According to Islamic law, the ill, travellers or others whose health could be at risk from fasting are exempted from this obligation. The sick or pregnant Muslim women might want to fast during the month of Ramadan.
- **Pilgrimage** to Mecca, the Holy City of Islam is the fifth duty (figure 2.3). Every pious Muslim strives to perform this duty at least once in his/her lifetime.



**Figure 2.4**

***Id during the hajj (pilgrimage), in Mecca***

Source: media4islam (2008)

According to Leininger and McFarland (2002:304), these pillars produce a sense of fulfilment, well being, health and a source of guidance for Muslims and shape their culture.

Maintaining spiritual health for Muslims, according to Leininger and McFarland (2002:303), is important because the concept of “*tawhid*” (unity) implies that physical health is not separate from the spiritual dimension of “mind and body unity”.

## **2.5 REPRODUCTIVE HEALTH**

According to Boonstra (2001:3), Muslims control their reproductive lives. In addition, the concept of “*Ijtihad*” in the Islamic teachings allows the formulation of independent judgement and interpretation. Muslims therefore are able to take decisions that affect their lives and can make choices on reproductive health issues. Boonstra (2001:5) states that, “the extent of reproductive health services provision varies across the

Muslim world according to the cultural and political context in which women's rights are defined”.

### **2.5.1 Menstruation**

Menstruation is regarded as a normal physiological change in the female body and some cultures associate this period with taboos and the polluting power of the blood (Helman 2002:115). According to Panter-Brick (1991:1298), Muslim women often use oral contraceptives in preparation for their pilgrimage obligations in Mecca, in order to avoid menstruation and the ritual pollution. Muslims practise seclusion during menstruation and women are not allowed to pray or visit the mosque to observe purity (Leininger & McFarland 2002:102).

### **2.5.2 Birth control**

Birth control and family planning are traditionally sensitive topics in Muslim culture. Traditionally, the Muslim woman would consult the husband to decide on the choice of a family planning method (Leininger & McFarland 2002: 307). Islam is permissive of family planning (Andrews & Boyle 2003:479; Boonstra 2001:1; Family planning in Islam and contraception allowance 2007). Islam values procreation and fertility. Children are regarded as a gift from God, the “decoration of life”, according to the Qur'an, because they ensure a continuation of life (Boonstra 2001:3; Leininger & McFarland 2002:306). Most Muslims desire relatively large families.

Burns (2001:4) quotes a verse from the Qur'an namely: *“Allah created you from dust, then from a little fluid, and then He made you pairs (male and female), no female bear or bring forth off-springs save with His knowledge”*. The emphasis is that God does not wish to burden believers, hence the well being of children overrides concerns for a larger family. Based on this, the use of oral contraceptives or implants is encouraged, provided they do not interfere with a woman's health and well being (Boonstra 2001:3). Artificial insemination, on the other hand, is only permitted between a husband and his own wife and no surrogating is allowed or supported (Andrews & Boyle 2003:479; Lawrence 2001:232). Sterilisation is regarded as doing permanent harm to a person's body and is therefore unacceptable to Islam (Boonstra 2001:3; Family planning in Islam and contraception allowance 2007).

Andrews and Boyle (2003:479) state that Islam objects to abortion. Abortion is only permitted for the most serious congenital conditions and/or danger to the women's life, and it is only permissible in the first trimester of pregnancy (Aramesh 2007:30; Boonstra 200:4; Family planning in Islam and contraception allowance 2007).

## **2.6 SOCIAL STRUCTURE**

In other cultures, including those in Latin America, Asia, Africa, and the Middle East, the family and not the individual is the primary unit (Galanti 2006:99). The Saudi Arabian Muslim culture strongly upholds the married status, which is reinforced by the Qur'an teachings that men and women are created mates to treat one another with love, affection and compassion within the bonds of matrimony (Leininger & McFarland 2002:277; Lawrence 2001:230). The Qur'an provides guidance and regulates the relationship between males and females (Tjale & De Villiers 2004:97). The family is the major unit of social organisation of the Muslim culture. The Saudi Arabian is born into the extended family that uses kinship ties to achieve various daily activities and learn values throughout life (Leininger & McFarland 2002:306).

Saudi Arabian Muslims base their moral behaviour and decisions on the Qur'an, which contains the tenets of Islamic religious beliefs and practices. The emphasis is on family honour, unity and social and domestic family responsibility (Panter-Brick 1991:1297). According to Leininger and McFarland (2002:102), men protect and maintain the family and women on the other hand educate the children. Furthermore, one should be careful not to negotiate health care decisions with the woman alone, even if the issue or procedure directly relates to her care. The husband or father should be present. It is traditionally not allowed for the woman to take decisions alone; the husband should be consulted (Al-Shahri 2002:136; Leininger & McFarland 2002:307). Muslims, according to Leininger and McFarland (2002:277), honour family unity, social and family responsibilities.

Leininger and McFarland (2002:308) reflect that visiting the sick by family and friends is regarded as an important social and political function and contributes to the reflection of a caring behaviour. Roberts (2003:254) explains that, by encouraging family and friends to gather during hospitalisation, the Saudi Arabian family is able to provide mutual

support, act as a sounding board for the expression of feelings, and strengthen the ties between members. These gatherings also serve to reaffirm religious convictions. For the Muslims, visiting the sick and dying is more than a courtesy, it is a religious obligation.

## **2.7 CULTURAL AND HEALTHCARE PRACTICES OF MUSLIM CHILDBEARING WOMEN**

Tjale and De Villiers (2004:33) define culture as “an integrated pattern of human behaviour” and the belief and value influenced by the religious and social nature of the person. Ember, Ember and Peregrine (2002:217) define culture as “a set of learned behaviours, beliefs, attitudes and ideals that characterises a particular society or population”.

In Muslim tradition, mothers during pregnancy have certain health care beliefs and engage in practices that may affect their health and that of the unborn baby. Some of the Saudi Arabian health care and cultural practices may adversely affect women during the pregnancy and the lactation period. Some of the practices are thought to be due to gaps in knowledge and false beliefs (Abdulaziz, Al-Othman, Saeed, Bani & Al-Murshed 2002:910).

### **2.7.1 Pregnancy**

Different societies interpret and perceive the changes associated with childbirth, differently. The management of health care issues are affected by and dependent on cultural beliefs, health, medical care, reproduction, and the role and status of women (Mattson 2000:38). These beliefs may contribute to an unwillingness to comply with healthcare practices. Mattson (2000:38) reports that, in the United States of America, health care for women and their unborn babies includes such cultural practices or rituals as formal prenatal care (including childbirth classes), ultrasound viewing of the foetus and hospital delivery. Monitoring foetal status, inducing labour, providing anaesthesia for labour and delivery, and expecting the woman to deliver primarily lying on her back are regarded as part of the Western health care system (Mattson 2000:38).

According to Mattson (2000:42), one should ask the following questions when assessing cultural beliefs and attitudes during the ante partum period:

- Determine society's acceptance of the pregnancy-age, and marriage requirement. *Do they consider pregnancy as a state of illness or health?*
- Dietary prescriptions or restrictions-adherence. *What particular foods must she have or avoid?*
- Activity restrictions or prescriptions, including the use of massage. *What is a "good" environment for the expectant mother?*
- *What emotions may be expressed and what should be restrained?*
- *What is the extent of modesty and its influence during a physical examination?*

Abdulaziz et al (2002:911) express concern over the average daily food intake of the Saudi Arabian pregnant mother. They regard the mother's cultural practices and beliefs associated with their diet during pregnancy as far from satisfactory. Moreover, the Saudi Arabian mother's nutrition lacks in food groups, including milk and milk products, meat and vegetables during pregnancy.

Throughout the world, pregnancy and lactation are considered to be periods of vulnerability to the well being of both mother and child. When the pregnant women's diet does not supply the required nutrients, for example protein, vitamins and essential minerals, for her and the foetus needs, the foetal requirements are met by withdrawing from the tissues of the maternal body. It is therefore important not only to convince mothers to breast-feed but to follow a well balanced diet plan during the ante- and postnatal sessions (Abdulaziz et al 2002:911).

### **2.7.2 Delivery of the foetus (intrapartum period)**

Mattson (2000:42) lists the following questions when assessing cultural beliefs and attitudes during the "intra-partum" period:

- What is an acceptable length for labour? What are acceptable interventions to assist the child during birth? What is the extent of male involvement and support?
- What food intake should be permitted? Are herbal teas used for pain relief and to "hasten birth"?
- What is acceptable for relief of discomfort? What expressions of discomfort are allowed?

- How should the placenta and/or umbilical cord care be disposed?

Leininger and McFarland (2002:484) report that the father usually performs the ritual of whispering a prayer into both ears of the newborn baby immediately after birth. An infant's hair may be shaved and weighed, the value of which in silver is donated to charity. Saffron water is applied to the shaven head and the baby is named (Leininger & McFarland 2002:484). These wards off the "evil eye", the father may read from the Qur'an and/or clean the baby with water containing date stones (Panter-brick 1991:1297).

According to Lovering (2006:392), pain has both a personal and cultural meaning, for the Saudi Arabian Muslim. Expression of pain is culturally determined and communicated to others. The causes of pain are believed to have supernatural or religious explanations without any reference to medical or physiological conditions (Lovering 2006:393). The Saudi Arabian patient attributes pain to predestination and the belief that disease or pain is the "will of God" and provides an opportunity for the atonement of sins and to earn a greater reward in the afterlife. Saudi Arabian women may believe that pain is caused by supernatural spirits, such as the "evil eye" (Panter-brick 1991:1297). An Arab labouring woman will scream and may be highly stressed. The family will be in a panic and demand that the health care provider intervenes (Al-Shahri 2002:134).

Care of the umbilical cord in the Saudi Arabian culture is quite different from that in some Western countries. The Western world has adapted the dry cord care management whereby it is not exposed to air and no ointment or any alcohol is applied to the cord. Muslim mothers usually prepare a cotton belt to wrap around the waist and over the cord of the newborn infant to prevent potential umbilical hernias (Zahr & Hattar-Pollar 1998:352). Muslim culture practices male circumcision of the male infant within a few hours after birth (Lawrence 2001:231). This procedure may be performed by the surgeon at the hospital at the request of the parent.

### **2.7.3 Puerperium**

Mattson's (2000:43) cultural beliefs assessment questions during the puerperium period are:

- Determine when the postpartum period begins and ends. The Western world may say it is six weeks; some cultures believe it lasts 30 days, others longer.
- What dangers for both mother and infant are feared? What are the activity restrictions and prescriptions? These may include restrictions on ambulating, bathing, infant-care taking.
- Are the women considered to be in a state of impurity during the puerperium, which results in seclusion?
- What are the dietary expectations? Some requirements are based on the “hot and cold” theory. The puerperium is a "cold" time (heat has been lost at delivery from the pregnancy that was a "hot" time), so foods should be "hot" in nature. Cold packs for perineal comfort and healing may not be acceptable to women from some cultures, because cold air and water are believed to be harmful and the cause of uterine problems.

Kim-Godwin (2003:76) lists women from the Middle East among those who practise 40-day postpartum seclusion. After birth, the Muslim mother is kept in seclusion for 40 days in which she is massaged and served food rich in nutrients such as milk-based products (Leininger & McFarland 2002:484). This view is contrary to Abdulaziz et al's (2002:911) concern that the Muslim woman's food intake during pregnancy lacks dairy products. Kim-Godwin (2003:76) explains the “hot and cold” theory as a belief among some women that after the birth the bones are still open and having cold drinks will result in health problems like arthritis and rheumatism.

Muslim families may request that the placenta be saved. They believe that everything that lies between the heavens and the earth belongs to “Allah”. The act of burial of the placenta or other removed organs of the human body allows the symbolic return of these to the Creator (Roberts 2003:252).

#### **2.7.4 Breastfeeding**

For the assessment of cultural beliefs and attitudes regarding the newborn, Mattson (2000:43) lists the following:

- Feeding of the infant, including the best method and timing. Is the first feed of colostrum good or bad for the baby (or is it "dirty")? Is bottle-feeding preferred or used until the milk comes in the breast?
- Is there an appropriate person to bathe the infant?
- What ritual beautification practices exist? Where does the baby sleep? How is the umbilical stump cared for?
- Are circumcision and other rituals performed?
- Is there fear of evil influences on the baby?

Muslim women practise both exclusive and partial breastfeeding. Bella and Dabal (1997) investigated the reasons for the decline in breastfeeding among the Saudi Arabian women and found that Saudi Arabian women needed health education about the prenatal period regarding the benefits of breastfeeding. It is important to understand that breastfeeding may not be simply a nutritional or health care choice, but has a religious basis in this population (Roberts 2003:253). Privacy during breastfeeding is difficult but attainable by using portable privacy screens for enclosure and using small baby blankets to cover the mother's breast. Modesty and privacy concerns may lead the hospitalised Muslim woman to use breast pumps and bottle-feed the expressed milk to her newborn baby (Roberts 2003:253).

Al-Jassir, El-Bashir, Moizuddin and Abu-Nayan (2006:6) investigated infants' feeding practices in Saudi Arabia to understand the mothers' attitudes and practices. They noted that more mothers living in a nuclear family unit provided colostrum than mothers who lived with an extended family. This could indicate that established feeding practices are still prevalent and perpetuated through generations. Breast milk is thought to be harmful to a child when the mother is pregnant (Bella & Dabal 1997). According to Al-Jassir et al (2006:8), mothers start feeding their babies with the bottle believing that their breast milk is insufficient

### **2.7.5 Death**

The attitude towards death and dying and the cultural expression of grief may vary in different societies. Traditionally, Muslims believe that whatever happens in life is a result of the destiny of God's will (Leininger & McFarland 2002:308).

Saudi Arabians have their own ritual procedures for preparing the dead for burial. Preparation of the body after death involves the performance of special rituals of washing the body and wrapping it in a special cloth shroud (Andrews & Boyle 2003:480; Leininger & McFarland 2002:309). The foetus that is more than 130 days old is considered a fully-grown human being (Andrews & Boyle 2003:480). The Saudi Arabian may request burial without embalming, often within 24 hours (Roberts 2003:254). Requests for an autopsy should be handled sensitively because this is not a routine practice in this population (Roberts 2003:254). According to Leininger and McFarland (2002:309), in Islamic law a person does not "own" his or her body, therefore organ donation is usually not considered. For Saudi Arabian Muslims, it is important to keep the entire body (including all organs) intact and in their natural state. The body should be buried because they believe in the afterlife (Leininger & McFarland 2002:275). Some families will want to send their loved ones back to their homeland (rural areas) for burial (Roberts 2003:254).

General knowledge and respect of the Islamic religion allows health care providers to deliver competent, compassionate, and respectful care that will help meet the spiritual needs of grieving family members as their newborn approaches death (Robert 2003:253).

### **2.7.6 Saudi Arabian herbal use**

It is believed that Saudi Arabian Muslim mothers use herbal treatment and ointments and that religious healing is acknowledged (Lovering 2006:392). Muslims believe that Allah puts cures in this world and some cures come in the form of herbs. Muslims believe that Muhammad himself used herbal remedies in his time because herbs heal all harms except death (Muslim herbal+remedy: use of herbs for infertility 2007). Herbs are natural thus assumed harmless but there are elements of "*haram*"

forbidden/prohibited ingredients in especially gelatine seeds (Muslim herbal+remedy: use of herbs for infertility 2007). The seed gelatine comes from three main sources, pig, cow and vegetables. Pigs are prohibited by Muslims (Muslim herbal+remedy: use of herbs for infertility 2007). Any medication containing gelatine is prohibited because it may be derived or extracted from pork.

“Black seeds” are derived from a herb and are used for the elimination of flatulence, to provoke menstrual flow and increase milk production. “Fenugreek” is a herb that may be used in the treatment of infertility by increasing semen and stimulating menstruation. “Blessed thistle” increases milk supply (Muslim herbal+remedy: use of herbs for infertility 2007). Herbs to avoid during pregnancy include borage oil, fenugreek, licorice root, St John’s wart, and wormwood (Muslim herbal+remedy: use of herbs for infertility 2007).

According to Burns (2001:1), prescription drugs, over-the-counter medication and herbs can be harmful to the unborn child, but some healing herbs are the best choice for medicine for pregnant women. Herbs that should never be used during pregnancy are tansy, rue, pennyroyal oil, comfrey and goldenseal (Burns 2001:1). Herbs that induce menstruation and thus cause abortion or birth defects are angelica, birthroot, black cohosh, parsley (figure 2.5), yarrow. Senna, coffee, ephedra are considered too strong for pregnant women (Burns 2001:2).



**Figure 2.5**

**Parsley**

Source: Ovvorganics (2007)

Safe for pregnancy is Chamomile tea to aid sleep, spearmint (figure 2.6) to treat fever, and lemon balm, oat straw and red raspberry leaf are helpful in a bath. Ginger roots are good for colds and flu. Lady Mantle and red raspberry leaf, ginger root and slippery elm powder are used for morning sickness (Burns 2001:2).

Oat straw is commonly used for yeast infections and stress during pregnancy. A combination of nettles, red raspberry leaf, spearmint, oat straw and dandelion leaf is recommended for use as a natural multivitamin formula for pregnant women (Burns 2001:2).



**Figure 2.6**

**Spearmint**

Source: Ovvorganics (2007)

Honey and black cumin (Nigella seeds) are believed to have healing powers (Al-Shahri 2002:135).



