CHAPTER ONE

ORIENTATION TO THE STUDY

1.1   INTRODUCTION

The nursing profession needs a knowledge base or science on which to build its practice (Perry & Jolley 1992:24). Nursing science is considered to be "*the creative study of nursing phenomena which reflects the systematization of knowledge using rigorous and explicit research methods*" (Leininger 1991:30). The field of transcultural nursing is committed to developing a knowledge base related to cultural care; this knowledge of cultural care differences and similarities helps nursing to develop its theoretical and practical bases (Leininger 1991:31). Through this study the transcultural nursing knowledge base is expanded by knowledge on the urban Pares living in Moshi, Tanzania.

1.2   BACKGROUND TO THE STUDY

1.2.1   Tanzanian social economy

Tanzania is a country of great beauty and geographical variety. It is situated in East Africa, a few degrees south of the equator (see Figure 1.1). A democratic country which became independent in 1961, Tanzania is divided into 20 regions. It is the tenth poorest country in the world when judged by GNP per capita (Haub & Cornelius 2000:3). The economy is based on agricultural production; coffee, cotton, sisal, tea, tobacco and cloves are among the major exports. It has been estimated that 51% of the population are Christians, 35% are Muslims and 13% follow traditional religions (Johnstone 1993:527).

1.2.2   Tanzanian tribes

The population of Tanzania is made up of heterogeneous groups of people, a result of "colonial land carving". There are said to be "*more than 120 loosely defined 'tribes'* " (Amin 1992:28). The estimated population in the year 2000 was 35.3 million people (Haub & Cornelius 2000:3).
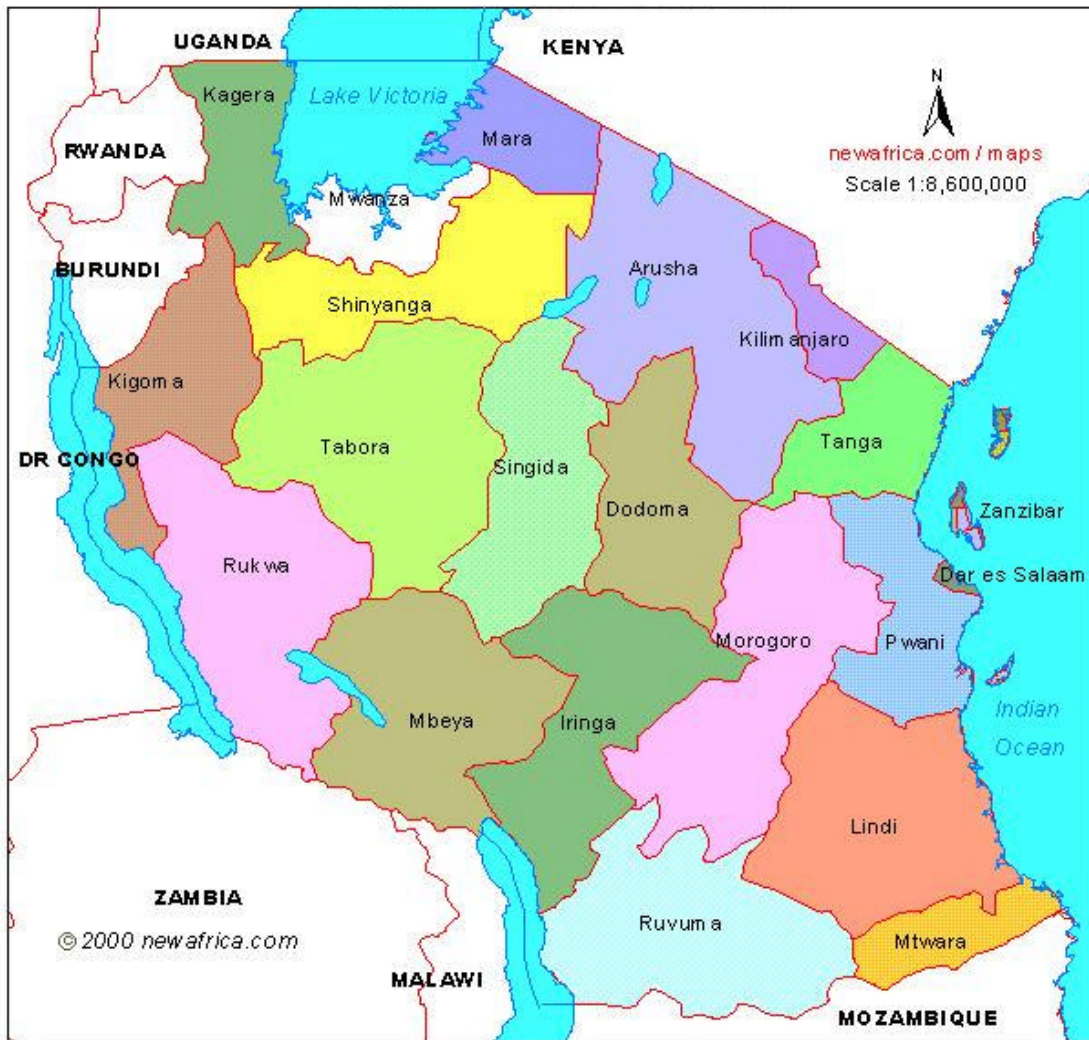
Figure 1.1

