TRANSCULTURAL SELF-EFFICACY AMONG STUDENT NURSES AT A PRIVATE NURSING SCHOOL IN DURBAN KWAZULU-NATAL

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Dissertation submitted in fulfilment of the requirements for the Degree of Master's in Nursing in the Faculty of Health Sciences at the Durban University of Technology

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Date: January 2022

Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

21 January 2022

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M Nursing

Abstract

Introduction

Transcultural nursing is a formal area of study and practice focused on comparative holistic culture, care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and ways of life with the goal of providing culture-congruent, competent, and compassionate care (Leininger 1991:29).

Nurses are in a unique position to embrace transcultural nursing as it impacts on health care practices and their ability to communicate effectively with patients. An increase in cultural competency usually leads to culturally congruent customary care to accommodate patients' beliefs, cultural values, lifestyles, practices, and traditions (Schmidt 2015:3).

Aim of the study

The aim of the study was to explore the level of transcultural self-efficacy among student nurses at a private nursing school in Durban, Kwa Zulu-Natal.

Methodology

A qualitative research design with an ethnographic, descriptive narrative was used in this study. Ethnography is a qualitative paradigm which involves the description of cultural behaviour, cultural patterns and experiences and shared meanings that shape behaviour (Polit and Beck 2018:220). Data collection comprised of four stages, participant observations, focus group interviews, diaries, and reflections. Focus group interviews were analyzed using Leininger and McFarland's (2002: 97) four phase data analysis.

Findings

The research questions were answered regarding the competence, skills, self-efficacy, and confidence of student nurses in their experience of nursing patients from diverse cultures. Three major themes, sub-themes and categories emerged, and these were awareness and self-awareness of culture, respect, caring and self-efficacy. The results showed that nurses believed that the more knowledge and experience they were exposed to, the more skilled and competent they would become, and this would enable them to be confident and efficient in delivering transcultural nursing care.

DEDICATION

I dedicate this dissertation to my only precious daughter Sabine Kalinka for her love, support, and encouragement. You have inspired me.

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At the outset, I would like to thank and give all Glory to my Heavenly Father for His faithfulness and His promises given to me in His word.

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To my late parents Sharky and Daily, who led by example in embracing all cultures

To my late husband Robert, to whom I have promised that someday I would complete this study.

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LIST OF ACRONYMS

AIDS	Auto-immune deficiency syndrome
CPAP	Continuous positive airway pressure
DENOSA	Democratic nursing organisation of South Africa
DHET	Department of higher education and training
DUT	Durban university of technology
HIV	Human immune virus
IREC	Institutional research ethics committee
LTT	Leininger's Thompson Temlinn model
NICU	Neonatal intensive care unit
OPD	Out-patients department
R683	Regulation 683 for enrolled nurses bridging programme to registered nurses
SANC	South African nursing council
SICU	Surgical intensive care unit
OPD	Outpatients Department

LIST OF DEFINITIONS

Cultural competence

Cultural competence is the ability of the nurse to provide care to clients of diverse cultures according to their values, customs, beliefs, and practices, and applying the knowledge the nurse has of different cultures.

Self-efficacy

Self-efficacy in transcultural nursing is defined as “a nurse’s confidence when providing nursing care to patients from different cultural backgrounds” (Li and Lou 2020: 4).

Transcultural nursing:

Leininger (1990) defines transcultural nursing as “a formal area of study and practice focused on a comparative study of human cultures with respect to discovering universalities (similarities) and diversities (differences) as related to nursing phenomena of care (caring), health wellness or illness patterns within a cultural context and with a focus on cultural values, beliefs and lifeways of people and institutions” (McFarland and Webe- Alamah 2019: 191).

Culture

Culture is defined as material and spiritual values which are handed down through the generations. Culture is diversified in every community and is differently experienced by individuals and understood as phenomena such as health, illness, and feelings (Deger 2018: 5).

CHAPTER ONE
INTRODUCTION

1.1 Introduction

Transcultural nursing is defined as a formal part of nursing which focuses on cultural care, values, beliefs and practices of individuals or groups of people with similar or different cultures. Transcultural nursing is a knowledge component of nursing which combines the construct of “culture” from anthropology and the “care” construct of nursing. Transcultural nursing was developed in 1975 by Madeleine Leininger who founded the Transcultural Nursing Society (Scherman 2017: 1).