**Figure 2.7**

***Dandelion leaf (A) and Dandelion leaf tea***

Source: Ovvorganics (2007)

According to Burns (2001:3), pettigrain may be used as postnatal antidepressant oil. Tangerine mixed with carrier oil is rubbed daily to the abdomen to prevent stretch marks. Cypress is an astringent and diuretic and is used for the treatment and prevention of varicose veins. Tea tree oil may be used as an anti bacterial or antiviral herb (Burns 2001:3). In addition, Dandelion leaf (figure 2.7) can help control pregnancy bloating and nettles can increase circulation during the last trimester. All herbal remedies for chronic conditions should be taken not more than three times per day (Burns 2001:4).

### **2.7.7 Diseases common to Saudi Arabian Muslims**

According to Panter-Brick (1991:1295), the Saudi Arabian culture is tribal and heavily consanguineous and this is the leading cause for autosomal recessive diseases. Cousin marriages are the result of the rare, unique common disorders like sickle cell anaemia and Thalassaemia, Sanjad Sakati syndrome and Al-Aqeel-Sewairi syndrome (Al-Aqeel 2004). According to this author, prevention is possible by either pre-implantation genetics diagnosis or prenatal diagnosis according to the recommendations of the Islamic leader. Among other diseases common to this group is the classic phenylketonuria, maple syrup urine disease, Nieman Pick disease, Morquio's disease,

Andhoff's, glycogen storage, fructose diphosphate deficiency, galactocaemia, hypercholesterolaemia, maple syrup urine, classic phenylketonuria homocystinuria, methylmaloric acidaemia, propionic acidaemia (Al-Aqeel 2004; Panter-Brick 1991:1297).

Al-Aqeel (2004) points out that awareness of these disorders is important to facilitate early diagnosis and initiation of treatment especially in cases of organic acidurias and aminoacidemias to prevent neurologic crippling. Premarital screening, pre implantation genetic diagnosis should be done if the exact molecular defect is known. Abortion may be done before 120 days of conception or 134 days from the last menstrual period, if the disorder is life threatening to the mother or gross abnormalities of the foetus is diagnosed (Al-Aqeel 2004).

## **2.8 MUSLIM CHILDBEARING WOMEN'S RITUALS, TABOOS, CULTURAL AND HEALTHCARE BELIEFS**

Saudi Arabian Muslim culture prescribes rituals demonstrated during prayer, taboos associated with food and other health care practices that distinguishes them from other cultures (Lawrence 2001:228).

### **2.8.1 Rituals**

A ritual "is a religious or solemn ceremony involving a series of actions performed according to a set order" (*Oxford Dictionary* 2004:775). People who practise that ritual perform the series of actions in the same way, following a prescribed pattern.

In Saudi Arabian culture, after death the ritual of washing the body by a member of the same sex may be requested (Roberts 2003:254). Muslims have rituals associated with prayer and those performed by the father during the birth of a child. Women are expected to perform a ritual washing after the post partum period or menstruation (Al-Shahri 2002:135). This is a purification ritual, because they regard blood as dirty.

## **2.8.2 Taboos**

A taboo is a “social or religious custom of placing a ban or restriction on a particular thing or person” (*Oxford Dictionary* 2004:924).

Muslims classify some foods as “*halal*” (permitted); others are considered “*haram*” (forbidden) (Roberts 2003:253). Dietary rules and taboos are derived from the religious laws. The consumption of pork, alcohol and improperly slaughtered meat is prohibited (Leininger & McFarland 2002:307). Food is closely linked to care, health and well-being of an individual which indicates that, according to the Muslim, what a person eats and drinks should be in accordance with what is permitted and prohibited by the religion (Leininger & McFarland 2002:208).

Various types of medications are derived from religiously unacceptable sources or contain hidden ingredients that are forbidden by Muslim dietary laws. These medications may contain alcohol, commonly used as a stabilising agent, or some form of pork and its by-product these are banned or forbidden by the Muslims (Roberts 2003:253). Commonly used cough and cold syrups contain alcohol and are forbidden by Muslims. Some brands of gelatine-coated pills and easy-to-swallow capsules are coated with pork gelatine (Roberts 2003:253). Hospital formulary heparin is often pork-derived. Gelatine comes from three main sources, pig, cow and vegetables (Muslim herbal+remedy: use of herbs for infertility 2007).

## **2.8.3 Cultural and health care beliefs**

By looking at providing culturally sensitive care to the childbearing Islamic family, Roberts (2003:251) noted that orthodox Muslims would want to consult the Qur'an for ethical decision-making.

### **2.8.3.1 *The use of “henna”***

Muslim women usually use a substance to paint their hands and feet. Henna (a herbal dye) is applied to the palms and top of the hands and soles and top of the feet as a good omen when used in marriage and other ceremonies by women (Leininger &

McFarland 2002:102). Henna is known for its cooling effect on the head, palm of the hand and the sole of the feet during the hot summers.

### **2.8.3.2 The meaning of the “evil eye”**

The Saudi Arabian childbearing women believe that illness is a form of God's (Allah's) punishment, for the remission of sins of the past (Al-Shahri 2002:134). It is God who inflicts illnesses and God who heals (Tjale & De Villiers 2004:99). They also believe that disease is caused by supernatural powers such as the “evil eye”, which is a very powerful force that is inflicted or cast by envious people (Leininger & McFarland 2002:308).



**Figure 2.8**

#### ***Muslim prayer beads***

Source: Photographerdirect (2007)

Saudi Arabian mothers use relics, amulets, such as charms, blue beads and other protective measures to ward off the “evil eye” (Leininger & McFarland 2002:308). The *Oxford Dictionary* (2004:756) defines relics as “belongings or objects treated as holy”. Muslim mothers may feel the need to use amulets or blue beads to protect the sick child from the harmful effects of the evil eye (Zahr & Hattar-Pollara 1998:354). Amulets are defined as “pieces of jewellery worn as protection against evil” (*Oxford Dictionary*

2004:27). Amulets should not be removed from the child's clothing or bed, even when the child is going for surgery. Sensitivity to and understanding of such deeply held folk beliefs, as well as allowing such practices if not harmful, enhance mutual respect, reciprocity, and compliance. (Zahr & Hattar-Pollara 1998:354).

Lovering (2006:392) shares a story related by one of the participants whose sister died suddenly because the family member cast the "evil eye" upon her. The family member admired her beauty and did not conclude the praise with "*masha'Allah*". "*Masha*" meaning blessing and "Allah" is the Islamic name for God. This means that the family member failed to invite or ask for Allah's protection of the beauty against the "evil eye" (Lovering 2006:392). To avoid the contribution that may lead to the casting of the evil eye, if the admiration is given by a nurse she needs to follow the praise with the words "*Bis-mallah*" (God's blessings) and touching the infant (Leininger & McFarland 2002:308).

### **2.8.3.3 *The practice of consanguinity***

Consanguinity is "the custom of marrying one's cousin" (Panter-Brick 1991:1299). This practice contributes to the high incidence of metabolic and neurological disorders. According to Al-Aqeel (2004), some of the metabolic diseases may not be understood by health practitioners from the Western world.

### **2.8.3.4 *The meaning of "Ko'hl"***

Muslims use a substance called Ko'hl (a charcoal-like substance) as an eye cosmetic or they apply it on the umbilical cord to dry faster (Leininger & McFarland 2002:102). However, recent research findings prove that Ko'hl is damaging to the growth and development of the child.

Ko'hl, which contains lead sulphate, is used for beauty and curing of diseases, according to Muslim beliefs (Leininger & McFarland 2002:152).



**Figure 2.9**

***Koh'l***

Source: Anvil (2007)

#### **2.8.3.5 The significance of modesty**

For a traditional woman, keeping her body covered is essential. Although most healthcare professionals may be too busy to worry about something as seemingly inconsequential as modesty, for the Muslim patient it can make a huge difference. Privacy, being cared for by a female health care provider, covering the body and head and face is a very important way of demonstrating modesty (Leininger & McFarland 2002:305).



A



B

**Figure 2.10**

***Muslim women's dress: the Tarha (A) and Abaya (B)***

Source: Immigrationwatchdog (2007)

When caring for Muslim women, modesty must be respected at all times. Their religion requires strict sexual segregation (Galanti 2006:98). Furthermore, Galanti (2006:99) relates a story of a nurse caring for an Arab-Muslim woman being prepared for a colonoscopy. It was important to the patient that everyone involved in her care should be female. Accommodating the patient required shifting the entire staff. The patient also requested that she be covered at all times, so they provided a towel for her head and additional draping.

Saudi Arabian women wear an “*Abayah*” (figure 2.10 B), a black, cloak-like long dress and a “*tarha*” (figure 2.10 A), a head scarf (Al-Shahri 2002:135).

Tsianakas and Liamputtong (2002:26) studied the types of headdress worn by the Muslim women called the “*hijab*”. In the women’s’ opinions, the way they presented themselves caused them to endure many difficulties. They explained that covering up due to their tradition of modesty restrictions, created problems when accessing health care.

Leininger and McFarland (2002:304) state that, the “halal” code is also demanded in the manner of dress. Clothing according to Islamic code must be considered at all times, as this represents decency, modesty and chastity for both men and women.

Traditionally, females expect to have female caregivers. The female nurse should remain with the client if a male physician visits, to prevent exposure and maintain privacy and it is preferred that the husband should be present during medical examinations (Leininger & McFarland 2002:305).

Muslim women need female doctors. If the physician is male, privacy and respecting religious beliefs and ensuring that there are female doctors and nurses, is important (Tsianakas & Liamputtong 2002:31). Women claim that all it would take is to tolerate and accept people’s cultures and religions and provide equal care for all. The best way for health care providers to understand cultural practices and taboos is to gain background information about people who come from different cultural backgrounds than themselves (Tsianakas & Liamputtong 2002:32).

#### **2.8.4 General considerations when caring for Muslim women**

Gebara and Tashjian (2006:387) formulated a nursing action/intervention checklist to use when caring for the Muslim clients: This checklist contains the following:

- Ensuring or maintaining the patient’s spirituality for example respecting and providing religious material.
- Providing privacy.
- If the health care provider is a Muslim, she may read the holy Qu’ran for the patient.
- Keep the patient’s private parts covered.
- Respect and provide privacy for religious practices like prayers or reading the Qu’ran.
- The dead person’s feet or soles should face the “*Qibla*” (arrow indicating the direction of prayer).
- Timing of burial should be done as soon after death as possible before the last prayer of the day.

- Non-Muslims may comfort a bereaved family by saying “Thanks be to God (*Al-hamduli’llah*)” and “we all come from Allah and we shall return to Him”.

## 2.9 CONCLUSION

This chapter emphasised that the nursing goal is to provide cultural congruent nursing care, which is defined as those assistive supportive, facilitative or enabling acts or decisions that include culture care values, beliefs and life ways to provide meaningful, beneficial and satisfying care for the health and well being of people or for those facing death or disability.

Moreover, all cultures recognise pregnancy and birth as a special transition period and many have particular customs and beliefs. Saudi Arabians have a rich cultural heritage with culturally patterned behaviours, health beliefs, and health practices and with a specific value orientation that is different from that of the West. If cultural factors are not given due consideration, the health-related interactions of Saudi Arabians with the Western health care system may become frustrating to the patient and the health care providers, and the desired outcomes may be jeopardised. Cultural education intervention is aimed at enhancing the understanding of cultural factors and concepts that could affect the outcome of Western health care provided to Saudi Arabian childbearing women.

It is evident from the information provided in this chapter that nurses have a difficult job and frequently care for a number of patients at one time. Having several family members underfoot *and* asking questions can be overwhelming. However, nurses who want to be culturally competent need to consider the needs of their patients. For many people, particularly those from cultures in which the family is the primary unit, when someone is ill, it can be devastating.

Chapter 3 describes the research design and methodology, including data collection and analysis, population and sampling, validity and reliability, scope and limitations and ethical considerations of the study.

## **CHAPTER 3**

### **Research design and methodology**

#### **3.1 INTRODUCTION**

This chapter describes the research design and methodology used to achieve the set objectives of the study. Accordingly, the population, data collection, validity and reliability, and the ethical considerations are described. All these steps form part of the research process and are logically connected to each other as well as to the theoretical foundation of the study (Burns & Grove 2007:31).

The purpose of this study was to explore non-Muslim nurses' cultural knowledge and competence in rendering quality care to Saudi Arabian obstetric patients. The design and methodology enabled the researcher to conduct a needs assessment to determine whether the respondents in this study lacked Muslim cultural knowledge or not.

#### **3.2 RESEARCH DESIGN AND METHODOLOGY**

Polit and Beck (2004:49) refer to the research design as the “architectural backbone of the study”. The research design describes the strategies researchers select in order to generate evidence that is accurate and interpretive. It incorporates important methodological decisions that researchers make (Polit & Beck 2004:162). McMillan and Schumacher (2001:166) add further that the intended goal of the design is to provide “credibility in answering the research question and to eliminate or minimise errors”. According to Terre Blanche and Durrheim (2004:29), the research design is a “strategic framework for the execution or implementation of the research process”. It guides the researcher to obtain the intended information (Burns & Grove 2001:223). The design identifies the individuals to be studied, where, when and under what circumstances (McMillan & Schumacher 2001:166).

Choosing a design depends on the problem and purpose of the study and the intent to generalise the findings (Burns & Grove 2007:38). In addition, Polit and Beck (2004:731)

regard the design as techniques in a study that enable the researcher to gather and analyse data systematically.

This study was quantitative in nature and followed an applied, non-experimental, descriptive design. Applied (practical) research is regarded as a scientific investigation conducted to generate knowledge that aims to directly influence or improve the quality of care in practice (Burns & Grove 2007:27). The findings of the study would determine whether the participants possessed Saudi Arabian cultural knowledge that would enable them to render culturally competent care.

### **3.2.1 Definitions of terms**

For the purpose of this study, the following research terms were used as defined below: *applied, convenience, descriptive, non-experimental, probability and quantitative.*

#### **3.2.1.1 Applied research**

Applied research as a scientific investigation enables the researcher to “generate knowledge with the aim to directly influence or improve clinical practice” (Burns & Grove 2007:27). Burns and Grove go on to explain that knowledge discovered through applied research is examined for usefulness in practice.

The outcome of the needs assessment in this study would determine whether the participants had sufficient knowledge of Saudi Arabian culture and cultural practices, especially regarding Saudi Arabian obstetric patients. This knowledge should empower nurses to render culturally competent care to these patients. Culturally competent care is directed at the patient and aimed at improving clinical practice.

### **3.2.1.2 Convenience**

Convenience sampling, or non-probability sampling, enables the researcher to use any available elements of the population that meet the criteria to participate in the study (Tylor, Kermodé & Roberts 2006:205). In this study, all the non-Muslim nurses working in the obstetric units and who fit the selection criteria (see sections 3.3.3 and 3.3.4) were targeted to participate.

### **3.2.1.3 Cumulative percentage**

The cumulative percentage adds the percentage for a given value to the percentages for all the preceding values (Polit & Beck 2004:469).

### **3.2.1.4 Descriptive**

In descriptive studies, researchers' intention is to "portray an accurate picture of reality" (Stommel & Wills 2004:437). McMillan and Schumacher (2001:283) describe descriptive research as "concerned with the current status of something and 'asks' what is and reports things as they are".

The purpose of descriptive research is "to observe, explore, describe and document aspects of a situation as it naturally occurs" (Polit & Beck 2004:192). Descriptive studies have little or no researcher control. Subjects are examined as they exist in their natural settings, for example, in their homes, hospital or at work (Burns & Grove 2007:28). Descriptive research is "the exploration and description of a phenomenon in real-life situations. It provides an accurate account of characteristics of particular individuals, situations or groups" (Burns & Grove 2007:24). The outcome of descriptive research includes the description of concepts, identification of relationships, and development of hypotheses that provide a basis for future quantitative research (Burns & Grove 2007:25).

In this study, the researcher aimed to describe Saudi Arabian cultural practices and to explore non-Muslim nurses' cultural knowledge. The knowledge assessment was current and the findings would determine whether or not the nurses had Saudi Arabian

cultural knowledge. The study was descriptive because it wished to describe and assess Saudi Arabian cultural knowledge among non-Muslim nurses working in the obstetric unit of the King Faisal Specialist Hospital and Research Centre, Jeddah.

### **3.2.1.5 Frequency**

According to Polit and Beck (2004:719), frequency indicates “the systematic arrangement of numeric values from the lowest to the highest together with a count of the number of times the score values were obtained”. Burns and Grove (2007:541) define a frequency distribution as “a statistical procedure that lists all possible measures of a variable and tallies each datum on the listing”. Adding up all the frequencies is called the “f”, and this equals the total number of the sample size ( $\Sigma f = n$ ) (Wilson 1989:513). In this equation, the symbol “ $\Sigma$ ” indicates the sum of (Polit & Beck 2004:469). The symbol “n” represents the number of subjects in a subgroup of a study (for example, “the group had an “n” of 23 for a total “N” of 50”) (Polit & Beck 2004:724).

### **3.2.1.6 Non-experimental**

In non-experimental studies, participants are not and ethically cannot be exposed to experimental manipulation (Polit & Beck 2004:188). The setting of the study is natural and is exposed to environmental influences. The researcher can thus not control nor influence the response of the participants (Stommel & Wills 2004:359).

In this study, the researcher did not manipulate the participants while exploring the common phenomenon under investigation. The cultural competence of healthcare providers is best investigated in the practical, natural environment.