Tanzania administrative map

(newafrica.com/maps 28 May 2003)

Among the largest tribal groups, with more than a million persons, are the Sukuma of southern Lake Victoria and the Chagga of Kilimanjaro Region. The main tribes of Kilimanjaro Region are the Chagga and the Pare. Chaggas are mainly resident in the northern districts of this region in Hai, Rombo, Moshi urban and Moshi rural districts, while the Pares are mainly resident in Same, Mwanga and Moshi rural districts (see Figure 1.2).

There has been considerable migration of Chaggas to other districts and regions, and some migration of Pares. Extrapolating from the census figures of 1988, it was

estimated that there would be about 1.1 million Chaggas and 300,000 Pares in 2001 (United Republic of Tanzania 1994:9) (see paragraph 2.6.3 and Table 2.1).
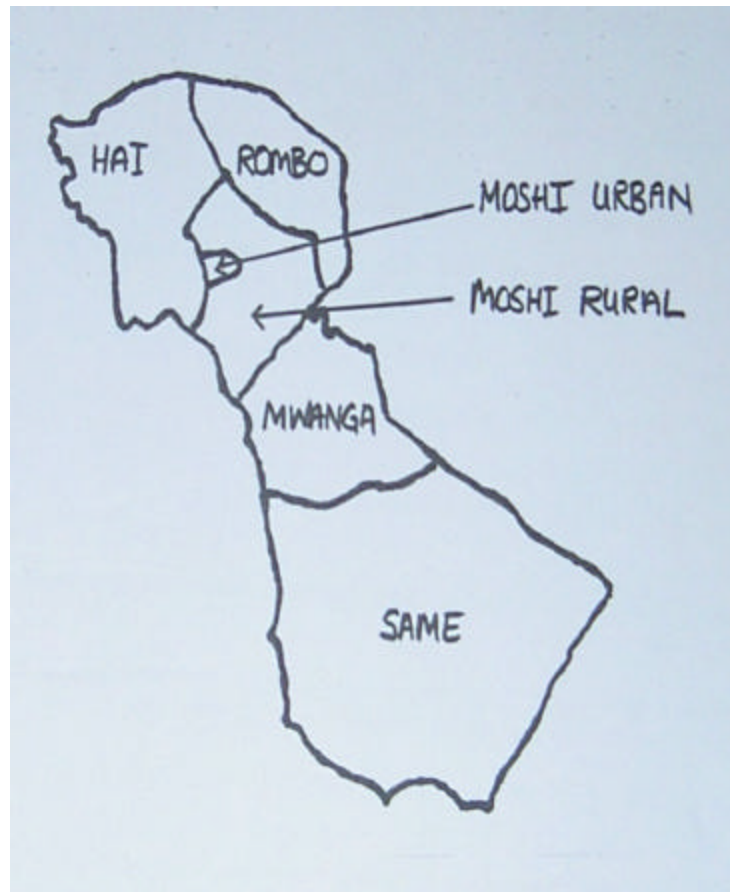

Figure 1.2

Map of Kilimanjaro region

(United Republic of Tanzania, President's Office, planning commission, Bureau of Statistics 1994: cover page)

These estimates appear to be fairly accurate according to the results of the 2002 census which are shown in Table 1.1. The population of Mwanga and Same districts was 327 945; this population is predominantly Pare by tribe. The population of the other districts in Kilimanjaro was 1 053 204; this population is largely Chagga by tribe. The net losses and gains of population from migration into and out of the region are not accounted for in this estimate of tribal groups. Dar-es-Salaam (the region which includes the largest city in the country) is the only region to have more males than females, suggesting that there is a net gain of males by migration to this area.