Transcultural nursing is an essential component of healthcare today, due to the increase in a multicultural population in South Africa and globally. Transcultural nursing focuses on holistic care and culture-based practices to assist people regain their health, embrace their disabilities, or ease the process of dying in a caring and acceptable way. It is, therefore, important that health services are geared towards providing culturally competent care for the targeted community they are servicing. Cultural characteristics are a dynamic factor of health and unless healthcare initiatives are based on transcultural nursing values, it will not be possible to attain the goals for complete care that has to be provided (Değer 2018: 3).

Self-efficacy relates to a person’s confidence and belief in their ability to achieve behavioural goals in specific fields. Transcultural self-efficacy is defined as a nurse’s confidence when providing nursing care for patients from different cultural backgrounds (Li *et al.* 2020: 191). According to Li *et al*. (2020: 191), when a nurse lacks transcultural self-efficacy, it impacts on his or her delivery of patient care. This further causes patients from diverse cultural backgrounds to feel discriminated against or marginalised which may lead to a different health outcome for the patient. Whilst nurses face a challenge to make provisions for individualised and holistic care, transcultural nursing requires nurses to recognise and appreciate cultural differences in healthcare, values, beliefs, and customs. This allows them to acquire the necessary knowledge and skills in cultural competency. Therefore, culturally competent care helps ensure patient satisfaction and has positive outcomes (Değer 2018: 6).

Transcultural nursing focuses on holistic care and culture-based practices to assist people regain their health, embrace their disabilities, or ease the process of dying in a caring and acceptable way. It is, therefore, important that health services are geared towards providing culturally competent care for the targeted community that they are servicing. Cultural characteristics are a dynamic factor of health and unless healthcare initiatives are based on transcultural nursing values, it will not be possible to attain the goals for complete care that has to be provided (Değer 2018: 3).

In this study, student nurses' culture, behaviour and dress code were observed while at the nursing college. They were then interviewed about their experiences in the clinical areas. Students were given diaries to record their cultural experiences while working on the wards. Focus group interviews were carried out at the nursing college and diary entries that focused on experiences and events that took place in the hospital wards during their clinical training, were discussed.

1.2 Background to the study

Culture is known as a way of perceiving, behaving, and summing up the external environment and this provides a map for decisions taken about values, beliefs, and practices. Culture is also a dynamic evolving process (Zezo 2019: 1). Through the centuries, communities have been trying to maintain their culture regarding their health views, their health behaviours and finding cures to health problems. The types of food, methods of cooking, sleeping habits and dressing are characteristics that differ from culture to culture (Değer 2018: 7). The same author notes that nurses who are aware of cultural differences and how these cultural differences impact on health care delivery, improve their therapeutic care by having a better understanding of the patient.

According to McFarland and Webe-Alamah (2019: 540), nurses have important roles and responsibilities to play in the functioning of the healthcare system such as providing high quality direct patient care across the care continuum, as well as assessing and monitoring patients' health status. The outcomes, planning, tailoring, implementing and evaluation of clinical interventions, facilitate self-management strategies so that individuals achieve the highest level of health, adhere to prescribed treatments, promote physical and mental

health through patient education are also of vital importance in the smooth functioning of the healthcare system.

Whilst transcultural nursing impacts on health care practices and the nurses' ability to communicate with patients in an appropriate manner, it is obligatory on nurses to acquire the knowledge, skills and attitudes that are appropriate to practice transcultural nursing and thereby provide culturally competent care to patients. An increase in cultural competency usually leads to quality care as it incorporates patients' beliefs, cultural values, lifestyles, practices, and traditions (Kaihlanen, Hietapakka and Heponiemi 2019: 1). It is also a factor that affects an individuals' understanding and views of health and health care which is characterized by their lifestyle. The health care of individuals is affected by the cultural practices of the patient and the provider, as well as the various environmental factors such as occupational hazards, climate change, natural and technological disasters, and exposure to hazardous substances (Değer 2018: 11).