### **3.2.1.7 Probability and non-probability sampling**

In probability sampling, the random selection of study participants ensures that the study findings will be generalised to the target population. A non-probability sample does not attempt to portray the study population and the results cannot be generalised (Taylor et al 2006:203).

The researcher conducted this study in one specific setting and selected the obstetric

unit. The findings of this study therefore only apply to the non-Muslim obstetric nurses at the King Faisal Specialist Hospital, Jeddah. Consequently, the study findings cannot be generalised beyond the study setting.

#### **3.2.1.8 Quantitative**

Quantitative studies allow the investigator to obtain answers to a question in a linear sequence of steps (Polit & Beck 2004:47-48). The specific steps in the study can be revised and implemented differently in order to reach the end point (Burns & Grove 2007:30). In quantitative studies, researchers make use of numbers to measure the phenomena under investigation (Stommel & Wills 2004:442). According to Polit and Beck (2004:49), quantitative study designs are highly structured, formal, objective, rigorous, and systematic processes for generating information about the world.

In this study, the researcher followed quantitative research method steps. The data-collection instrument was a structured questionnaire that would allow quantification of the data.

#### **3.2.1.9 Valid percentage**

Valid percentage is a percentage of each category after removing any missing values (Polit & Beck 2004:469). The missing value thus indicates the number of participants who did not answer a specific question. Some participants may not answer all the questions on the questionnaire.

### **3.3 RESEARCH METHODOLOGY**

Burns and Grove (2001:26) describe research methodologies as quantitative and qualitative and include the outcomes and intervention research. Polit and Beck (2004:731) define the research method as “techniques used to structure the investigation”. The data collection and analysis follows a systematic, well-organised plan. The research method is a process and includes specific steps linked logically to investigate the phenomena in the study (Burns & Grove 2007:28).

The population, sampling technique, inclusion and exclusion criteria, method of data

collection, validity and reliability, and the ethical considerations discussed in the following subsections.

### **3.3.1 Population**

Burns and Grove (2007:40) define the population as “all elements of individuals, objects, events, or substances that meet the study criteria”. The population selected should be able to answer the research question (Taylor et al 2006:201). In addition, Taylor et al explain that the population that the researcher wishes to study is called the target population.

In this study, the target population comprise all the non-Muslim nurses working in the obstetric units of the King Faisal Specialist Hospital and Research Centre, Jeddah because they need to have cultural knowledge about childbearing Saudi Arabian women.

### **3.3.2 Sample**

Terre Blanche and Durrheim (2004:44) state that sampling involves decisions about “which people, events, behaviour or social processes are selected and/or observed”. The aim of sampling is to select subjects that will be representative of the population about which the researcher aims to draw conclusions regarding what is being studied (Terre Blanche & Durrheim 2004:44).

The population in this study comprised all the nurses of different nationalities working in the obstetric unit. The sample selected consisted of non-Muslim nurses because the researcher assumed that they might not have the cultural knowledge needed to care for the childbearing Islamic women.

The population for the study consisted of all the nurses, from the head nurse to the lowest level of nursing assistants, who staff the obstetric units. In this case, the population totalled sixty-seven (67) nurses. Of the population, fifty-seven (57) were non-Muslim nurses who were approached to participate in the study. Only those willing to participate were targeted since participation was voluntary. Their willingness to

participate was assessed by means of the completed questionnaires returned. The questionnaires were self-administered. No nurse was coerced to participate.

### **3.3.3 Sampling**

Burns and Grove (2007:40) define sampling as the process of “selecting a group of people, events, behaviours or other elements” able to give the information needed to conduct a study. Sampling means choosing from the population being studied (Taylor et al 2006:202).

According to Burns and Grove (2007:29), descriptive studies are often conducted with non-random or non-probability sampling in which the subjects are selected on the basis of convenience. In non-probability sampling, the subjective judgement contributes to the selection of the sample and allows exploratory research that will establish whether or not the problem exists. The results, however, cannot be generalised to the population from the findings of the sample (Taylor et al 2006:205).

In this study, the sample comprised non-Muslim nurses chosen from the population of the obstetric nurses at the King Faisal Specialist Hospital and Research Centre, Jeddah. The sample was conveniently chosen because they were available and met the selection criteria. In order to obtain their consent, the researcher explained the aim of the study and the subjects' role or responsibilities (see Annexure D: Questionnaire).

The researcher obtained a list of all the nurses currently working in the obstetric units from the duty rosters. Each individual was personally informed about the study and only those willing to participate in the study and who were non-Muslim were chosen. Those willing to participate completed the questionnaire when it was administered. It was not necessary to sign an informed consent form, the covering letter attached to the questionnaire contained information regarding the right to participate or refusal to do so (see Annexure D: Questionnaire).

### **3.3.4 Inclusion criteria**

In order for researchers to have the ideal participants who are able to give answers to the set objectives, inclusion criteria need to be stipulated. Stommel and Wills (2004:299)

point out those inclusion criteria are “delineated” according to characteristics that will differentiate study participants from the rest of the targeted population.

In this study, the researcher included all the non-Muslim nurses working in the obstetric units of the participating hospital.

### **3.3.5 Exclusion criteria**

From the accessible study population, researchers may exclude some members who lack one or more characteristics needed in the study (Stommel & Wills 2004:299).

In this study, the researcher excluded the Egyptian, Jordanian and Saudi Arabian Muslims from the study because they were of the Islamic faith and their culture was under study. The purpose of the study was to determine non-Muslim nurses’ knowledge of the Muslim culture/tradition.

### **3.3.6 Setting**

Burns and Grove (2007:29) describe the setting as “the environment in which a study is conducted, being natural or field setting or in a laboratory”. Furthermore, the natural setting is non-manipulative or unchanged by the researcher. Descriptive studies are conducted in a natural setting. Taylor et al (2006:200) add that in a naturalistic setting, people carry out activities of daily life such as working, playing or whatever phenomenon is under investigation.

This study was conducted at one of the Saudi Arabian hospitals, the King Faisal Specialist Hospital and Research Centre, Jeddah. The target population comprised non-Muslim nurses working in the obstetric units of this hospital. The setting was natural because the study was conducted in the obstetric units of the King Faisal Hospital where the participants worked.

### **3.3.7 Data collection**

Burns and Grove (2007:41) point out that during this stage, researchers use precise and systematic methods of gathering information relevant to the research purpose or the

specific objectives, questions or hypothesis of a study. The researcher must obtain permission from the setting or agency where the study is to be conducted (Burns & Grove 2007:41).

Researchers use a variety of techniques for collecting and measuring the data; for example, interviews, questionnaires, and scales (Burns & Grove 2007:41). Data collection and measurement are related and in quantitative research, the measurement requires quantification by means of standardised procedures for converting the data collected into numerical scores to facilitate analysis (Stommel & Wills 2004:244).

In this study, the researcher used a structured questionnaire that would enable the data analysis to be quantitative (see Annexure D: Questionnaire). The researcher obtained permission to conduct the study from the Institutional Research Board of the King Faisal Specialist Hospital and Research Centre, Jeddah (see Annexure B: Application for approval from King Faisal Specialist Hospital and Research Centre, Jeddah's Institutional Review Board). After several submissions and corrections, permission to conduct the study was granted by the hospital (see Annexure C: Approval from King Faisal Specialist Hospital and Research Centre, Jeddah's Institutional Review Board) and the Research and Ethics Committee, Department of Health Studies, Unisa (see Annexure G).

### **3.4 DATA-COLLECTION INSTRUMENT**

Measurement is the process of allocating numbers to objects or events or situations based on specific rules (Burns & Grove 2007:40). A component of measurement is "instrumentation" which is the application of specific rules to the development of a measurement device or instrument (Burns & Grove 2007:40).

A structured questionnaire enabled the researcher to analyse the data quantitatively. Structured questions (also called limited response or selected response questions) are followed with a set of choices and respondents select one of the choices as an answer (McMillan & Schumacher 2001:26-9). The questions developed for this study focused on assessing the non-Muslim obstetric nurses' cultural knowledge of the taboos, rituals, beliefs, health care and cultural practices of Saudi Arabian childbearing women, during

pregnancy, intrapartum, and postpartum. Some of the questions were general to Muslim women and some were specific to Saudi Arabian childbearing women.

### **3.4.1 Development of a data-collection instrument**

In order to collect the needed data or information in the study, researchers need to develop a measuring instrument, to be given to all the participants, to ensure uniformity and consistency. According to McMillan and Schumacher (2001:185), there might be a need to develop a new measuring instrument for the research evaluation for a specific setting.

Taylor et al (2006:222-224) list the following criteria for the development of a questionnaire:

- The concepts should be relevant to the study question
- Concepts should be translated into items
- One question per item
- Items should be worded clearly
- The most important items should be placed at the beginning of the questionnaire

In this study, the research methodology was quantitative, which required that all the participants to be exposed to the same measuring instrument. Accordingly, the researcher developed a new questionnaire in order to obtain the relevant information needed for this study. The questionnaire items facilitated quantification of the results thus meeting the requirements for quantitative data analysis.

### **3.4.2 Structure of the questionnaire**

Gerrish and Lacey (2006:369) state that when designing a questionnaire, the researcher should decide what, how and why questions need to be asked. In addition, Gerrish and Lacey (2006:369) stress that the questions should be relevant and the language should be at the level of the participants.

In this study, the questionnaire consisted of two sections. Section A consisted of the participants' demographic information. This section did not require the participants'

identity, thus ensuring confidentiality and anonymity. The purpose of this section was to determine the participants' nationality, age and experience.

Section A contained eight questions, requiring the following demographic data:

1. Age
2. Religion
3. Nationality
4. Designation
5. Nursing experience
6. Nursing units
7. Number of years in the specific nursing unit
8. Saudi Arabian nursing experience

Section B contained questions that investigated the participants' knowledge of the cultural and health care practices of Muslim women. The section included open-ended and closed questions. Ranking and Likert scales were used to quantify the responses (Gerrish & Lacey 2006:369-373; Terre Blanche & Durrheim 2004:295-297) (see Annexure D: Questionnaire).

The questions were structured to achieve the set objectives of the study. This section consisted of twenty-eight (25) questions to assess the participants' Saudi Arabian cultural knowledge. The questions were structured in such a way that they require answers to the cultural and health care practices of Muslim childbearing women, and covered the following aspects:

1. The assessment, upon admission, of herbal remedies use during pregnancy.
2. Herbal remedies used by Saudi Arabian women during pregnancy.
3. Nurses' considerations of specific diseases common among Saudi Arabians
4. Diseases common/specific to the Saudi Arabians
5. Nursing care plans that include Saudi Arabian cultural aspects
6. Muslim cultural practices associated with the placenta
7. Consideration of geographic, cultural, religious affiliation and occupation of the patient during nursing assessment

8. Saudi Arabian cultural practices associated with the prevention of ill health to the baby
9. How the Saudi Arabian women traditionally care for the cord of the newborn babies
10. Cultural beliefs and attitudes of Muslim women in Saudi Arabia regarding breastfeeding
11. Rituals performed by the Muslim father on and for the baby immediately after birth in the KSA
12. Muslims' taboos regarding medication and food
13. Saudi Arabian cultural: "henna", "evil eye", consanguinity, "ko'hl" and modesty principles
14. Nurses' knowledge regarding Saudi Arabian culture, health care beliefs and practices
15. Nurses' desire to learn about the Saudi Arabian culture
16. Reasons for not desiring to learn more about Saudi Arabian culture
17. Nurses' understanding of the Saudi Arabian language
18. Nurses' ability to speak Arabic
19. Knowledge regarding the taboos, rituals and cultural practices of the Saudi Arabians
20. Saudi Arabian cultural challenges/frustrations/problems encountered by nurses
21. Actions taken by nurses to improve their understanding of the Saudi Arabian culture
22. Cultural awareness presented by the recruiting agency
23. Cultural awareness classes and presentations at the King Faisal Hospital
24. Interest in educational activities related to Saudi Arabian culture
25. Culture-related educational topics

### **3.4.3 Refinement of the questions**

The questionnaire was submitted to the Institutional Review Board (IRB) for approval and consideration. The researcher then submitted the questionnaire to her supervisors, who are experts in the construction of questionnaires. The questionnaire was corrected and finalised after feedback. The researcher then gave the questionnaire to five colleagues to test the construction and relevance of the questions. These colleagues were excluded from participating in the actual study.

## **3.5 VALIDITY AND RELIABILITY**

The measurement of the data collected may be “strong or weak”. According to McMillan and Schumacher (2001:239), strong measurements increase the confidence that the findings are accurate and enhancing the reliability and validity of the instrument can achieve this.

### **3.5.1 Validity**

The validity of the measuring instrument indicates that it measures what it is supposed to measure. This includes content, construct and face validity of the measuring instrument (Burns & Grove 2001:400). On the other hand, Rossouw (2003:123) defines content validity as “the extent to which the method of measurement includes all the major elements of the concepts being measured. In most instances the measuring instrument is valid for the aim that it is designed for” (Rossouw 2003:123).

In this study, the questionnaire did not cover all the aspects of Saudi Arabian cultural practices, but a limited number of concepts were covered to assess the respondents' cultural knowledge.

### **3.5.2 Reliability**

Assessing the reliability of the instrument means “...to establish consistency and accuracy with multiple measures” (Rossouw 2003:122).

To test the questionnaire used in this study, the researcher gave it to colleagues for peer review and expert advice in order to determine whether they all interpreted the items the same. The researcher identified an Egyptian HN, and three Saudi Arabian Muslim, a Filipino, a British and a South African SNIs to test the questionnaire for relevance and structure. These colleagues did not participate in the study.

### **3.6 DATA COLLECTION**

The researcher was responsible for the distribution and collection of the completed questionnaires. The researcher visited each unit on specific days for both day and night staff in order to reach the targeted number of participants. The questionnaire was administered to a group of staff members usually during shift changes (night staff handing over to day staff). The researcher gave the participants the questionnaire at the beginning of either night or day shift in order to rule out the element of fatigue that might exist after duty. A self-completion method was followed, allowing each participant to read and complete the questionnaire at her own pace (Gerrish & Lacey 2006:379).

### **3.7 ETHICAL CONSIDERATIONS**

According to Polit and Beck (2004:141), if researchers use human beings in a study, then their rights should be protected. Burns and Grove (2007:204) emphasise that the following rights should be protected: self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm.

The researcher obtained approval to conduct the study from the Research Ethics Committee of the Department of Health Studies, Unisa. Following this approval, the researcher undertook an online study in order to familiarise herself with the ethical implications of a research study (see Annexure A: NIH certificate). In this study, no formal written consent was used (Burns & Grove 2007:204; Polit & Beck 2004:147). A covering letter attached to the questionnaire explained the purpose of the study, anonymity, confidentiality and the right not to participate. Completing the questionnaire indicated the participant's agreement to participate (see Annexure D: Questionnaire).

The researcher wrote an application letter through the head of department to obtain approval for the study from the Institutional Review Board of the King Faisal Specialist

Hospital and Research Centre, Jeddah (see Annexure B). The board is responsible for assessing any research study conducted in the institution in order to ensure that the participants are protected. Permission to conduct any research should be granted before a study can be commenced. The policy of the hospital is to obtain Institutional Research Board approval before the implementation of the study (see Annexure C: IRB approval).

The respondents remained anonymous since the questionnaire did not require their names. The researcher alone handled the completed questionnaires and no other person had access to them except the statistician.

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

Limitations are the restrictions in a study that may decrease the credibility and generalisability of the findings (Burns & Grove 2007:37). There are theoretical and methodological limitations. Theoretical limitations restrict the abstract generalisation of the findings; for example, unclear relationship among some concepts in the theorist's work, and unclear links to the concept (Burns & Grove 2007:37-38). The methodological limitations can limit the credibility of the findings and restrict the population to which the findings can be generalised. Methodological limitations result from such factors as a single setting, or an instrument with limited reliability and validity (Burns & Grove 2007:38).

Knowledge cannot be assessed in full. In this study, the participants were expected to explain concepts and practices associated with Saudi Arabian culture. They might have had additional information, which they could not recall or retrieve at that moment.

Self-administration of the questionnaire might have led to the misinterpretation of some questions because not all the non-Muslim nurses have a good understanding of the English language. However, all the nurses communicated in English.

The study was limited because it was conducted in a single setting. Generalisability of the findings is not possible because only nurses of the obstetric unit at the King Faisal Specialist Hospital and Research Centre, Jeddah, participated in the study.

### **3.9 DATA ANALYSIS**

In quantitative research, analysis includes descriptive and inferential analysis (Burns & Grove 2007:41).

The researcher used the guidance and service of a qualified statistician at the King Faisal Specialist Hospital and Research Centre, Jeddah for data entry and analysis (see Annexure E: Request for data analysis). The statistician prepared the spreadsheet according to the nature of the questions in the questionnaire. The researcher, with the guidance and support of the statistician, was able to enter the data. The statistician analysed and interpreted the data, which were then represented in tables and graphs (see Annexure F: Approval of data analysis). The Statistical Package for the Social Sciences (SPSS Version 11.5) was used to enter and analyse the data.

### **3.10 CONCLUSION**

This chapter discussed the research design and methodology, including the population, sampling and sample; data collection and analysis; data-collection instrument, and ethical considerations.

Chapter 4 deals with the data analysis and research findings.