The data presented in Table 1.1 also suggest that there are differences in household size between rural and urban areas in Kilimanjaro Region.

Table 1.1: Population by sex, number of households and average household size in Kilimanjaro Region of Tanzania, 2002.

DISTRICT	POPULATION NUMBER, MALES	POPULATION NUMBER, FEMALES	POPULATION NUMBER, TOTAL	HOUSE-HOLDS, NUMBER	HOUSE-HOLDS, AVERAGE SIZE
ROMBO	116 859	129 620	246 479	50 123	4,9
MWANGA	55 666	59 954	115 620	24 326	4,8
SAME	103 520	108 805	212 325	44 474	4,8
MOSHI RURAL	192 998	209 433	402 431	84 862	4,7
HAI	127 782	132 176	259 958	58 056	4,5
MOSHI URBAN	71 040	73 296	144 336	35 598	4,1
TOTAL	667 865	713 284	1 381 149	297 439	4,6

(United Republic of Tanzania, Bureau of Statistics 2002:189)

The 1967 Arusha declaration de-emphasized tribal differences, and aimed to promote a national identity (Jerman 1993:32-34). The first ruling party, the Tanganyika African National Union (TANU), opposed tribalism and all practices that were considered to lead to isolation amongst Africans (Cliffe & Saul (eds) 1972: 127,134).

1.2.3 The Pare tribe

The home of the Pares (pæ-reɪs) is in northeast Tanzania bordering on Kenya. Before the nineteenth century, there was at least one centralised kingdom in north Pare and about seven identifiable tribal units in the middle and southern parts (Kimambo 1991:1). Before 1928, the Germans administered the area in two parts, north and south Pare. The Pare district and the Pare tribe were "created" in 1928 during British colonial rule to promote smooth development of an area where common factors were "*the highland homeland, the Chasu language, and the lifelong experience in ritual*" (Kimambo 1991:173). Local people still speak of the Pare district, although since 1978 administrative boundaries have been changed so that the northern area is called Mwanga District and the southern is called Same District (Kimambo 1991:174) (see

Figure 1.2). The Pare tribe appears to have retained its identity. In the late 1960's, the 'tribal' identity was said to be "*growing, developing and increasing*" (O'Barr, cited in Kimambo 1991:173), and on questioning individuals living in Moshi, they readily describe themselves as belonging to a particular tribe such as Chagga, or Pare. In July 2002, it was found that of the new patients attending Kilimanjaro Christian Medical Centre in Moshi, the largest health care institution in the region, 20,6% were Pares and 56,5% were Chaggas (Mwanswila 2002:30). This suggests that Pares are a significant proportion of the health consumers in this institution, and of the population of Kilimanjaro Region.

1.2.4 Tanzanian health

Tanzanian life expectancy at birth is only 53 years; the infant mortality rate is 99/1000 live births and total fertility rate is 5,6 (Haub & Cornelius 2000:3). Health problems in Tanzania still include malnutrition, high rates of communicable disease, including HIV infection and diseases of poor sanitation and water supply, while non-communicable diseases are increasing (Mwaluko, Swai, & McLarty, in Mwaluko, Kilama, Mandara, Murru, & Macpherson 1991:219-234). According to Ministry of Health statistics from 1997, malaria was the most common disease to be treated in outpatient facilities in all age groups, and was the leading cause of admission to health care facilities. Outpatient statistics suggest that 4 895 487 cases of malaria were reported in one year, while upper respiratory tract infection accounted for 1 822 847 cases, and diarrhoeal disease for 1 008 115 cases. In comparison to these three commonest reported conditions, cardiovascular diseases accounted for 26 235 outpatient cases (0,2% of the total cases). These figures may be substantially lower than actual figures since regional statistical response rates are from 8–80%. Clinical AIDS was the leading cause of deaths in health facilities for patients over five years of age. Protein energy malnutrition accounted for more than 5% of deaths in under five year olds. The most frequent cause of an outbreak of notifiable disease was typhoid. Table 1.2 shows the proportions of cases notified of the five most frequent causes of an outbreak of notifiable disease in Tanzania, January 1997 (United Republic of Tanzania 1999:1–26,59).