The integration of appropriate knowledge, attitudes, values, beliefs, and behaviour into safe, affordable, and quality care for individuals and communities contributes towards transcultural nursing (Larsen, Mangrio and Persson 2021: 1). Patients are entitled to culturally competent care, for which nurses need to be prepared to recognize their needs and develop skills that would facilitate their achievement. The patient population of most countries, especially South Africa, is culturally diverse and in the absence of nursing students being exposed to the various cultures as part of their daily lives, they are likely not to be sensitive to the health and the health care of their patients. Older and more senior nurses are often better prepared than junior nurses to provide care to the culturally diverse populations (Kaihlalen et. al 2019: 1). The same study has noted that nursing students who portrayed pessimistic behaviours towards cultures different to their own, such as being judgmental and critical, will be challenged to render quality nursing care.

These concerns have made it vital that these nurses are taught how to understand and learn culturally competent skills to enhance their nursing capabilities. While appropriate training of nurses could improve the quality of care, nurses' competencies in this area needs to be continuously examined and improved due to the dynamic and diverse patient population and demanding health care service delivery.

What people believe and what they practice is an inherent part of the culture in which they live. These cultural characteristics should be recognized as a fundamental factor of health and disease. To provide quality health care to individuals, it is important to know how the patients that are receiving healthcare, see and react to health and illness according to their cultural beliefs that dictate their behaviour (Değer 2018: 20). The author also believes that when nurses know the key factors that influences a patient's health behaviour, they will be more prepared and skilled to provide for the cultural needs of their patients.

The need for nurses to deliver culturally competent care has escalated due to the increasing numbers of diverse populations in health care settings who have specific needs. Culturally competent care cannot be rendered to patients unless nurses understand what role cultural values and beliefs play in their patients' responses to care. Nurses need to learn the cultural competence skills to make assessments and effect nursing interventions that will be both medically sound and culturally appropriate (Matthews and Van Wyk 2018: 9).

Healthcare providers have a "duty to care" and to deliver holistic and culturally appropriate health care to their patients and therefore need to incorporate culturally congruent care for patients from diverse backgrounds (Shepherd et al. 2019: 10).

Studies have reported that nurses lack awareness of cultures different to their own, which may lead to them imposing their own values on their patients. To render effective and culturally responsive heath care services to the diverse population of South Africa, nurses are required to be aware of the diverse populations and to be skilled and competent to render appropriate care (Kaihlanen et al. 2019: 6).

Providing health care that accommodates different cultures by people who are skilled and competent is an evolving process that entails the caregiver reflecting on their own values and beliefs to identify how this influences their approach to diverse patients (McFarland and Wehbe-Alamah 2019: 540). Cultural competence in nursing is the consideration of the patient's culture when caring for the patient. In this study, cultural competence is

viewed as possessing a set of skills and behaviours that enable a nurse to work proficiently within the cultural context of a patient (Kaihlanen et al. 2019: 6).

An insight into the competencies of nursing students will possibly assist nurse educators utilise teaching strategies that address student nurses' assumptions and biases that can lead to prejudice that will ultimately result in a more culturally competent nursing workforce. Nursing programme requirements for clinical experiences of student nurses in health care settings, whether internationally or locally, should encompass caring for people of different nationalities, culture, and traditions (Değer 2018: 59).

This provides opportunities for students to practice the process of self-respect which will help in developing the interpersonal skills required to provide care that promotes human dignity and respect. Removing obstacles to culturally competent nursing care, for example, bias and prejudice from student nurses, can be a difficult task for nurse educators and preceptors. Nurse educators should allow students to reflect on their ability to demonstrate respect for all patients. There should be no discrimination in patient care based on race, religious belief, weight, or other differences. Student nurses should reflect on the following statement "Do I genuinely care about others enough to be a nurse?" (Dunagan et al. 2016: 345).

South Africa is called the rainbow nation because it comprises of four main racial groups namely white, black (African), coloured (mixed race) and Indian[1] with eleven official languages and many diverse cultures and religions within the four racial groups that are differentiated by several factors such as geography (urban or rural), religions for example, Muslim, Hindu and Christian. The South African population also speaks several different languages, some of the most popular being IsiZulu, isiXhosa, Pedi, Tswana, Hindi, Guajarati and English. Apart from the diverse languages spoken, people have diverse gender orientations such as gay, lesbian, homosexual, bisexual, and transgender. These different people are united by calling South Africa their home and they contribute to the country's heritage, identity, and culture. Having a clear understanding of South Africa as a country with its diversified influences is essential for people to understand and respect

[1] The Population Registration Act was the cornerstone of the apartheid policy that legalised discrimination. It was introduced in 1950 and divided South Africans into four broad groups - white, African, coloured and Indian - to enforce the minority government's policy of racial segregation (Ramutsindela 1997: 99).

each other and to learn from each other's cultural practices (South African History Online [SAHO] 2019: 1).