## CHAPTER 4

### Data analysis and interpretation

#### 4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation, and reports on the findings of the study. The analysed data were obtained from the respondents' answers to the questionnaire. The findings are tabulated, graphed, charted and conceptually described.

The questionnaire comprised two sections that enabled the researcher to collect the data that could facilitate quantitative analysis and interpretation.

#### 4.2 DATA ANALYSIS AND RESULTS

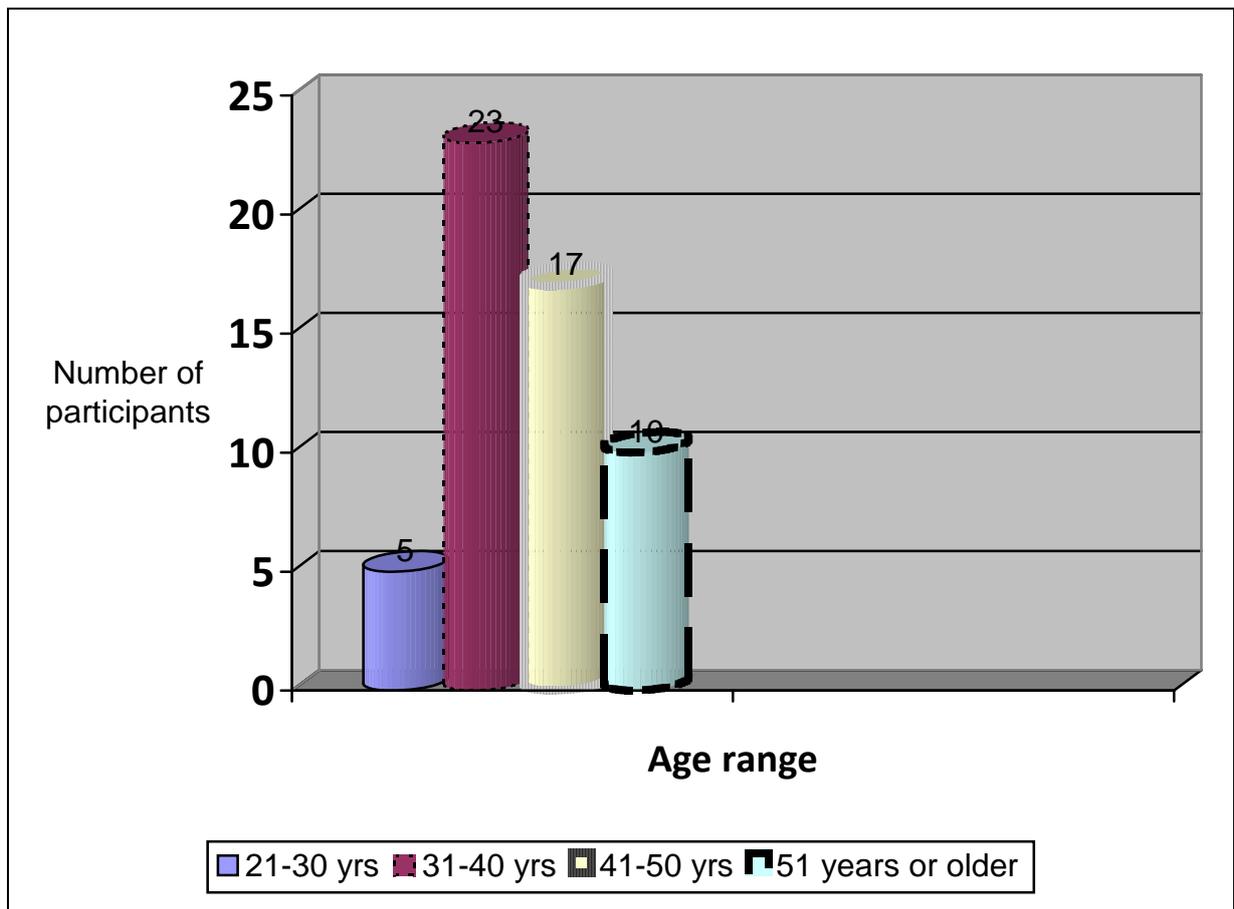
The following sections present the results systematically according to the findings as reflected in the questionnaire.

##### 4.2.1 Demographic data

The demographic data in section A reflect the respondents' age n, religion, nationality, designation, nursing experience and number of years working in their respective units.

##### 4.2.1.1 *Respondents' age distribution*

Figure 4.1 depicts the respondents' ages.



**Figure 4.1 Respondents' age (n=50)**

Figure 4.1 indicates that, of the respondents (n=50), 46% (n=23) were between 31 and 40 years old, and 34% (n=17) were 41 to 50 years old. Of the respondents, 10% (n=5) were 21 to 30 years and 10% (n=5) were 50 and older. These findings indicate that only 10% (n=5) of the respondents were 30 or younger, while 90% were 31 and older. Consequently, the majority of the obstetric unit's nurses were mature women.

#### **4.2.1.2 Religion**

The respondents' religious affiliations are indicated in table 4.1.

**Table 4.1 Respondents' religious affiliation (n=50)**

<b>Religion</b>	<b>Frequency</b>	<b>Percentage</b>	<b>Cumulative Percent</b>
Buddhist	1	2.0	2.0
Christian	47	94.0	96.0
Other	2	4.0	
<b>Total</b>	<b>50</b>	<b>100.0</b>	<b>100.0</b>

Table 4.1 indicates that of the 50 respondents, the majority (94%; n=47) were Christian; 2% (n=1) were Buddhist, and 4% (n=2) indicated "other" but did not specify.

#### **4.2.1.3 Nationality**

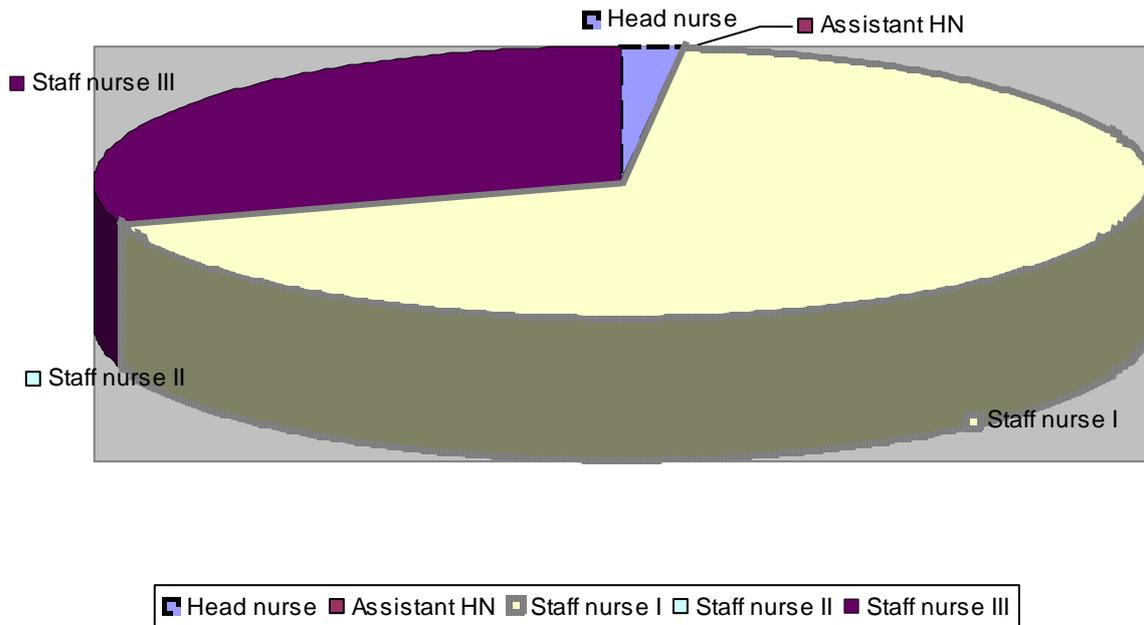
Table 4.2 depicts the respondents' nationalities. All the respondents were expatriates and did not originate from Saudi Arabia. Of the respondents, 74% (n=37) were Filipinos; 20% (n=10) were South Africans; 4% (n=2) were Indians, and 2% (n=1) was a European.

**Table 4.2 Respondents' nationality (n=50)**

<b>Nationality</b>	<b>Frequency</b>	<b>Percentage</b>	<b>Cumulative Percentage</b>
European	1	2.0	2.0
Filipino	37	74.0	76.0
Indian	2	4.0	80.0
South African	10	20.0	100.0
<b>Total</b>	<b>50</b>	<b>100.0</b>	

#### **4.2.1.4 Respondents' designation**

Figure 4.2 presents the respondents' categories during data collection.

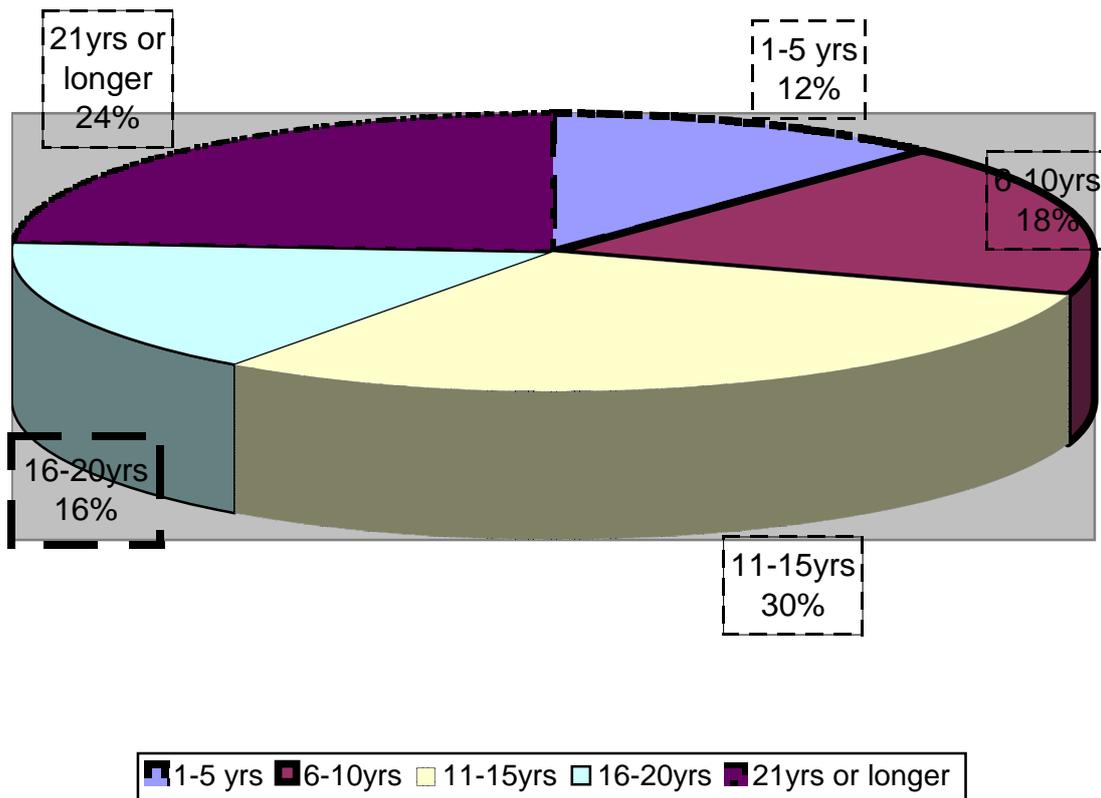


**Figure 4.2 Respondents' nursing categories**

Of the respondents, 68% (n=34) were classified as staff nurses I and II; 30% (n=15) were staff nurse III, and only 2% (n=1) was a head nurse. The staff nurses I, II and III spend most of their nursing time caring for the patients' basic needs. According Baldacchino (2006:887), this is what obstetric patients need in the health care environment. The head nurse and the assistant head nurse do not provide direct patient care, but need to have the cultural knowledge because as leaders, they are regarded as resource persons (Jooste 2003:93).

#### **4.2.1.5 Nursing experience**

Figure 4.3 depicts the respondents' experience, which ranged from one year to more than 21 years in the nursing profession. Of the respondents, 24% (n=12) had more than 21 years' nursing experience; 16% (n=8) had 16 to 20 years, and 30% (n=15) had 11 to 15 years' experience. In addition, 18% (n=9) had 6 to 10 years' experience and only 12% (n=6) reported 1 to 5 years' experience. The majority of the respondents (88%; n=44) had more than 5 years' nursing experience.

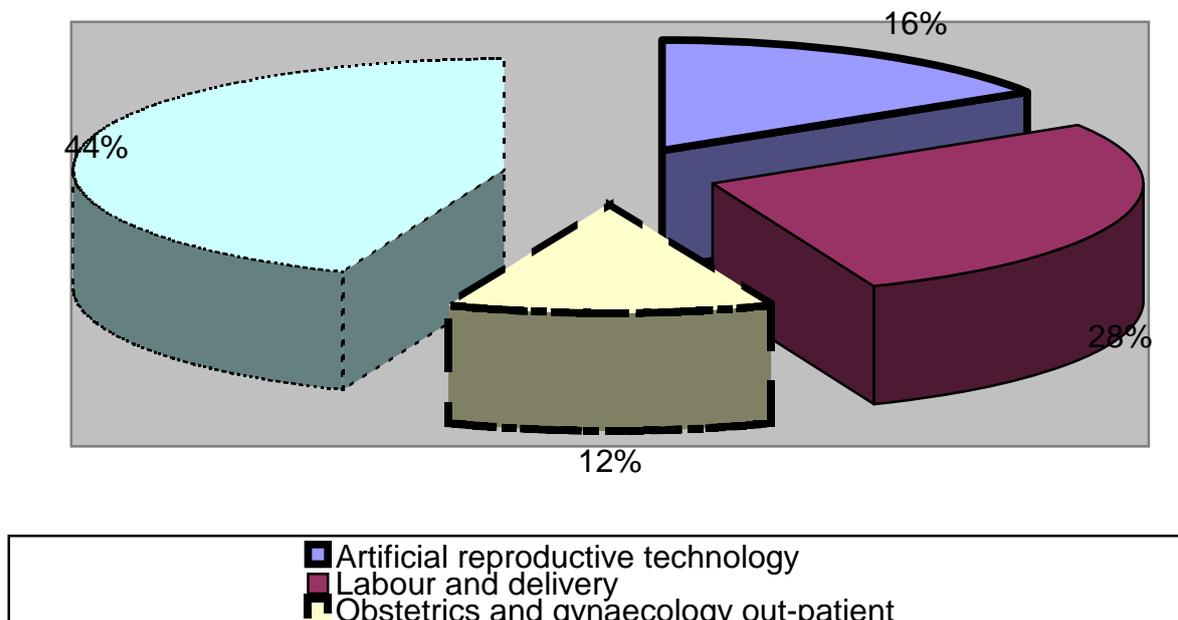


**Figure 4.3 Respondents' years of nursing experience**

#### **4.2.1.6 Nursing units**

Figure 4.4 presents the units in which the respondents worked at the time of the data collection.

Of the respondents, 44% (n=22) worked in the obstetric and gynaecology in-patient unit, followed by 28% (n=14) who worked in the labour and delivery unit. Then, 16% (n=8) worked in the artificial reproductive technology unit, and 12% (n=6) in the obstetric and gynaecology outpatient unit. The obstetric and gynaecology inpatient unit and labour and delivery units had more respondents because they were in-patient units. The other two units had fewer nurses because they functioned on an outpatient basis.



**Figure 4.4 Respondents' nursing units**

#### **4.2.1.7 Respondents' years' experience in current units**

Table 4.3 depicts the number of years that the respondents had worked in their current units. All the respondents indicated the number of years they had worked in their current units (see table 4.3). Figure 4.4 indicates that 26% (n=13) had worked for 7 years and longer, 16% (n=8) for 5 to 6 years, 22% (n=11) for 3 to 4 years, 12% (n=6) for 1 to 2 years, and 24% (n=12) from 1 to 11 months in their respective units.

**Table 4.3 Respondents' number of years working in the current unit (n=50)**

Number of years	Frequency	Percentage	Cumulative Percentage
Up to 11 month	12	24.0	24.0
1-2 years	6	12.0	36.0
3-4 years	11	22.0	58.0
5-6 years	8	16.0	74.0
7 years or longer	13	26.0	100.0
<b>Total</b>	<b>50</b>	<b>100.0</b>	

From table 4.3, it is evident that only 22% (n=11) had less than one year’s experience in their current units, while 78% (n=39) had more than one year’s experience. Consequently, it may be assumed that the majority of the respondents had been interacting with Saudi Arabian childbearing women for a period that allowed them to acquire knowledge of the Muslim culture.

**4.2.1.8 Respondents’ Saudi Arabian work experience**

Table 4.4 depicts the number of years that the respondents had worked in Saudi Arabia.

**Table 4.4 Respondents’ years’ working in Saudi Arabia (n=50)**

Number of years	Frequency	Percentage	Cumulative Percentage
< 1 year	2	4.0	4.0
1-2 years	3	6.0	10.0
3-4 years	6	12.0	22.0
5-6 years	14	28.0	50.0
7 years or longer	25	50.0	100.0
<b>Total</b>	<b>50</b>	<b>100.0</b>	

Table 4.4 indicates that 50% (n=25) of the respondents had been in Saudi Arabia for 7 years and longer; 28% (n=14) had been there 5 to 6 years, and 12% (n=6) indicated 3 to 4 years. Of the remaining respondents, 6% (n=3) had been in Saudi Arabia for 1 to 2 years, and 4% (n=2) for less than one year.