Table 1.2: The five most frequent causes of notifiable disease in Tanzania, January 1997.

NOTIFIABLE DISEASE	PROPORTION OF DISEASE CASES NOTIFIED
Typhoid	37%
Measles	29%
Relapsing fever	20%
Plague	7%
Cholera	5%

(United Republic of Tanzania 1999:59)

1.2.5 Tanzanian health care

1.2.5.1 History

Health care in Tanzania has a long and fascinating history. Traditional medicine has been practised for centuries, and it is claimed that even in the year 2001 "*about 70 – 80 % of the population use traditional medicine for social and health problems*" (Goergen 2001:2). Medieval Arab medicine spread to East Africa after the tenth century; later Portuguese and French Navy surgeons practised at the coast. During the German colonial rule of 1889 – 1916, dispensaries were set up in the coastal areas, and later a network of nine dispensaries was set up inland. During the period of British colonial rule from 1916 – 1960, Western medical facilities became available to more of the population (Goergen 2001:5–15).

From 1900, Lutheran missionaries were actively introducing Christianity and western style medicine in north Pare and later in south Pare. "*The Pare people did not embrace the modern institutions introduced by the missionaries as readily as the Chagga. The stronger position of local healers meant that traditional medicine was never rejected as an inferior or backward tradition ...*" (Moland 2002:37).

Nurse training began in the 1930's in mission hospitals, and the first government nursing certificate was awarded in 1943. By 1960 there were 13 nurse training institutions (Sanga 1994:36).

The way Western medical care was introduced into Africa has been criticized for being inappropriate and involving maldistribution, neglect of health promotion and preventive care and overdevelopment of curative services (Sanders 1985:135).

1.2.5.2 *Current provision of health care*

In 1999 there were reported to be 5 284 health facilities nationwide including 416 in Kilimanjaro region (United Republic of Tanzania 1999:2–8). These facilities include regional and district hospitals, clinics and dispensaries; some of these are government institutions. Others receive some funding from government and still others are privately owned and run. In addition to these institutions functioning according to the biomedical model, there are many traditional healers. The two main groups of traditional healers *(waganga wa kienyeji)*, are the herbalists *(waganga wanaotumia tiba za miti shamba),* who could be considered to operate within the holistic paradigm, and those who deal with spiritual forces *(waganga wanaotumia tunguri)* who operate within the magico-religious paradigm. Traditional healers do not generally appear to advertise, but work from their homes, and are known by the community. There are some herbalists who sell medicines at the side of the street in towns.

The official health services are of the biomedical paradigm. Traditional practitioners have a national association known as CHAWATIATA (Goergen 2001:4). There are also some alternative practitioners, such as practitioners of acupuncture and Chinese medicine, who practice within different paradigms including the holistic paradigm.

While the Ministry of Health recognised traditional healers from 1968 (Goergen 2001:4), there is a need for improved collaboration between the traditional and biomedical practitioners. There is concern that the introduction of 'cost-sharing' has made government funded institutions less accessible to the population, so that the economically disadvantaged members of society may return to more affordable traditional practitioners (Moland 1998:3). There is an identified need to improve nursing practice in Tanzania, (Juntunen & Nikkonen 1996:536-544; Kohi & Horrocks 1994:77-86; Moland 2002:167–8; Msoka 1996:252-3).

1.2.5.3 Transcultural nursing education

The curriculum for general nurse training in Tanzania now has 10 hours of specified cultural content included in a short course of sociology (United Republic of Tanzania, Ministry of Health 2001:85). This content includes a limited amount of information on cultural aspects of care although helpful guidelines are available (Leininger 1995:22). However, Bachelor of Nursing courses may have more transcultural nursing content if Tumaini University is typical; their curriculum includes 50 hours of anthropology and 4 hours of transcultural nursing (Tumaini University 1999:34). Nursing degree courses are however available to a small number of nurses.