War, ethnic challenges, oppression, environmental and economic crises together with globalization have forced people to migrate to South Africa or encouraged South Africans to emigrate to other countries. This has resulted in multicultural populations which are made up of individuals, families, and groups of people from different cultures and subcultures and this trend is fast developing around the world (Değer 2018: 11).

Hence, it is important for nursing students to understand the social processes that are influenced by a multilingual, multicultural, and diversified population. This situation is compounded by globalisation which is defined as the analyses of social processes or a range of events and trends in the development of the world. Globalisation is commonly used as a term that brings about stabilisation of world order, increases the growth of trade and industry migration and leads to the formation of multicultural communities as well as the expansion of Western cultures.

These factors contribute to the exchange of cultural values on the one hand by providing an opportunity for people to communicate more with each other and bridge the gap between the different races and cultures. Unfortunately, it also results in young people losing sight of their own cultural heritage while in the process of acquiring and accepting other cultures (Ozer 2019: 1).

In the province of KwaZulu-Natal in South Africa, the population is made up of a mix of the different race groups namely whites, Indians, coloured and Africans (black). At this juncture, it becomes important to explain the term 'race'. Race is defined as a social concept referring to a group of people who share the same physical characteristics. In the province of KwaZulu-Natal, the largest race group is made up of black South Africans who speak IsiZulu, the dominant language of the black people. Also, the largest population of Indians outside of India are domiciled in KwaZulu-Natal and they predominantly are English-speaking. However, there are a few Indian people who speak their vernacular languages. There is a small group of coloured and white people living in

Kwa Zulu-Natal, who mainly speak English or Afrikaans. All these groups of people seek health care in the public and private sector (SAHO 2019: 3).

While integration of the children of different race groups has taken place at schools, among the more affluent, opportunities for the different races and cultures to engage with each other are few, as the population is still largely segregated along racial lines. Amongst the less affluent, the children do not attend the same schools or churches as children from other races and cultures, which results in them having limited opportunities to engage with children from other race groups and cultures. The separation of cultures, while enabling each one to retain their own identity, has resulted in few opportunities for common understandings of their diversity, specifically in the health context. Prior to 1994, nursing education and training was confined to certain institutions for specific race groups and cultures and many years after apartheid was abolished, this situation is still prevalent in certain areas. This has piqued my interest and that is why I have decided to embark on this study so I can explore the level of transcultural self-efficacy among student nurses at a private nursing school in Durban, the largest urban city in the province of Kwa Zulu-Natal.

1.3 Problem Statement

Leininger's (1988: 152) theory of cultural differences and similarities alludes to the existence of differences in cultures. Sub-cultures also exist among cultures. Bandura's (1997) self-efficacy theory is defined as a nurse's confidence in provision of nursing care for patients of different cultures. A lack of self-efficacy will cause miscommunication which may lead to risk of depression and pain in patients. Bandura (1997) proposes that individuals with high levels of perceived self-efficacy will gain more knowledge to improve their transcultural skill and competence. This improvement in self-efficacy is important for nurses as they are challenged with increasing numbers of patients from different cultural backgrounds (Li et al. 2020: 191).

The researcher is a professional nurse working in a private nursing college in Durban, a large urban area in the KwaZulu-Natal Province, South Africa. The researcher engages with student nurses during their times of instruction in the nursing college and on the

wards during their clinical practice and when they are not on duty for example in their social spaces, on the nursing college campus. The researcher is responsible for providing sociology lectures which entails a portion of transcultural nursing as part of their program. The researcher has noticed that the students tend to gravitate towards students of their own race and who speak the same language when they interact socially. Given that the nursing profession is attempting to keep abreast of global trends, including transcultural nursing and considering the country's many cultural groups, the researcher was interested in exploring to what extent the nursing students have been exposed to other cultures. It is important to engage with these students to enable them to provide better care for their diverse patients. As the school curriculum in the country does not specifically deal with exploring its diverse cultures, and the students come from a variety of backgrounds where their engagement with other cultures is unknown, it cannot be assumed that they have all had similar exposure to and engagement with the cultures of the fellow students or the patients. The problem is exacerbated by the fact that there are no known studies done to explore the student nurses understanding of factors affecting transcultural nursing in a private health facility in the KwaZulu-Natal Province, South Africa. In the absence of this information, it is not possible to establish to what extent student nurses from private colleges who undertake their clinical practice at private hospitals, are skilled, competent or have the perceived self-efficacy to render transcultural nursing to their patients.