In comparing the information in tables 4.3 and 4.4, the researcher concluded that 24% (n=12) of the respondents had been working in their current units between one and eleven months. Only 4% (n=2) indicated working in Saudi Arabia for less than eleven months. It was thus assumed that the respondents might have misinterpreted or overlooked the word “current”. They appeared to have included the number of years that they had been working in a similar unit of a hospital other than the King Faisal Specialist Hospital and Research Centre, Jeddah.

Secondly, in table 4.4, 50% (n=25) of the respondents indicated working in Saudi Arabia for 7 years or more, but only 26% (n=13) reported working in their current unit for 7 or more years. The researcher assumed that some respondents had worked in other

Saudi Arabian hospitals prior to coming to King Faisal Hospital and had either included that number of years as well, or had worked in different units at King Faisal hospital.

#### **4.2.2 Respondents' knowledge of Muslim women's cultural and health care practices**

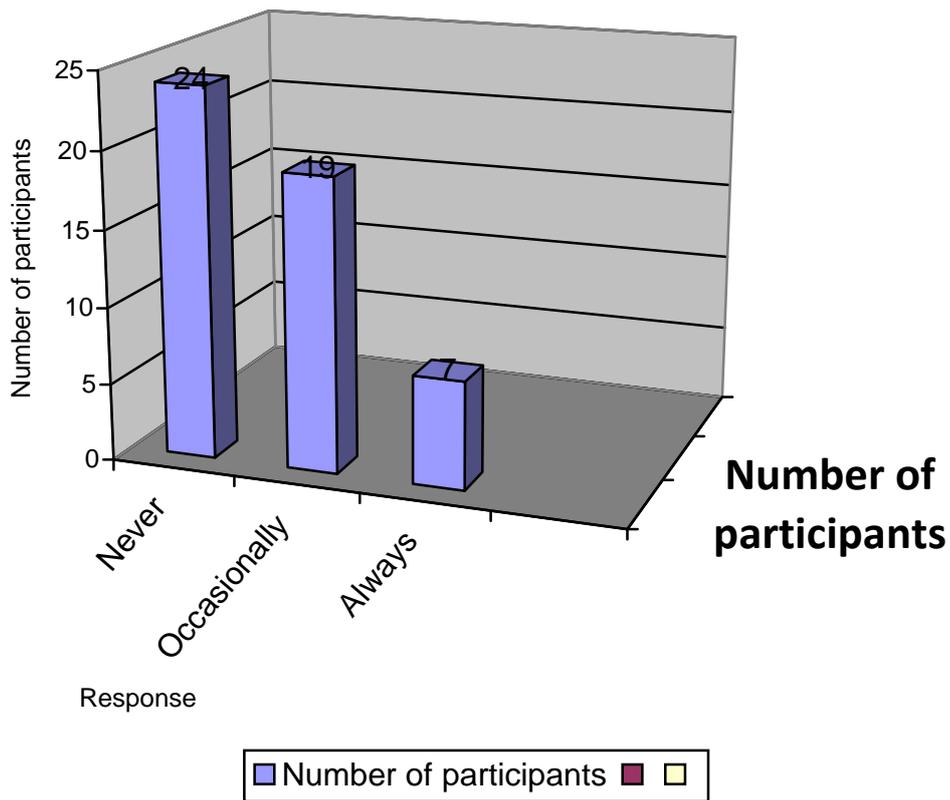
Section B of the questionnaire required the respondents to self-assess their knowledge of Muslim women's cultural and health care practices. The questions ranged from self-assessment rating scales to listing and describing the cultural practices of the Muslim childbearing women.

Some respondents completed each question and others did not answer every question, which accounted for the differences in the total number of responses to different items.

##### ***4.2.2.1 Respondents' assessment on admission of herbal remedies used during pregnancy***

In figure 4.5, the respondents had to rate their actions/behaviours when interacting with childbearing Muslim women during admission.

All the respondents answered this question and 48% (n=24) indicated that they never asked the women whether they used herbal remedies or not; 38% (n=19) occasionally asked, and only 14% (n=7) always asked mothers this question on admission (see figure 4.5).



**Figure 4.5 Respondents' assessment of herbal use during pregnancy**

**4.2.2.2 Respondents' knowledge of herbal remedies used by Saudi Arabian women during pregnancy**

Table 4.5 indicates the names of the herbal remedies that the respondents listed as used by Saudi Arabian women during pregnancy.

**Table 4.5 Respondents' indication of herbs used by Muslim women during pregnancy (n=82)**

<b>Response</b>	<b>Frequency</b>
Don't know	43
No response	18
Dates	11
Castor oil	8
Drink water and lemon	1
<i>Tarya oil</i>	1
<i>Splina</i>	1
<i>Garwa</i>	4
Juice	1
<b>Black oil</b>	1
Mint leaves	4
Cardamom	2
Saffron	1
Olive oil	1
Honey	2
Use of sand	1
<b>Total</b>	<b>100</b>

In table 4.5, the respondents had to list at least two types of herbs that Saudi Arabian women used during pregnancy. Not all the respondents listed two herbs, which thus resulted in a total of 82 instead of 100 responses. Some respondents did not leave blank spaces, but rather indicated that they “did not know”.

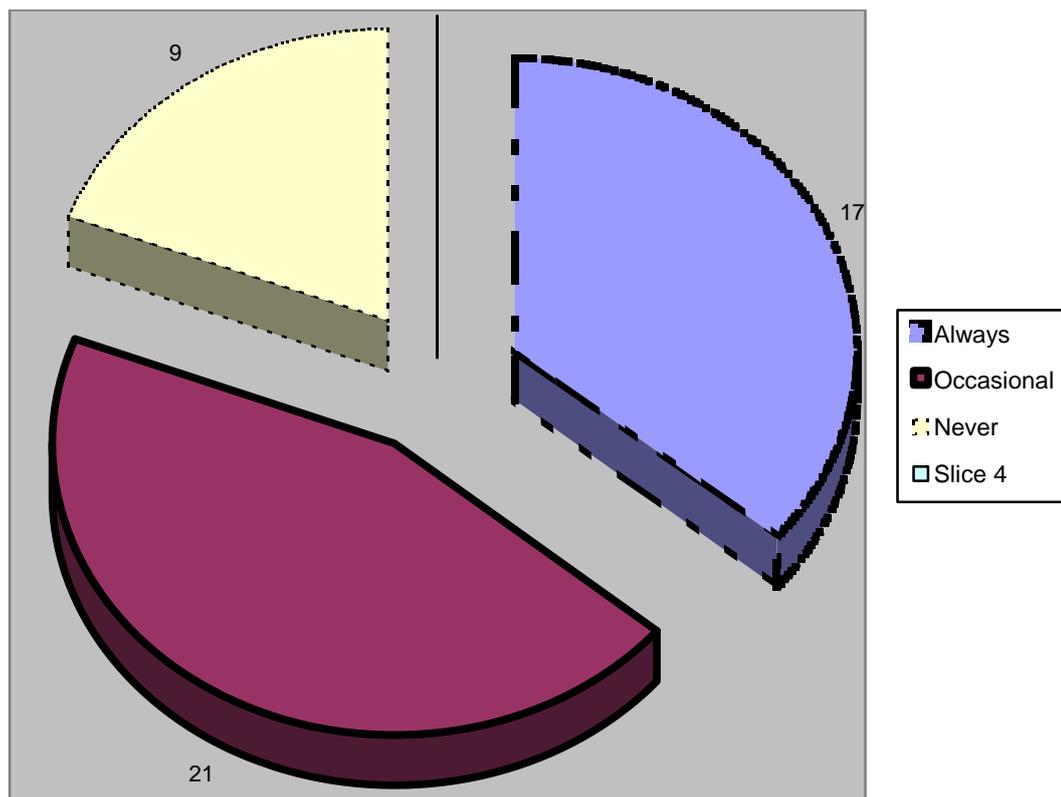
According to the *Merriam-Webster Dictionary* (ONLINE dictionary:[www.Merriam-Webster.com](http://www.Merriam-Webster.com)), dates (11 responses), juice (1 response), and sand (1 response) cannot be classified as herbs. In addition, *Carwa*, *Splina* and *Tarya* oil are not classified as herbs (Merriam-Webster ONLINE dictionary:[www.Merriam-Webster.com](http://www.Merriam-Webster.com)). Castor oil (8), mint/mint leaves (4), cardamom (2) and lemon (1) were the correct responses. The respondents did not appear know what herbal remedies pregnant Saudi Arabian women used.

Burns (2001:1) points out that Saudi Arabians use mint in their tea for flavour and in the treatment of fever. Burns (2001) adds that lemon balm is used for headache remedies, aids circulation and acts as an antiseptic agent. Castor oil is used as a laxative and cardamom as and antispasmodic agent (ONLINE dictionary:[www.Merriam-Webster.com](http://www.Merriam-Webster.com)).

Figure 4.5 indicates that only 38% (n=19) of the respondents reported that they occasionally enquired and assessed the use of herbal remedies, while 14% (n=7) always asked about herbal use among the pregnant women. From the figures presented in figure 4.5, the researcher expected that more of the respondents would have listed the names of the herbs and remedies that pregnant Muslim women used. There could be several explanations for the poor responses in table 4.5. For example, the respondents might have forgotten the names of the herbs and remedies when answering the questionnaire.

#### 4.2.2.3 Nurses' consideration of specific diseases common among Saudi Arabians

Figure 4.6 indicates the number of respondents who, when caring for Saudi Arabian women, considered diseases commonly found among this population.



**Figure 4.6 Respondents' consideration of common Saudi Arabian diseases**

Only 6% (n=3) of the respondents did not answer the question. According to 34% (n=17) of the respondents, when interacting with the patient, they always considered common diseases. However, 42% (n=21) occasionally did so, and 18% (n=9) never considered the diseases common to these patients.

#### 4.2.2.4 Respondents' knowledge of diseases common among Saudi Arabians

Table 4.6 presents the respondents' knowledge of diseases common among Saudi Arabians.

According to Panter-Brick (1991:1299), the practice of consanguinity among the Saudi Arabian population is said to be the cause the high rate of congenital metabolic and neurological conditions. Thalassaemia, sickle cell anaemia, hepatitis B and systemic lupus erythematosus are some of the common diseases among Saudi Arabians (Al-Aqueel 2004; Panter-Brick 1991:1297).

According to table 4.6, some respondents indicated that they did not know the diseases common or specifically found among the Saudi Arabian population. Some respondents listed conditions, like hypertension, depression, and pregnancy-induced hypertension, that are not specific to this population. Other diseases not specific to Saudi Arabians, but which were listed, included Thalacaemia, Sickle cell, systemic lupus erythematosus, hepatitis B, congenital heart disease, and genetic diseases.

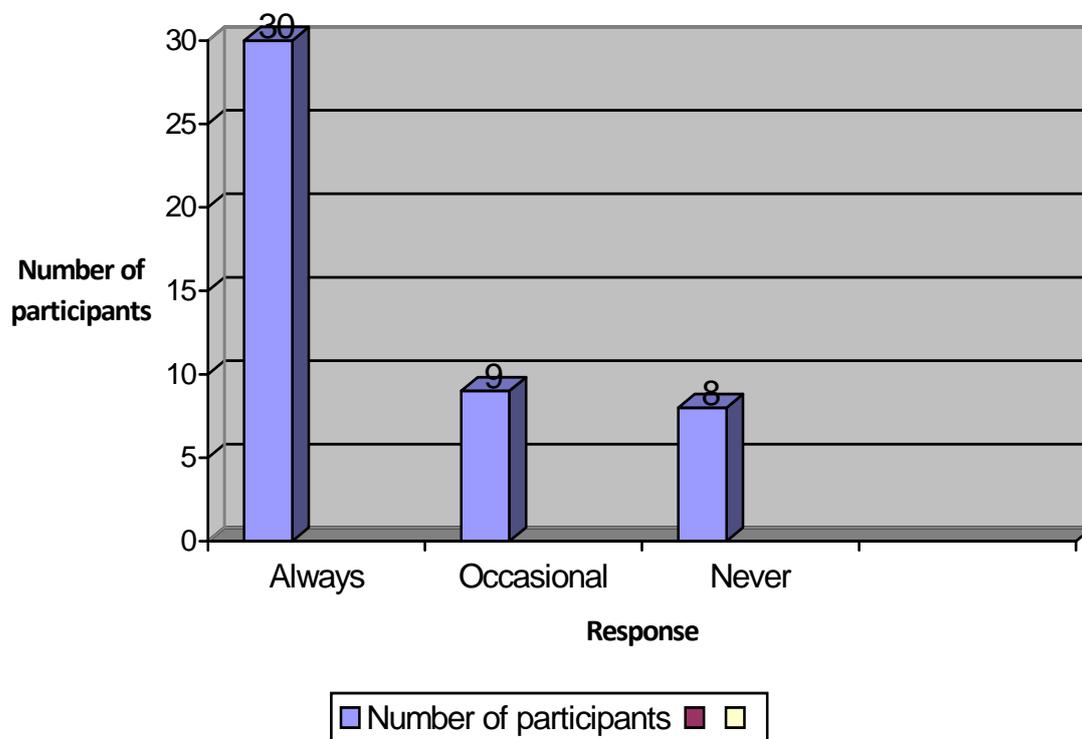
**Table 4.6 Respondents' knowledge of diseases common to Saudi Arabians (n=100)**

<b>Response</b>	<b>Frequency</b>
Don't know	34
Urinary tract and genital infection	6
Pregnancy induced hypertension	5
Diabetes mellitus	23
Hepatitis B	4
Hepatitis A	2
Sickle cell anaemia	2
Gram B Staphylococcus	5
Thalacaemia, anaemia	2
Breast cancer	1
Infertility	1
Hypertension	8
Systemic Lupus Erythematosus	1
Skin disease	1
Inflammation of the cervix	1
Depression	1
Congenital heart and genetic diseases	3
<b>Total</b>	<b>100</b>

Of the responses reflected in table 4.6, only nine were correct, which indicated that the majority of the respondents could not answer the question while others could not name the common diseases among Saudi Arabians.

#### **4.2.2.5 Respondents' inclusion of Saudi Arabian cultural aspects in nursing care**

Figure 4.7 represents the respondents' inclusion of Saudi Arabian cultural aspects when they drew up nursing care plans.



**Figure 4.7 Respondents' inclusion of Saudi Arabian cultural aspects in nursing care plans**

Figure 4.7 shows that 60% (n=30) of the respondents always included cultural aspects in their nursing care plans, whereas 18% (n=9) occasionally did so, and 16% (n=8) never did this. Of the respondents, 6% (n=3) did not answer the question.

According to Wells (2000:199), nurses should be encouraged to develop care plans that incorporate cultural aspects in the management of patients' conditions.

#### 4.2.2.6 Respondents' knowledge of Muslim cultural practices associated with the placenta

Table 4.7 indicates the respondents' knowledge of cultural practices of Muslim childbearing women associated with disposal of the placenta.

Muslims are particularly conservative about the disposal of the placenta. The placenta should be offered or kept for the family to send home for burial. According to Robert (2003:252), Muslim families prefer to dispose of the placenta by burial, as this is believed to be a symbolic return of the organ or any body part to its creator (Allah).

Of the respondents, 54% (n=27) indicated that they did not know what happened to the placenta; 16% (n=8) did not notice any practices associated with the placenta and/or this knowledge was not applicable to their unit, they stepped over the placenta, they took it to a bank. Two respondents (4%) indicated they did not handle such patients, as they did not work in the labour or delivery units.