Documented research for use as teaching/learning material and as literature sources for nurses wishing to undertake research appears to be lacking. While there are some interesting anthropological studies of various tribal groups, with the Masai receiving the most attention, there are a limited number of written sources of information about health care practices of different groups in Tanzania (see Chapter 2).

1.2.5.4 Application of transcultural nursing in Tanzania

It may be that some nurses currently working in Tanzania are unaware of the importance of culture in nursing care. This may reflect the lack of transcultural nursing in the curriculum at diploma level up to the present and the lack of Tanzanian transcultural nursing literature. As there are few transcultural nurse specialists in the country, there is probably little transcultural nursing content in continuing education programmes, and health service users may not be aware of their right to culturally congruent care (see paragraph 5.4.5.7.1).

1.3 PROBLEM STATEMENT

Based on personal experience and considering the minimal amount of transcultural content in the curriculum, there appears to be a lack of knowledge of the culture of the urban Pares of Moshi. This lack of knowledge would be expected to result in failure to provide culturally congruent care for this group, particularly as the official health services function within a different paradigm to the traditional health services. While

a full cultural assessment of urban Pares is awaited, a study of their health beliefs can provide some data to assist health workers to provide culturally congruent care.

1.4 RESEARCH QUESTION

The following research question was formulated:

- What are the health beliefs of the urban Pares living in Moshi, Tanzania?

1.5 PURPOSE OF THE STUDY

The purpose of the study was to explore the health beliefs and practices of the urban Pares of Moshi. It aims to determine what are normal care patterns, expressions and practices.

Nursing needs to build up its scientific knowledge base; transcultural nursing assessments are able to provide valuable knowledge to improve education, research and practice. Health beliefs are a critical determinant of people's behaviour; knowledge and understanding of a culture by health workers can make a great difference in the quality of care they provide. All cultural groups, including the urban Pares of Moshi, deserve culturally congruent care.

1.6 OBJECTIVES OF THE RESEARCH

The following research objectives were formulated to guide the researcher. In this study the researcher aimed to do the following:

- gain an understanding of the health beliefs and practices of the urban Pares of Moshi, Tanzania
- describe the health beliefs and practices of the urban Pares of Moshi, Tanzania
- recommend how nurses may modify their current practices to provide culturally congruent care for this group.

1.7   ASSUMPTIONS

Assumptions are statements which are not tested, but are considered to be 'true' for the particular study. The following assumptions have been identified, according to Mouton's classification of assumptions (1996:123-124). These relate to what the researcher accepts to be the nature of truth, reality, and suitable methods to use in studying the truth and reality of the phenomenon of interest. The researcher who functions within the qualitative paradigm is guided by these assumptions at all stages in the research process.

1.7.1   Epistemological assumptions

Epistemological assumptions are statements about what is truth and what is the nature of knowledge and science (Mouton 1996:123). With regard to epistemological assumptions in this study, it is assumed that:

- 'Truth' is subjective and depends on the context. In the qualitative paradigm it is accepted that *"there is more than one way to know something and that knowledge is context bound"* (Streubert & Carpenter 1995:9).
- Tradition and culture shape knowledge and ideas about truth.
- The worldview of the individual alters perceptions and conceptualisations of people.
- Biomedicine, personalistic systems and naturalistic systems guide knowledge, knowledge systems and ethics (Holland & Hogg 2001:15–25).

1.7.2   Ontological assumptions

Ontological assumptions involve statements concerning the nature of the research object (Mouton 1996:124), in this instance health beliefs and related practices. It is assumed that:

- Humans are complex and experience life in individual ways.
- Human behaviour and expectations are strongly influenced by the culture of an individual.

- Health beliefs and practices exist in all cultures; some of these are universal and others are specific to a cultural group.
- Professional care differs from folk or generic care systems.
- Health beliefs and practices are related to worldview and cultural and social structure dimensions of life.