**Table 4.7 Practices associated with the placenta (n=50)**

Response	Frequency	Percentage
Don't know	27	54.0
Not applicable	3	6.0
Some women step over the placenta in the belief that they will have a child (wishing for a baby)	1	2.0
No practices noted	3	6.0
Some ask for the placenta to be taken home for burial	11	22.0
Sometimes they ask to take the placenta home to fulfil their cultural beliefs	1	2.0
Unsure of what they do, have not worked in the labour and delivery	2	4.0
They are particular about how the placenta is disposed of	1	2.0
To get the blood from the placenta and keep it in a special bank for if needed by the baby when sick	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

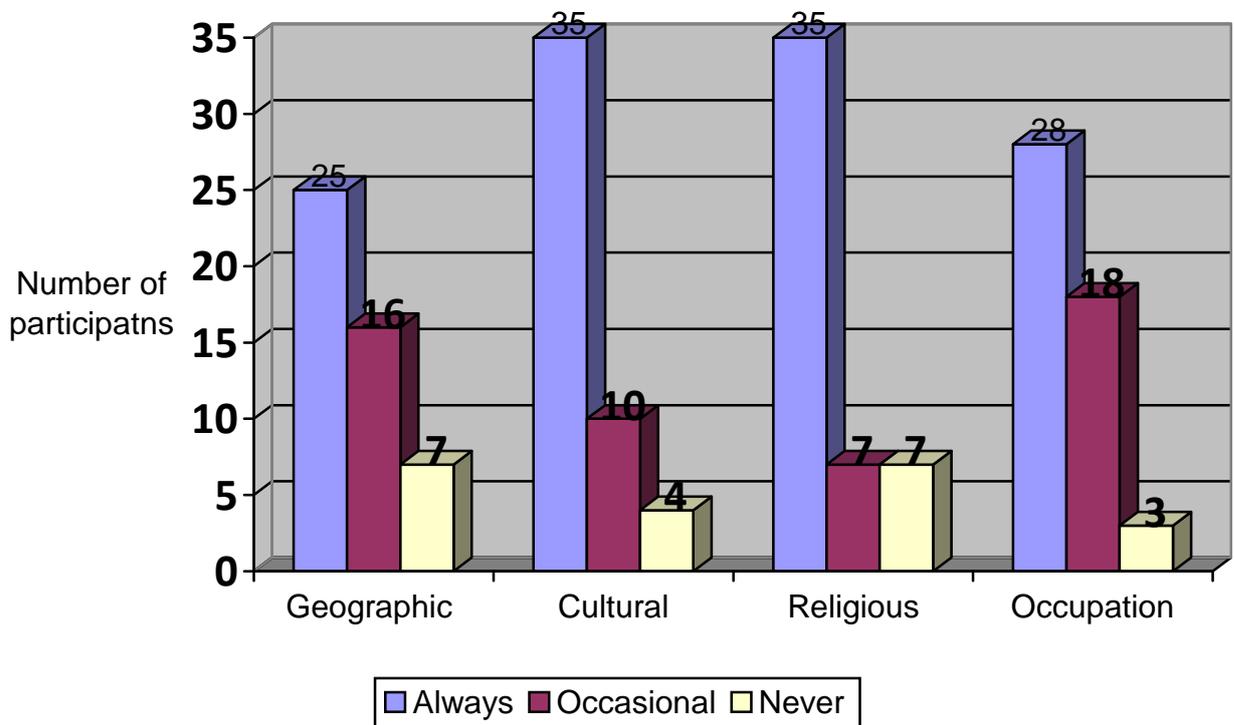
Of the respondents, 22% (n=11) stated that Muslims would take the placenta home for burial; 2% (n=1) indicated they did not know how the placenta had to be disposed of, and 2% (n=1) indicated that women took it home to fulfil their cultural obligations.

From table 4.7, it could be concluded that only 24% of the respondents knew the practice associated with the disposal of the placenta, as the rest did not list this practice.

**4.2.2.7 Respondents' consideration of patients' geographic, cultural, religious and occupational aspects during assessment**

Upon admission or a nurse's first encounter with the patient, certain subjective data are gathered in order to develop a plan of care based on the information obtained.

Figure 4.7 illustrates the nurses' decisions to consider geographic and cultural aspects, religious affiliations and the occupations of the patients during the initial patient assessment process.



**Figure 4.8 Respondents' consideration of patients' geographic, cultural, religious and occupational aspects**

According to figure 4.8, 50% (n=25) of the respondents always considered the patients' geographic origins; 32% (n=16) indicated that they only occasionally did; 14% (n=7) never did, and 4% (n=2) did not answer this question.

It could be deduced that the 50% (n=25) of the respondents who indicated that they always considered patients' geographic origins might have listed the diseases associated with Saudi Arabians (see table 4.6). Although they assessed patients' geographic origins, some might not have considered the diseases common to Saudi

Arabians, because the majority of the respondents could not recall these diseases. Of the respondents, 70% (n=35) always asked the patients about their cultural origins; 20% (n=10) occasionally did, while 8% (n=8) never asked the patients, and only 2% (n=1) did not answer this question.

When interacting with the patient, 70% (n=35) of the respondents always asked the patients about their religious affiliations, whereas 14% (n=7) asked sometimes, and 14% (n=7) never asked. Only 2% (n=1) did not answer this question.

Of the respondents, 56% (n=28) reported that they always asked about the patients' occupations; 36% (n=18) occasionally did, and 6% (n=3) never asked. Only 2% (n=1) did not answer this question.

Of the respondents, 50% (n=25) asked the patients about their geographic, cultural, religious and occupational aspects because this information formed part of the admission assessment criteria of the hospital. Part of the responsibilities of SNI and SNII nurses is to obtain this information upon admission of any patient.

#### ***4.2.2.8 Respondents' knowledge of Saudi Arabian cultural practices associated with the prevention of ill health to the baby***

Table 4.8 indicates how the respondents perceived Saudi Arabian cultural practices to prevent their babies' ill health. The respondent was of the opinion that they might have observed or read about such practices.

The respondents were required to list two Saudi Arabian cultural practices associated with the prevention of ill health in the newborn. Not all the respondents listed two responses; some listed one or indicated that they did not know. Of the 96 responses obtained, 52 responses of "don't know" indicated that much cultural education was needed among the respondents.

**Table 4.8 Respondents' knowledge of practices associated with the prevention of ill health to the baby (n=48)**

<b>Response</b>	<b>Frequency</b>
Don't know	52
Saying <i>bismillah</i>	1
Giving dates to the newborn	8
Importance of baby check-up	1
To say a prayer right after the delivery	5
Giving honey	1
Leaving the Qur'an with the baby in the cot	2
Always saying <i>hamdulillah</i>	1
Black necklace with an eye pendant to prevent the evil eye	1
Reading verses from the Qur'an	1
Use of <i>ko'hl</i> around the baby's eyes	8
Importance of vaccination	1
Not applicable	2
Washing in holy water at birth	1
If you want to give a compliment, like "your baby is beautiful", you must say <i>masha-Allah</i> 3 times	6
Breastfeeding	1
Religious rituals done immediately post delivery	1
The use of amulets	1
Needed sunlight	1
Nowadays they do not care	1
<b>Total</b>	<b>96</b>

Of the responses captured, "saying a prayer" was listed five times; "leaving the Qur'an in the cot" was listed twice, and one mentioned the "use of amulets". Eight respondents listed the application of "ko'hl to the eyes" and "reading of the Qur'an" occurred once and six responses indicated "acknowledging God after every praise uttered (*masha-Allah*)" and the phrase "*al hamdulilar*" ("thanks be to God") also assisted in the prevention of ill health. These responses indicate that the majority of the respondents could not clearly explain these practices. Some responses were irrelevant to the question asked.

Zahr and Hattar-Pollara (1998:354) mention that Muslims use amulets such as beads and verses of the Qur'an to protect their babies from the harmful effects of the "evil eye" that causes ill health. The father may read the Qur'an to the baby to ward off the "evil eye" (Panter-Brick 1991:1297). The father's whispering in baby's ear and the use of amulets or blue beads are attempts to ward off the "evil eye" (Robert 2003:254; Zahr & Pollara 1998:354).

#### 4.2.2.9 *How the Saudi Arabian women traditionally care for the cord of the newborn*

Table 4.9 lists the respondents' understanding and observation of how Saudi Arabian women traditionally cared for the umbilical cords of the newborn babies.

**Table 4.9 Respondents' knowledge of traditional care of the umbilical cord (n=50)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	28	56.0
Cleaning with alcohol	7	14.0
Using abdominal binder	5	10.0
Breastfeeding will free from any disease	1	2.0
They don't handle the umbilical cord until it falls	3	6.0
They follow the health teaching given to them	1	2.0
They are not particular whilst hospitalised	1	2.0
Ko'hl used many years ago	1	2.0
Nowadays nothing	1	2.0
Have herbs or ash placed on the cord. When the cord falls off, it is buried where the placenta was buried	2	4.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

According to table 4.9, 56% (n=28) of the respondents reported that they did not know how Saudi Arabian women traditionally cared for the umbilical cord; 10% (n=5) indicated that the mother applied a binder to the baby's umbilicus; 2% (n=1) indicated that they applied "ko'hl", and 4% (n=2) indicated that Muslims buried the stump of the umbilical cord where the placenta had been buried. The remaining 28% (n=14) indicated non-traditional practices like cleaning with alcohol and that breastfeeding would protect the baby from any disease that associated with the cord practices of Muslim women.

According to Leininger and McFarland (2002:102), Muslims apply "ko'hl" to the umbilical cord to facilitate drying.

#### **4.2.2.10 Respondents' knowledge of Muslim women's cultural belief and attitudes regarding breastfeeding**

Table 4.10 presents the respondents' understanding of Saudi Arabian women's attitudes towards breastfeeding their babies within the first 12 hours after birth.

Nurses interact with the patients 24 hours every day. It is during these interactions that nurses are able to assess the patients' attitudes and behaviours towards care (Masson 2005:97). The nurse caring for childbearing women is able to assess the attitudes of the mother towards the baby and reach conclusions about these assessed interactions.

Table 4.10 indicates that, of the respondents, 4% (n=2) did not answer the question and 28% (n=14) reported that they did not know/had no idea of what Muslim women's attitudes were regarding breastfeeding. The rest gave their interpretations and/or opinions of how Muslim mothers perceived breastfeeding during the first 12 hours after birth.

Of the respondents, 38% (n=19) indicated that Muslim mothers were "reluctant", "lazy", "not keen", "not eager to" or reported "not enough milk" and "milk will not come". These responses indicated that the respondents perceived Muslim women as not keen to breastfeed their babies within 12 hours after birth.

**Table 4.10 Respondents' knowledge of Saudi Arabian women's attitude towards breastfeeding (n=48)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	14	28.0
No response	2	4.0
They believe it should be initiated immediately to encourage bonding. Makes the baby healthy and strong. Colostrum is good for the baby.	9	18.0
Some insist on breastfeeding right after delivery, as breastfeeding is encouraged by the Qur'an.	1	2.0
They did not know the importance of breastfeeding	1	2.0
Some prefer to breastfeed with the understanding that it is good for them. They think it can't be possible, until they are informed	3	6.0
They are not keen on breastfeeding their babies within the first 12 hours. Report that there is no milk, and milk is not coming.	14	28.0
Depends on whether the mother is modern or Bedouin. Modern mothers go for formula.	5	10.0
Breast needs to be cleaned first and mother needs to rest and baby should have a bath	1	2.0
Bedouin give dates, honey and water before they feed the baby. Giving dates to baby before starting feeding, according to them, is good to have appetite to feed	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

However, of the respondents, 14 (28%) indicated that the mothers knew the importance of bonding and were proud to be mothers; preferred to breastfeed after the delivery; some believed that the Qur'an encouraged breastfeeding, and colostrum should be given to the baby. One response (2%; n=1) was incomplete and not clear enough to interpret, namely "to pass out stool".

According to Al-Jassir et al (2006:8), Saudi Arabian mothers often bottle-feed their babies because they assume that their breast has no milk or that the milk is of a poor quality. Roberts (2003:253) comments that for the Muslims, breastfeeding is both a religious and nutritional choice. However, modesty and privacy concerns prevent Muslim mothers from breastfeeding in the presence of visitors or others.

#### 4.2.2.11 Respondents' knowledge of rituals performed by Muslim father for the baby immediately after birth

Table 4.11 lists the respondents' responses on their knowledge of the cultural practices performed by the father for the baby, immediately after the delivery.

Of the respondents, 22% (n=11) reported that they did not know what rituals fathers performed for the newborn; 4% (n=2) wrote, "giving light" and "circumcision", and it was assumed that they did not know about the cultural rituals. Of the respondents, 34% (n=17) stated that the father whispered a prayer in the baby's ears; 4% (n=2) indicated that the father would recite from the Qur'an; 34% (n=17) indicated that the father, grandfather or priest would pray, and 2% (n=1) stated that the father would dance with the baby.

**Table 4.11 Respondents' knowledge of fathers' rituals for the newborn (n=50)**

Response	Frequency	Percentage
Don't know	11	22.0
Giving light after the delivery	1	2.0
Circumcision	1	2.0
The father prays for the newborn baby	13	26.0
The father or the grandfather takes the baby and pray the <i>adan</i>	1	2.0
He make <i>adan</i> (prayer) to the baby, giving small pieces of dates	1	2.0
Prays to drive out evil spirits	1	2.0
They pray to Allah and offer their baby to Him. Sometimes the father calls the Oman or priest to pray for the baby	1	2.0
Says <i>adan</i> in both ears	13	26.0
Whispering then praying, after that blessings and thank 3 times for the baby	1	2.0
Pray in the baby's eyes and ears, the father place a piece of date in the baby's mouth	1	2.0
The father holds the baby up, and whispers the Qur'an prayer in his/her ears, thanking Allah for him/her	1	2.0
Praying and calling Allah, prayer in the baby's ear	1	2.0
Dance and sing a song for the baby	1	2.0
Reciting the Qur'an	2	4.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Nurses working in labour and delivery units could be expected to know about this ritual because the practice may be performed immediately after birth. However, nurses from the other three units might not have observed but might have acquired knowledge about

these rituals performed by the Muslim fathers for their babies immediately after birth from literature.

According to Leininger and McFarland (2002:484), the father whispers a prayer in the baby's ears. Panter-brick (1991:1297) states that the father may recite the Qur'an or clean the baby with water containing the seeds of dates immediately after birth.

#### **4.2.2.12 Respondents' knowledge of Muslims' taboos regarding medication and food**

Tables 4.12 and 13 present what the respondents listed as Muslim taboos associated with medication use and food.

According to table 4.12, of the respondents, 56% (n=28) reported that they did not know what taboos were associated with medication use among Muslims; 8% (n=4) did not answer the question, and 4% (n=2) indicated that the question was not applicable to them. Therefore, a total of 68% (n=34) responses could be used. A further 10% (n=5) of the responses were irrelevant to the question and could not be used: "castor oil", "It will heal them with their disease", "vitamins" and "prescribed medication".

**Table 4.12 Respondents' knowledge of medication taboos (n=46)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	28	56.0
No response	4	8.0
Not applicable	2	4.0
Cannot give medication by the left hand	4	8.0
Give medication to patient with the right hand	1	2.0
Not allowed to take any medication containing alcohol	2	4.0
Prohibited drugs like cocaine	1	2.0
Addiction to drugs	1	2.0
Giving IV fluid or IV medication during Ramadan	2	4.0
Castor oil	1	2.0
It will heal them with their disease	1	2.0
To explain first	1	2.0
Vitamins	1	2.0
They can only take medication prescribed by physicians	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Ten percent (n=5) of the respondents mentioned that it was taboo to give medication to the Muslim using the left hand and 8% (n=4) reported that medication containing alcohol

and prohibited drugs were taboo. Of the respondents, 4% (n=2) indicated that it was taboo to give intravenous infusion (IV) medication during the month of Ramadan.

From table 4.12, it is evident that of the respondents, 42% (n=21) did not know the taboos associated with food for the pregnant Muslim women. Another 14% (n=7) were inappropriate and could therefore not be interpreted, namely “thamis”; “they love all kinds of food”; “dates”, and “refusal to drink water”.

**Table 4.13 Respondents’ knowledge of taboos associated with food (n=50)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	21	42.0
Dates, the healing fruit	3	6.0
They love all kinds of food	1	2.0
Thamis	1	2.0
They refuse to drink water after the delivery	1	2.0
No eating with left hand, it's dirty	1	2.0
Eat “halal” only	2	4.0
Pork is not allowed	18	36.0
The mother fasts during menstrual period and also during the month of Ramadan	2	4.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Of the respondents, 4% (n=2) indicated that the food should be “halal”, but what “halal” meant; 36% (n=18) indicated that no pork was allowed, and 4% (n=2) reported that there were restrictions on food associated with the month of Ramadan.

Since the questionnaire was self-administered, misinterpretation of terms might have contributed to confusion in answering this question.

Robert (2003:253) mentions that medication with hidden ingredients like alcohol or coated with products obtained from pork (for example, Insulin) is regarded as taboo by Muslims. Leininger and McFarland (2002:307) point out that Muslims regard eating pork as taboo.

**4.2.2.13 Respondents' knowledge of Saudi Arabian cultural concepts: "henna", "evil eye", consanguinity, "ko'hl" and modesty principles**

The respondents were expected to explain their understanding of Saudi Arabian cultural concepts such as, "henna", "evil eye", "consanguinity", "ko'hl", and "modesty principles". These cultural concepts have certain definite cultural meanings and are significant to Muslims. It is thus important that nurses have some knowledge about these concepts.

Tables 4.14 to 4.18 present the respondents' explanations of these aspects.

**"Henna"**

According to table 4.14, 20% (n=10) of the respondents indicated that they did not know what "henna" was and 6% (n=3) did not answer the question. Twelve percent (n=6) of the respondents indicated that "henna" was used for cosmetic and beautification purposes; 22% (n=11) indicated that Muslim women use henna to paint or dye their hair, and 10% (n=5) indicated that it was used for the purpose of art. In addition 12% (n=6) of the respondents indicated that brides used "henna" at weddings, and 16% (n=8) indicated that Muslim women used it to paint the hands and feet.

**Table 4.14 Respondents' perceptions and knowledge of "henna" (n=47)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	10	20.0
No response	3	6.0
For cosmetic and beautification purposes	6	12.0
To make their hair beautiful and healthy	11	22.0
Is used by the newly married women and at weddings	6	12.0
For aesthetic purposes or for the sake of art	5	10.0
Used to paint hands and feet in special designs	8	16.0
Using for their passion	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Two percent (n=1) of the respondents in table 4.14 mentioned the "henna" was used for their passion.

"Henna" is a herbal substance applied on the hands and sole of the feet as a good omen in marriages and has a cooling effect during the hot summer (Leininger & McFarland 2002:102).

## “Evil eye”

Table 4.15 presents what the respondents understood by the concept of the “evil eye”. The responses to this question were incomplete statements and could not be interpreted properly. The researcher captured the key words in order to facilitate quantification of the data.