1.7.3   Methodological assumptions

Mouton (1996:124) defines methodological assumptions as pertaining to *"the nature of the research process and the most appropriate methods to be used"*. In this study, methodological assumptions include:

- An exploratory design is suitable for this topic not previously been studied from the informant's point of view (Brink & Wood 1998: 316).
- Description is suitable when there is an underlying conceptual framework for the study and a known concept is being studied in a new population (Brink & Wood 1998:290). A conceptual framework is a previously developed theoretical structure within which the phenomenon of interest can reasonably be situated, such as Leininger's theory of nursing: culture care diversity and universality.
- Life experiences and perceptions of other people can be studied by observing them or communicating with people involved.
- The qualitative interview is a communication tool which enables the researcher to gain insight into the informants' lifeworld.
- A valid sample can be obtained by selecting informants living the experience which is being studied.

1.8   SIGNIFICANCE OF THE STUDY

The significance of the study relates to it's *"potential for contributing to and extending the scientific body of nursing knowledge"* (LoBiondo-Wood & Haber 1994:166). The findings of this study have the potential for improving education and research which are foundational to health care practice, as well as having a direct impact on health care.

1.8.1 Education

1.8.1.1 Curriculum development

A critical criterion for inclusion of material in a curriculum is relevance; "*because nursing is a practical profession, what is taught must be relevant to practice*" (Ewan & White 1991:21). A curriculum for professional education must be derived ultimately from the needs of the community (Guilbert 1989:3-17). The needs of the community can be clarified through community assessments, such as transcultural nursing assessments.

1.8.1.2 Teaching / learning activities

When local material is available and presented and utilised, it can help to raise awareness of and interest in the issue of transcultural health care. While there are some excellent transcultural nursing texts and material in print, learning theoretical constructs is only the beginning point. If students and qualified staff are to internalise and utilise concepts such as cultural sensitivity, up to date relevant material is needed. Learning by students and qualified staff is facilitated when it is related to the 'known'; when it can be linked to something already understood (Reilly & Oermann 1992:34–35). It is hoped that the results of this study may encourage nurses to develop an interest in transcultural nursing, and develop a greater respect for people of different cultures. Transcultural nursing knowledge helps to broaden perspectives and promotes personal development.

1.8.2 Research

The research activity of performing a transcultural nursing assessment in itself helps to build up the knowledge base of nursing, thereby enhancing nursing's professional and academic status and credibility. Any assessment will produce research questions and facilitate subsequent studies including comparative or compiled research. Transcultural nursing assessments provide valuable information for others carrying out research. They may serve as background information, and assist researchers to develop more valuable projects, for example, by ensuring that questionnaires are

culturally appropriate. This particular study will facilitate subsequent studies of Pares, and provide material for comparative studies of Tanzanian cultural groups. It is hoped that nurses will be encouraged to undertake further research into the culture of the Pares, and of the other cultural groups in Tanzania.

1.8.3 Practice

It is now recognised that professional nurses should provide individualised evidence based care, rather than ritualistic and stereotyped care (Walsh & Ford 1990:ix-xi). Evidence based care requires the utilisation of research findings. Transcultural nursing assessments provide information for direct application to practice, for example in the development of individual care plans and in providing relevant information for quality assurance programmes. This not only improves care provision and client satisfaction by providing culturally congruent care, but also improves job satisfaction for health workers.

Transcultural nursing assessments are valuable for purposes of employee orientation, including that of national and expatriate health workers, visiting students, and experts. New employees should be oriented not only to the work area but to the culture of the groups served by the facility. Appropriate orientation improves the quality of work, and the experience gained. An understanding of the health beliefs of a cultural group promotes appropriate communication and respect between health care providers and their clients.

This study aimed to increase the awareness of health workers to the needs of this group, and thereby to improve the quality of health care provision. The data presented may help to serve as a basis for proposals to improve the quality of care in health institutions in Kilimanjaro Region. Specific recommendations arising from this study necessitate reviewing of priorities in allocation of health care resources by those involved in health care planning.

1.9 CONCEPTUAL FRAMEWORK AND RESEARCH METHOD

1.9.1 Conceptual framework

This study was undertaken within the broad guidance provided by Leininger's theory of nursing: culture care diversity and universality. The assumptive premises (Leininger 1991:44–46) and the orientational definitions (Leininger 1991:46–49) guide the study. The work of other authors who have built on the foundation laid by Leininger was utilised, including work by Giger & Davidhizar (1995), Boyle & Andrews (1989), Andrews & Boyle (1999) and Tripp-Reimer, Brink & Saunders (1984).