According to table 4.15, 42% (n=21) of the respondents indicated they did not know the meaning of the concept “evil eye”, and 6% (n=3) did not answer the question. Then, 22% (11) could not be interpreted without making assumptions. For example, “looking through the eye”, “bad luck” “the baby is gorgeous” and similar phrases were incomplete and could not be interpreted in any manner relevant to the question asked.

Twenty four percent (n=12) of the respondents indicated that when Muslims give praise to others, it should be followed by the words “*masha Allah*”, which mean, “thanks be to God for the blessings”. Six percent (n=3) indicated that the application of “ko’hl” over the eye was an attempt to prevent the effects of the “evil eye”.

According to Lovering (2006:392), Muslims believe that if a baby or a person is praised, the praise should be concluded by “*mash Allah*” otherwise the person who is praised would become ill. Muslims believe that God “Allah” should be acknowledged because He is the provider of protection against the “evil eye”.

**Table 4.15 Respondents' knowledge of the "evil eye" (n=47)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	21	42.0
No response	3	6.0
You must say <i>masha Allah</i> when you appreciate something or beauty as protection against the "evil eye"	12	24.0
You should not say the baby is gorgeous for the evil eye will cause harm	1	2.0
If you appreciate them without saying a prayer	1	2.0
If seen by the evil eye, it gives bad luck	2	4.0
Someone unintentionally calling someone ill by just looking through the eyes of someone	1	2.0
If a person is sick they will say that some "evil eye" has been cast on him	1	2.0
If the person is seen by the evil eye they will get sick or ill	3	6.0
Bad spirit will go away	2	4.0
Putting ko'hl on the eye of the baby to prevent bad omen	3	6.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

- **Consanguinity**

According to table 4.15, only 4% (n=2) of the respondents' replies were correct by indicating that consanguinity was a cultural belief among Muslims of allowing marriage between cousins. Panter-Brick (1991:1299) defines consanguinity as the "custom of marrying cousins" and indicates that it is practised among Saudi Arabians.

**Table 4.16 Respondents' knowledge of consanguinity (n=45)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	31	62.0
No response	5	10.0
Blood relative marriage is allowed	10	2.0
Allowed to have first cousins marry	2	2.0
Marriage within the family is allowed	2	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Of the respondents, 4% (n=2) stated marriages between families, and 20% (n=10) listed marriages between relatives as general practice. The words "family" and "relatives" were not sufficient, as the correct term to use is "cousins". The majority of the respondents (62%; n=31) did not know what "consanguinity" meant, and 10% (n=5) did not answer the question.

**Table 4.17 Respondents' knowledge of "Ko'hl" (n=48)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	29	55.8
No response	2	3.8
For art sake	10	19.2
Cough	1	1.9
A black charcoal substance applied on both eye brows of the baby for beauty	4	7.7
To prevent bad evil and protection against the "evil eye"	4	7.7
Cosmetics	1	1.9
Protection for the eyes put on babies	1	1.9
<b>Total</b>	<b>52</b>	<b>99.9</b>

- **"Ko'hl"**

According to table 4.17, 55.8% (n=29) of the respondents indicated that they did not know what "ko'hl" was; 3.8% (n=2) did not answer the question, and 1.9% (n=1) listed "cough". Another 19.2% (n=10) indicated that "ko'hl" was used on the eyebrows for cosmetics/beauty, and 7.7% (n=4) indicated that it was used to protect the baby by warding off the "evil eye".

According to Leininger and McFarland (2002:102) "ko'hl" is a charcoal-like substance used for eye cosmetic and may be applied to the umbilical cord to facilitate drying.

**Table 4.18 Respondents' knowledge of modesty (n=46)**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	24	48.0
No response	4	8.0
Women must be covered when in public or when strange men are around. Women and should avoid "direct contact with men".	7	14.0
Female should wear abaya and tarha to "cover themselves"	8	16.0
Always say the word asamalaykum	5	10.0
Women are not allowed to smoke	1	2.0
Women need to cover their body, including the hair, because it is according their "religion" to forbid body parts exposure	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

- **Modesty**

Table 4.18 indicates that 48% (n=24) of the respondents did not know what “modesty” was; 8% (n=4) did not answer the question; 10% (n=5) indicated that modesty was demonstrated in the way Muslims greeted each other, while 2% (n=1) indicated that women were not allowed to smoke.

Of the remaining respondents, 16% (n=8) indicated that it was very important for Muslim women to be covered by wearing the “*tarha*” and “*abaya*”. The other 14% (n=7) stated that this concept was also associated with men not coming into contact with women. Al-Shahri (2002:135) and Galanti (2006:98) emphasise that for Saudi Arabian women, it is important to cover their bodies and to be separated from men in public.

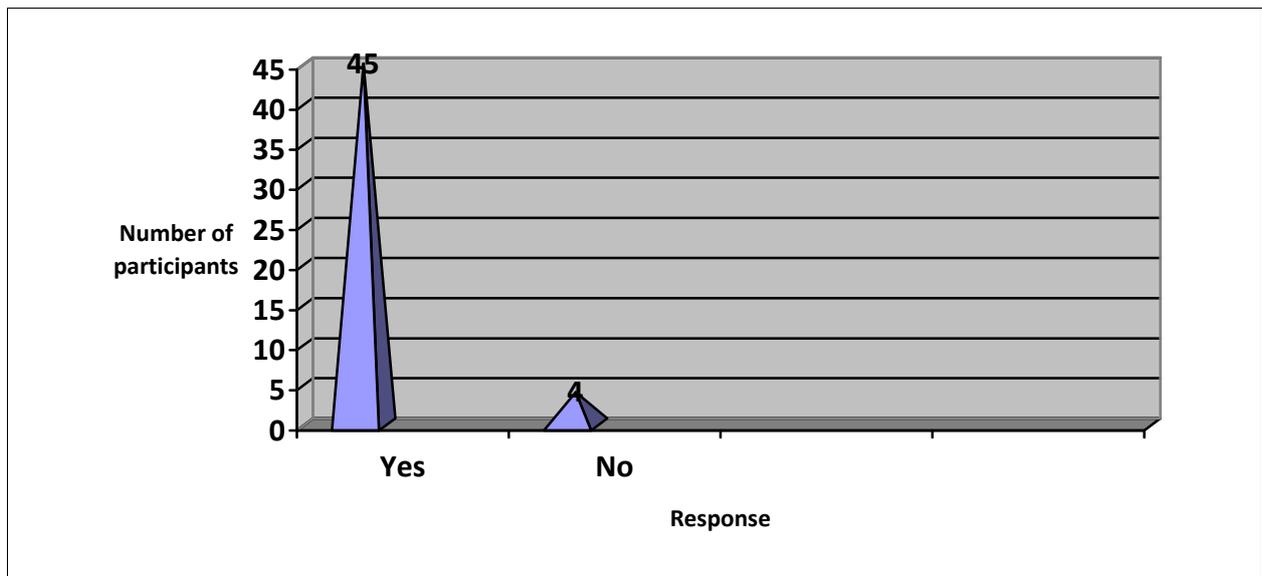
#### ***4.2.2.14 Respondents’ knowledge of Saudi Arabian cultural, health care beliefs and practices***

Figure 4.10 is a schematic presentation of how the respondents rated their own knowledge of Saudi Arabians’ health care beliefs and cultural practices. It is a combined bar chart comparing the respondents’ answers.

The respondents were asked to assess themselves using the rating scale of 1 for poor and 10 for excellent. Of the respondents, 6% (n=3) did not answer this question; 60% (n=30) rated themselves between 1 and 5, while 34% (n=17) rated themselves between 6 and 10. This was an indication that over half the respondents indicated that they had limited Saudi Arabian cultural knowledge.

#### ***4.2.2.15 Respondents’ desire to learn about Saudi Arabian culture***

In response to whether they wanted to learn more about Saudi Arabian cultural practices, 90% (n=45) said “yes” and 8% (n=4) were not interested. Of the respondents, 2% (n=1) did not answer this question (figure 4.9).



**Figure 4.9 Respondents' desire to learn about Saudi Arabian culture**

#### **4.2.2.16 Respondents' reasons for not wanting to learn about Saudi Arabian culture**

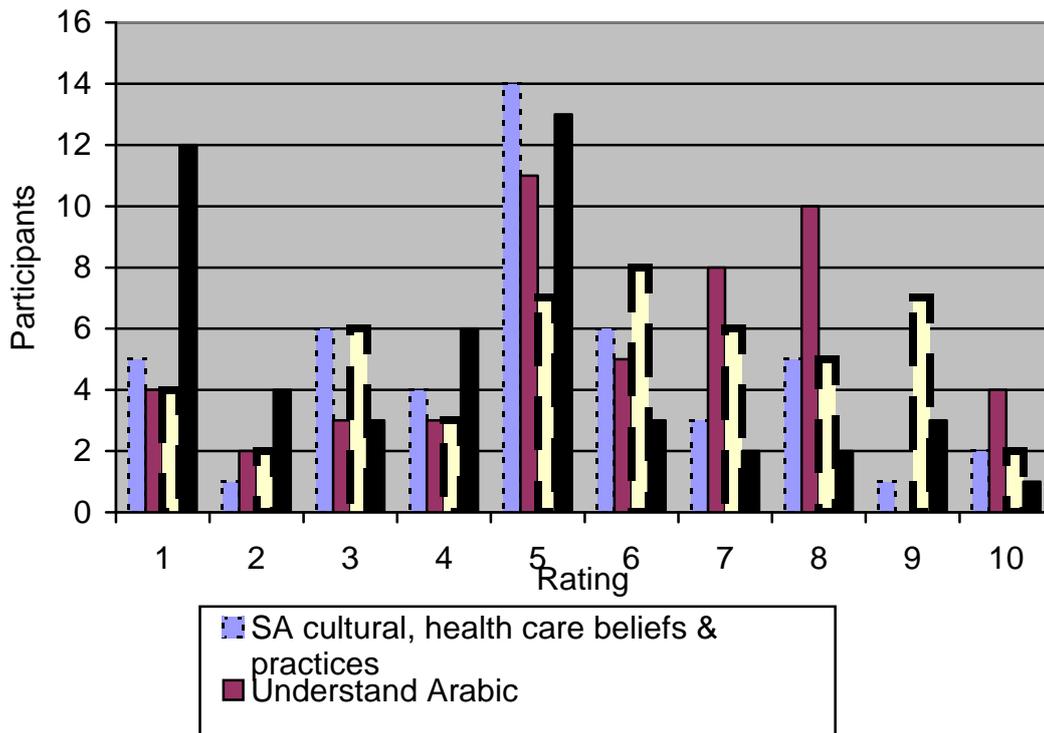
In response to the question why they did not want to learn more about Saudi Arabian cultural practices, 6% (n=3) said they were not interested. Comparing the data in figure 4.9 and table 4.19, 4% (n=2) did not state the reasons why they were not interested in learning about Saudi Arabian cultural practices.

**Table 4.19 Respondents' reasons for not desiring to acquire Saudi Arabian cultural knowledge (n=50)**

Frequency	Percentage	Cumulative percentage
Interested	47	94.0
Not interested	3	100.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

The majority of the respondents reported that they were interested in learning about Saudi Arabian culture.

#### 4.2.2.17 Respondents' understanding of Saudi Arabian language



**Figure 4.10 Respondents' knowledge of Saudi Arabian cultural taboos, health care practices, and Arabic**

Figure 4.10 captured the rating of respondents' knowledge of the Saudi Arabian language (Arabic). Of the respondents, 46% (n=23) rated themselves between 1 to 5, and 54% (n=27) rated themselves between 5 and 10, which is regarded as excellent. This indicated that more than half of the respondents understood the Arabic language.

#### 4.2.2.18 Respondents' ability to speak the Arabic language

The respondents were asked to rate their ability to speak the Arabic language. According to figure 4.10, 2% (n=1) did not rate herself. Of the respondents, 76% (n=38) chose a rating from 1 to 5, and 22% (n=11) chose ratings between 6 and 10. It was therefore concluded that although 54% understood Arabic, 22% rated themselves as speaking the language poorly. The difference between understanding and speaking Arabic could not be explained on the basis of the research results. However, it is possible to understand a difficult language like Arabic, without being able to speak it.

#### ***4.2.2.19 Respondents' knowledge of Saudi Arabian taboos, rituals and cultural practices***

The respondents had to rate their knowledge regarding their understanding of Saudi Arabian taboos, rituals and cultural practices. From figure 4.10 it can be noted that 44% (n=22) rated themselves between 1 and 5 whereas 56% (n=28) chose a rating from 6 to 10.

If these responses are compared to those in figure 4.10, 34% (n=17) of the respondents rated their understanding of Saudi Arabian cultural and health care beliefs between 1 and 5; 44% (n=22) rated their understanding of Saudi Arabian taboos and rituals between 1 and 5. There was some difference in the respondents' ratings of their knowledge of Muslim beliefs and rituals.

#### ***4.2.2.20 Saudi Arabian cultural challenges/frustrations/problems encountered by the respondents***

As expatriates, the respondents had to list the challenges/frustrations/problems with which they had to deal when they cared for Saudi Arabian women. In table 4.20, 16% (n=8) indicated that they did not know of any challenges nor did 14% (n=7) have any experience and/or could not remember such challenging experiences.

The frustrations and challenges indicated by 70% (n=35) of the respondents in table 4.20, included communication barriers, privacy issues, religious obligations, cultural issues, and visitors and family involvement in the management of the patient.

According to Leininger and McFarland (2002:308), the family, especially the male figure, is the decision maker and the presence of large number of family members and visitors culturally demonstrates a caring attitude among Muslims.

**Table 4.20 Respondents' challenges/frustrations when caring for Saudi Arabian patients (n=50)**

<b>Response</b>	<b>Frequency</b>	<b>Percent</b>
Don't know	8	16.0
Nothing or no experience	9	18.0
The relatives and family interference in the care of the patient thus creating a problem	8	16.0
Language barrier	7	14.0
Privacy issues: Not cooperative during examinations and refusal to be examined by men	5	10.0
Attitudes towards the nurses: Saudis are more demanding and sometimes they treat people as their servants	4	8.0
Cultural issues: During Ramadan most women are fasting even when pregnant, sick and refuse treatment	3	6.0
Attitude towards health: Lack of knowledge regarding health issues	2	4.0
Visitors: The number of visitors is frustrating.	3	6.0
Limited knowledge about their culture and practices	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Of the respondents, 2% (n=1) indicated that her limited Muslim cultural knowledge frustrated her.

#### ***4.2.2.21 Respondents' actions to improve their understanding Saudi Arabian culture***

In table 4.21, the respondents listed the actions that they had taken in order to overcome cultural barriers and gain some understanding of the Saudi Arabian cultural knowledge when interacting with Saudi Arabian women.

Of the respondents, 18% (n=9) stated that they did not undertake any action; 4% (n=2) did not answer the question, and 16% (n=8) indicated that they did not know what actions they took. Of the respondents, 50% (n=25) listed their observations, interacting with the Muslim nurses, doctors, the family members and patients as their means of gaining an insight into Saudi Arabian culture. Finally, 12% (n=6) listed attending cultural classes offered by the hospital.

Masson (2005:97) maintains that the nurse is expected to observe, listen, ask and work together with the patient in order to understand the beliefs and attitudes that affect the patient's life. Only 50% (n=25) of the respondents gained an understanding of the Saudi

Arabian culture by doing what Masson (2005:97) proposes.

**Table 4.21 Respondents' actions taken to improve their understanding of Saudi culture (n=48)**

<b>Response</b>	<b>Frequency</b>	<b>Percentages</b>
None	9	18.0
Don't know	8	16.0
No response	2	4.0
From observation: Attending to the needs of childbearing women and observing	2	4.0
From healthcare providers: I asked and talk to the Muslim doctors and nurses	6	12.0
Attending lectures: cultural awareness programmes in the hospital	6	12.0
Reading the booklet provided in the unit and ask my co-workers	4	8.0
Listening to stories, reading newspapers and magazines	2	4.0
Research	1	2.0
Ask the patient and families regarding traditions, reading	1	2.0
By having given ante natal classes	1	2.0
Exercise patience	1	2.0
Trying to speak their language the best way that I can	2	4.0
To respect their culture	1	2.0
I am trying my best to speak and communicate with them in their language	4	8.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

#### **4.2.2.22 Cultural awareness presentations by the recruiting agency**

According to figure 4.11, 74% (n=37) of the respondents indicated that they received cultural awareness lectures from their recruiting agents before leaving their country of origin for Saudi Arabia. The other 24% (n=12) did not receive such information and 2% (n=1) did not answer the question.

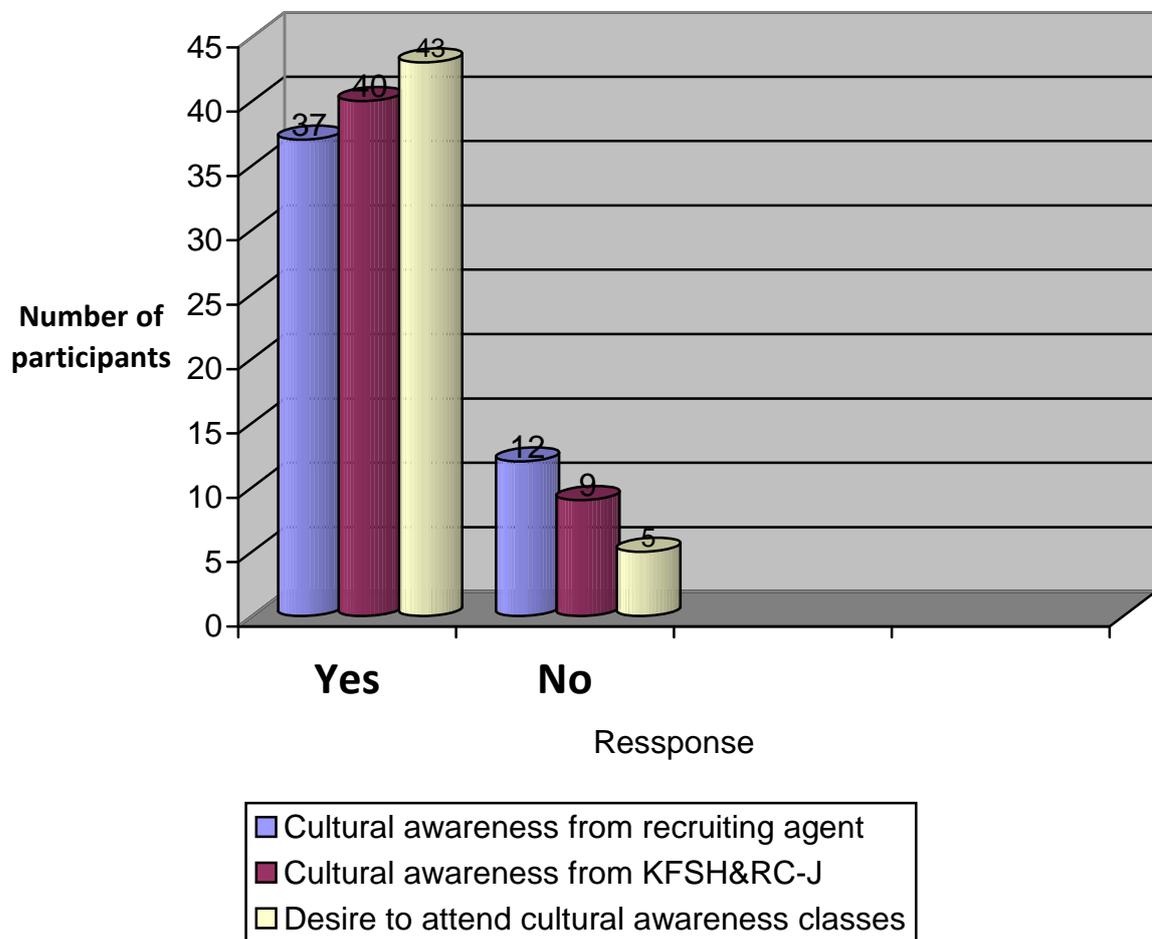
#### **4.2.2.23 Cultural awareness classes presentations at the King Faisal hospital**

The King Faisal Specialist Hospital and Research Centre, Jeddah conducted cultural awareness lectures according to 80% (n=40) of the respondents; 18% (n=9) did not know, and 2% (n=1) did not answer the question (see figure 4.11).

#### 4.2.2.24 Respondents interested in educational activities regarding Saudi Arabian culture

From figure 4.11, 86% (n=43) of the respondents indicated that they desired to participate in educational activities regarding Saudi Arabian culture; 10% (n=5) were not interested in such activities, and 4% (n=2) did not answer the question.

The majority of the respondents were interested in participating in educational activities regarding Saudi Arabian culture.



**Figure 4.11 Cultural awareness activities**

#### 4.2.2.25 Culture-related educational topics

In table 4.22, 16% (n=8) of the respondents did not answer the question and 8% (n=4) indicated that they did not know. Only 26% (n=13) of the respondents indicated that

they would like to attend classes on any topic. The remaining 50% (n=25) listed cultural topics covering the antenatal, labour and breastfeeding period.

**Table 4.22 Educational topics in Saudi Arabian culture that respondents would like (n=50)**

<b>Response</b>	<b>Frequency</b>	<b>Percentages</b>
No response	8	16.0
Any topic	13	26.0
Don't know	4	8.0
Childbearing Saudi women in the past and present culture	1	2.0
What are taboos and rituals	3	2.0
Breastfeeding, antenatal classes	2	4.0
Saudi Arabian cultural values of taking care of newborns	2	4.0
Psychosocial views of postpartum depression and management. Support of women during infertility, abortion and postnatal care. Religious requirements dealing with abnormal sick infants	6	12.0
Cultural beliefs and attitudes of Muslim women and their husbands regarding childbirth and the rituals associated with it	4	8.0
Cultural aspects during labour, prenatal and post partum. Remedies used generally and in pregnancy. Socialization within family and community	3	6.0
List of herbal medication and their action	2	4.0
How to read and write Arabic language	1	2.0
Cultural belief regarding breastfeeding, Muslim rituals performed by both parents for the baby	1	2.0
<b>Total</b>	<b>50</b>	<b>100.0</b>

Table 4.22 is supported by the findings in figure 4.11 that the respondents were interested in cultural educational activities, and the respondents listed the preferred topics and suggested others as well.

Based on the information in table 4.22, the topics listed cover the Saudi Arabian culture. In addition to the cultural topics, the respondents would have appreciated and supported topics on the psychosocial views of the Saudi Arabians, their religious practices and how to read and write Arabic.

### **4.3 CONCLUSION**

This chapter discussed the results of the data analysis. These were presented in the form of tables and graphs. The respondents' responses were compared with findings from the literature. From the analysed data it would appear that not all the nurses were

knowledgeable about Saudi Arabian cultural aspects. Some nurses indicated that they were eager to participate in Muslim cultural education activities.

Chapter 5 concludes the study, discusses the limitations, and makes recommendations for education, guidelines on Muslim cultural aspects for expatriate nurses, and future research.

## **CHAPTER 5**

### **Summary, limitations and recommendations**

#### **5.1 INTRODUCTION**

In the preceding chapters the research questions and objectives were introduced and literature was reviewed to identify the significance and relevance of the research study to the nursing profession. The literature review indicated that cultural knowledge and competence in today's health care arena is a necessity that is required of nurses who interact with multicultural societies from both the staff and patient population.

Data collection and analysis yielded results that assisted the researcher to make informed conclusions. These conclusions will be used to plan and direct the educational guidelines for nurses who attend to pregnant Muslim women in Saudi Arabia.

This chapter concludes the study, summarises the findings, discusses the educational intervention guidelines and limitations, and makes recommendations for future research.

#### **5.2 SUMMARY**

In summarising the research process and findings, the research questions and objectives will be used to guide the discussion.

##### **5.2.1 The research process**

According to the literature reviewed, knowledge of one's own cultural affiliation, beliefs, values, and life ways is important but the acquisition and development of knowledge of other cultural beliefs, values, and life ways should be aimed at. Non-threatening/non-fear provoking interactions with different cultures may enhance tolerance,

accommodation and respect of those involved. Appreciating, accepting and respecting other's cultures is the goal for effective transcultural interaction.

Culture competence development is essential in order to empower the nurse and this knowledge may be used to direct and shape the care rendered to patients. If the nurse does not understand the culture of the patient being served, this may lead to misunderstandings and conflict. In order for nurses to create a therapeutic environment, they should respect patients' cultural practices. This can only be done if the nurse possesses some knowledge about the relevant cultural aspects. The needs of the patients include the physical, psychological, religious, social and cultural aspects. In an encounter with the patient, the nurse strives to ensure that these needs are met. The study focussed on the nurses gaining Saudi Arabian cultural knowledge and to use this knowledge and understanding to care for the needs of pregnant Muslim women in Saudi Arabia.

Saudi Arabians are deeply rooted in their culture and religious practices. Understanding these cultural beliefs and practices is likely to demonstrate cultural competence. Culture is a complex and dynamic process and cannot be learned in totality. It is thus the responsibility of the nurse to acquire and develop this knowledge with each nurse-patient interaction.

The specific objectives of this study were to

- investigate non-Muslim nurses' understanding of the cultural practices associated with pregnancy, labour, the postpartum period and breastfeeding of the Saudi Arabian childbearing woman
- investigate non-Muslim nurses' understanding and knowledge of Muslim cultural taboos, rituals, and health beliefs practised by the Saudi Arabian childbearing women
- provide guidelines on what educational needs to be provided to non-Muslim nurses working with Saudi women to enhance their culture competent care

The researcher conducted a quantitative study with an applied, non-experimental, descriptive design. The information generated was intended to directly influence or

improve practice. The purpose of applied research is to identify solutions that address problems identified in the clinical area in order to improve practice.

The respondents were 50 non-Muslim nurses working in the obstetric units of the King Faisal Specialist Hospital and Research Centre, Jeddah. To be included in the study, respondents had to be

- Nurses from the obstetric (ante-natal, post natal, labour and delivery) units
- Non-Saudi Arabian and not of the Islamic faith
- Any categories, including head nurses and staff nurses of levels I, II and III

The nurses excluded from the study were of Saudi Arabian origin and belonging to the Islamic faith.

Data collection was done by self-administered structured questionnaires that facilitated the quantification of the findings for analysis. The researcher distributed the questionnaires and allowed each respondent to complete the questions according to her knowledge. The researcher collected the completed questionnaires in order to ensure confidentiality and control. This ensured anonymity and adherence to the ethical considerations discussed in chapter 3.

### **5.2.2 Findings**

The purpose of this study was to assess the Saudi Arabian cultural knowledge among the obstetric non-Muslim nurses and to compile educational guidelines for an educational intervention based on the identified needs. The study contributed to cultural knowledge development among non-Muslim nurses.

The findings were used to evaluate the respondents' self-assessment.

### **5.2.2.1 Does the non-Muslim nurse understand the cultural practices associated with pregnancy, labour, postpartum and breastfeeding of the Saudi Arabian childbearing woman?**

The study found that the respondents could not adequately demonstrate that they possessed the needed information regarding the Saudi Arabian women's herbal uses (see table 4.5). For example, the respondents could only list only four types of herbs that Saudi Arabian women use (see table 4.5).

Certain diseases are specific to people from certain geographical areas. Saudi Arabians also have diseases specific to their geographic origin (see chapter 2, 2.7.7). Only eleven respondents correctly identified diseases classified as specific to the Saudi Arabians. Nurses should know about such specific diseases in order to expect them and to know how to manage them should they be encountered.

The respondents did not reflect a good understanding of Saudi Arabian cultural practices during the antenatal, intra- and post-partum periods. The respondents also displayed a lack of knowledge of how Muslims practise prevention of ill health to the baby (see table 4.8). Regarding practices associated with the cord care, only 18% (n=9) of the responses listed the application of Ko'hl and the burying of the umbilical stump. This indicates that the respondents need to develop their knowledge regarding Saudi Arabian traditional practices. Furthermore, the respondents displayed inadequate knowledge of Saudi Arabian women's attitudes and practices regarding breastfeeding.

When interpreting the self-assessment rating on their knowledge of Saudi Arabian cultural practices (see figure 4.10), it was found that 60% (n=30) of the respondents indicated that they lacked Saudi Arabian cultural understanding and knowledge. These nurses need to increase their cultural knowledge because they are constantly in contact with the Saudi Arabian Muslim women. Understanding their cultural practices and beliefs would improve the patient-nurse relationships and may reduce the challenges and frustrations associated with the lack of cultural knowledge.

### **5.2.2.2 Do non-Muslim nurses have the knowledge of the cultural taboos, rituals, and health beliefs practised by the Saudi Arabian childbearing patient?**

The Saudi Arabians perform rituals including the one performed by the father for his newborn baby. The results of the study indicate that the majority of the respondents knew about this ritual, but whether they know the significance of this ritual is not known.

The respondents had to demonstrate their understanding of cultural concepts (see table 4.3), the results indicated that the respondents need to learn about cultural concepts and their significance as interpreted by the Muslims. For example, the concept of consanguinity was not understood; nor could the respondents explain how this practice affects the Saudi Arabians disease patterns. The same applied to the use of Ko'hl for warding off the effect of the "evil eye"; the requirement that Muslim women must cover the body and head by wearing the "*abaya*" and "*tarha*" and to avoid social contact with men other than their own. Knowledge of the medication and food taboos among the Muslims was not answered well (see chapter 4, table 4.12).

From the self-assessment rating, the findings depicted in figure 4.10 indicate that of the nurses in this study 56% (n=28) evaluated themselves as having an excellent understanding of the taboos, rituals and cultural practices of the Saudi Arabian childbearing women (rating 6-10). Although this excellent rating was given, the 44% (n=22) who rated themselves as having poor knowledge should not be overlooked. Based on these findings, a need was identified for nurses to increase their knowledge regarding the Saudi Arabian cultural knowledge.

All these findings thus indicated the need for an educational intervention.

### **5.2.2.3 What are the educational needs of non-Muslim nurses who work in the obstetric units in Saudi Arabia?**

In figure 4.11, 86% (n=43) of the respondents indicated that they were interested in educational activities based on the Saudi Arabian culture. Based on table 4.17, the respondents listed the educational activities that they felt would benefit them and assist them in increasing their Saudi Arabian cultural knowledge. The suggestions ranged

from any topic to topics that include Saudi Arabian cultural aspects specific to the pregnancy, labour, postpartum and breastfeeding. It can thus be concluded that there is a demand for a structured educational activity based on the Saudi Arabian cultural practices specific and general to the childbearing women.

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

The researcher identified the following study limitations:

- The study was conducted at one hospital in Saudi Arabia
- The study was conducted only among the nurses in the obstetric unit of the King Faisal Specialist Hospital and Research Centre, Jeddah
- The study involved only four nationalities as study respondents
- The respondents were only nurses
- The study results may not apply to nurses in other hospitals

### **5.4 RECOMMENDATIONS**

Based on the findings of the study, conclusions and limitations of the study, the researcher makes the following recommendations to improve patient care and for future research.

#### **5.4.1 To improve patient care**

The study allowed the nurses to assess their Saudi Arabian cultural knowledge and to identify areas that need improvement. Patient care within the cultural context can be improved by

- improving and structuring the hospital's existing educational programmes to empower the nurses with the knowledge of how to conduct literature search when confronted with cultural issues
- arranging cultural activities or events that promote sharing of information regarding the different cultural practices and how they are interpreted
- developing a resource corner in each unit with Saudi Arabian cultural information

- encouraging the nurses to incorporate cultural issues in the nursing care plan
- developing educational activities guidelines for non-Muslim nurses working in Saudi Arabian obstetric (and other) units
- identifying a resource person at each hospital who is knowledgeable about Muslim practices and who can be consulted by nurses at all times
- offering basic language courses in Arabic

#### **5.4.2 Future research**

Future research should be conducted on the following topics:

- A follow-up study after the educational intervention to determine whether knowledge was gained or not.
- A similar study in units other than the obstetric units, using face-to-face interviews to obtain more in-depth information (instead of self-administration questionnaires)
- A qualitative study to identify nurses' lived experiences of providing care to obstetric women of other cultures
- Information brochures, based on research findings, should be compiled for nurses.

### **5.5 EDUCATIONAL INTERVENTION GUIDELINES**

The following educational intervention guidelines are suggested for non-Muslim nurses working in Saudi Arabia:

- Resources: Information from culture specific articles, web-side, reading material.
- Introduction to nursing theories regarding cultural competence such as Campinha-Bacote's cultural competence theory or Leininger's theory of cultural care.
- Utilisation of theory to direct and influence practice as indicated in this study.
- Definition of terms: culture, cultural competence, diversity, taboos, rituals, modern and traditional health care and related terms.
- Understanding the dynamics of culture.

- Discussion of cultural knowledge development.
- Discuss the importance the nurse-patient relationship and the Muslim culture.
- Introduction to the foundation of the Islamic faith.
- Exploring how Islamic religion guides reproductive health issues such as menstruation, birth control and the usage of medicines.
- Investigating the importance of the family in the Muslim social structure.
- Search for information from the literature regarding cultural and health care practices of Muslim childbearing women as pertaining to pregnancy, delivery (intrapartum), puerperium, breastfeeding, death, Saudi Arabian herbal use, diseases common to Saudi Arabian Muslim communities.
- Searching for information from the literature regarding Muslim childbearing women's rituals, taboos cultural and health care beliefs as pertaining to medication and food.
- Understanding cultural concepts and health care beliefs related to the use of "henna", the meaning of the "evil eye", the practice of consanguinity, beliefs and traditions about modesty, and the use and meaning of ko'hl.

The educational activity will take the form of:

- Classroom, formal presentation and discussion.
- Unit presentation of current research findings on Saudi Arabian culture.
- Creation of a folder with the cultural articles and information leaflets.

## **5.6 CONCLUSION**

In the health care arena the challenge is to provide a culture-sensitive environment and to incorporate cultural issues in the management of patients. Improved cultural knowledge will enhance cultural competence that, in return, will improve nurse-patient relationships, if applied in practice.

The study found that nurses require additional information to increase their knowledge of Saudi Arabian cultural practices. The educational need was not only identified from their answers to the questions, but also from their ratings of their knowledge and their interest in participating in educational activities aimed at expanding their cultural knowledge. The study found further that there is a need to develop educational

guidelines to be used to structure the activities of an educational intervention.

Nurses come into contact with patients of different nationalities and cultural backgrounds. Nurses are required to have knowledge of the culture being served thereby ensuring that patients' needs are met. Cultural knowledge may be acquired by the interaction with the patients and people belonging to that cultural group. The interaction becomes meaningful when the parties involved, develop a desire to learn from each other, share their culture, are willing to accommodate each other's differences and learn from each other.