1.9.2 Research approach and design

A qualitative research design was used to allow the collection of data about life experiences and beliefs from the perspective of the informant. Characteristics of qualitative research including the belief in multiple realities, the role of the researcher and the aims of discovery, description and understanding are congruent with the assumptions and aims of this study (Streubert & Carpenter 1995:10-12).

Qualitative research involves the systematic collection and analysis of subjective data and identifies the characteristics and the significance of human experiences (Polit & Hungler 1995: 15-16). It takes into account human beings' participation in a situation by using the raw data from informants in written and oral descriptions, rather than as statistics.

The research question "What are the health beliefs of the urban Pares living in Moshi, Tanzania?" (see paragraph 1.4) required exploration of subjective views of informants. The purpose of the study was to explore the health beliefs and practices of the urban Pares of Moshi and to determine what are normal care patterns, expressions and practices (see paragraph 1.5). This also required an exploratory approach in which the researcher was collecting data on a previously unreported topic. The researcher aimed to achieve research objectives (see paragraph 1.6) including gaining an understanding of the health beliefs and practices of the urban Pares of Moshi,

Tanzania, and describing the health beliefs and practices of the urban Pares of Moshi, Tanzania. Understanding and describing require the use of a qualitative approach. The researcher therefore chose a qualitative approach because it was the most appropriate design to answer the research question, the purpose of the study, as well as the research objectives.

1.9.3   Population and sample

The research population for the study was the members of the Pare tribe now living in urban Moshi. Polit and Hungler (1995: 230) describe the accessible population as *"the aggregate of cases that conform to the designated criteria and that are accessible to the researcher as a pool of subjects for a study"*. A sample is made up of units or elements of the population (Polit & Hungler 1995: 230). The individuals who made up the sample in this study are referred to as informants, as they provided information about health beliefs to the researcher (Polit & Hungler 1995:643). A non-probability, purposive sample was used to select informants who met the criteria for selection (see paragraph 3.4.4.1). Informants were chosen by the researcher because of the need for a sample of experts in the phenomenon under study (Polit & Hungler 1995:235). Informants were contacted and agreed to participate in the research with informed consent (Streubert & Carpenter 1995:44). The size of the sample was considered satisfactory when data saturation was reached. Data saturation occurs when new data yields the same information as data already collected, and a sense of closure is reached (Polit & Hungler 1995:652). This study involved nine informants.

1.9.4   Data collection approach

Semi-structured interviews were used to collect data from informants. The interviews provided informants with the opportunity to explain their experiences related to health beliefs. The interviews were conducted face to face, in a comfortable environment. Open-ended questions from an interview guide (see Annexure B) were used during the interviews, and probing questions were used to explore themes further.

1.9.5   Data analysis

A thematic analysis was made following transcription and translation of interviews verbatim. Main themes and sub-themes were identified, which were then used as a framework for a descriptive account including informants' own words. For details of the research methodology, see Chapter 3.

1.10   TERMINOLOGY

The following key terms are used in this study, using the following definitions:

1.10.1   Culture

Culture can be defined as "*the learned, shared and transmitted values, beliefs, norms and life practices of a particular group that guides thinking, decisions and actions in patterned ways*" (Leininger 1991:47).

1.10.2   Health beliefs

Health beliefs are the ideas and practices related to health and illness, which are influenced by tradition and culture, and the prevailing worldview (Holland & Hogg 2001:15–17).

1.10.3   Transcultural nursing

Transcultural nursing can be considered to be "*a specialty within nursing focused on the comparative study and analysis of different cultures and subcultures. These groups are examined with respect to their caring behaviour, nursing care and health illness values, beliefs and patterns of behaviour*" (Andrews & Boyle 1999:4).

1.10.4 Cultural nursing assessment

Cultural nursing assessment involves the obtaining of relevant information about an individual's or a group's culture so that culturally congruent care can be provided (Giger & Davidhizar 1995:6; Tripp-Reimer et al 1984:78).

1.10.5 Culturally congruent care

Culturally congruent care is care that is acceptable, beneficial and meaningful to those receiving it in terms of their cultural patterns and beliefs (Leininger 1991:49).

1.10.6 Tribe

A tribe can be considered to be "*a social division of a people defined in terms of common descent, territory, culture*" (Collins Concise Dictionary 1995:1439).

Chagga tribe: the tribal group associated with Mount Kilimanjaro of north eastern Tanzania (Kesby 1977:69).

Pare tribe: the tribal group associated with the Pare Mountains (see Figure 2.5) (the Asu-Shambaa highlands) of northeastern Tanzania (Kimambo 1991:77).

1.11 SCOPE AND LIMITATIONS

The study aimed to assess the current cultural patterns of urban Pares living in Moshi. These will have some similarities and some differences to the urban Chaggas, and to the rural Pares, and probably to urban Pares in other towns. Culture is not static, and a cultural group which is rural and with fewer external influences may change less quickly than an urban group (Price 1995:21). The findings may not be applicable, or transferable to other groups, and will need revision over time to remain immediately useful to practice. However, with sufficient descriptive data to allow comparison, the assessment should be useful as outlined above in the discussion of significance, although not generalisable in the sense used for assessment of quantitative research (Krefting 1991:4).

The sample was small and may not be completely representative of all urban Pares in Moshi. Also, the instrument used for data collection may have limited credibility because it has not been used and tested before.

It was not possible to assess every aspect of the culture of urban Pares of Moshi, so this was not a comprehensive anthropological study. Only those aspects which appear directly relevant to health beliefs were addressed.

Limitations of the interview method of data collection include the risk of interviewer bias, and response biases such as social desirability response bias (Polit & Hungler 1995:289–291). The researcher is an expatriate who is known to some Moshi residents as a health worker, interviewing local informants in somewhat imperfect Swahili. However, Tanzanian informants interviewed in relation to this and other studies appear to be very helpful and co-operative, and translators are available to assist.

Time limitations restricted the number of informants interviewed; however, the aim was to achieve data saturation and to interview informants of different religious groups, different age groups and both sexes.

1.12   ETHICAL CONSIDERATIONS

1.12.1   Principle of beneficence

The interview schedule was constructed bearing in mind the need to obtain information but also the need to respect the informants' time. The researcher was aware that political implications (Brink & Wood 1998:327) and unwelcome results (Brink & Wood 1998:352) would need to be handled with great care (see paragraph 3.8.1).

1.12.2   Principle of respect for human dignity

The right to self-determination is protected by providing full explanations about the study and obtaining informed consent for the interview before proceeding (see

paragraph 3.8.2). Informants were notified that they could refuse or terminate the interview at any stage (Polit & Hungler 1995:122-124).

1.12.3 Principle of justice

Informants were treated with courtesy and respect at all times. Interviews were conducted in privacy and confidentiality was maintained by coding and careful storage of personal information details (see paragraph 3.8.3). Help with translation was obtained from individuals who were fully cognisant of the ethical considerations discussed here (Polit & Hungler 1995:124-125).

1.13 ORGANISATION OF THE REPORT

The report is organised into five chapters as follows:

Chapter 1. Orientation to the study. This provides background information, the problem statement, research questions, purpose and objectives of the study. It describes the assumptions and significance of the study and provides a summary of the methodological and ethical issues.

Available material published in books and journals, including relevant anthropological and nursing studies, is presented in *Chapter 2. Literature review*. This chapter is organised according to Leininger's Sunrise Model considering issues such as worldview, cultural values and health belief systems, environmental context, language and ethnohistory, and care expressions, patterns and practices.

Chapter 3. Research design, describes the qualitative approach to be used including choice of informants, method of data collection, pre-testing of the questionnaire, analysis and interpretation of the data, and the issue of assessment of trustworthiness.

Chapter 4. Presentation and discussion of data, presents the transcultural nursing assessment data related to health beliefs, and discusses them under the main headings of multiple world views and change and continuity.

Chapter 5. Conclusions and recommendations, considers ways in which nurses can provide culturally congruent care for this group of people on the basis of this assessment.

1.14 CONCLUSION

In this chapter the background and the context of the study was described. The importance of the study as well as the aims, purpose, research questions and objectives were explained.

Relevant concepts were defined and an outline of the study was provided. A literature study follows in the second chapter.