1.4 Aim of the study

The aim of this study was to explore the level of transcultural self-efficacy among student nurses at a private nursing school in Durban, KwaZulu-Natal to ascertain whether they have the necessary competencies to provide appropriate health care to patients from different cultures, race groups and languages.

1.5 Objectives of the study

The study had the following objectives:

1. To explore transcultural self-efficacy among student nurses
2. To explore students' experiences in transcultural nursing
3. To establish the level of competence among student nurses in transcultural nursing

The following research questions were asked:

1. What is the level of transcultural self-efficacy among student nurses?
2. What are the experiences of student nurses in transcultural nursing?
3. How competent and skilled are student nurses in transcultural self-efficacy?

1.6 Significance of the study

This study is significant because it relates to policy changes in private health care facilities regarding student nurses and their competency in maintaining transcultural quality nursing standards. This study will also help to improve the nursing curriculum in the discipline of transcultural nursing. At the beginning of the nurse's career as a student nurse, it is important that when they are placed in the clinical areas, student nurses must be orientated to the health facilities policy on transcultural nursing practices. Once student nurses have been orientated to transcultural nursing practices in the ward and spend time nursing patients of diversity, this study will make them aware that they must have the necessary experience required in transcultural nursing to become competent and provide quality nursing care.

1.7 Methodology

The study adopted an ethnographic, descriptive, narrative design. A qualitative approach using ethnography was adopted as this methodology focuses on cultural elements within a specific situation. The design included 4 phases: the first being observation of students at the college, focus group interviews with student nurses at the college, discussion of the entries in the diaries that were handed over to students to record patient's cultural events in the wards and discussions that took place at the college regarding these recorded events. The interviews were recorded and analyzed by the researcher to extract the relevant information which constituted the data for this study.

1.8 Culture Care Theory

This research study used Madeleine Leininger's Culture Care Theory (1988: 152-160) which defines nursing as a learned scientific and humanistic profession. The theory also focuses on human care phenomena and caring activities to help, support, facilitate or enable patients to maintain or regain health in culturally meaningful ways. It also speaks about helping patients to face handicaps or death (Petiprin 2020: 1).

The Culture Care theory contends that knowledge and understanding of different cultures with respect to nursing, health or illness, caring practices, beliefs, and values will lead to meaningful, efficacious nursing care services to people according to their culture, diversity, and similarity. Nursing according to the Culture Care theory is a learned, scientific, and humanistic profession that focuses on human care phenomena and caring activities to help support, facilitate, or enable patients to maintain or regain health in culturally meaningful ways The Culture Care theory is a sub-discipline of nursing, and benefits nurses who always use appropriate cultural knowledge during nursing practice. Transcultural nursing focuses on the similarities and differences in cultural care, values, beliefs and practices of individuals or groups. The goal of providing culture-specific and universal nursing care practices in promoting health is to help people to face sickness or death in culturally meaningful ways (Üzar-Özçetin, Tee and Kargin 2020).

Leininger (1988: 152-160) developed the Culture Care theory to make provision for a knowledge base for the transcultural discipline of nursing. An important factor of Culture Care theory is the differences and similarities in healthcare that await to be discovered to form a knowledge base that is appropriate for rendering culture-specific nursing care and facilitating nursing practice. The purpose of the Culture Care theory is to seek knowledge that can be utilized in the provision of care that is culturally congruent, meaningful, and safe that will benefit the people of diverse cultures (McFarland and Wehbe-Alamah 2019: 540).

Culture Care theory aims to provide care measures that are in line with an individual or group's cultural beliefs, practices, and values. In the 1960's, Leininger (1988: 152-160) coined the term *culturally congruent care* which is the core goal of transcultural nursing practice. Culturally congruent care becomes possible when the nurse and the patient create specific care for the health of the patient: this plan requiring the use of generic and professional knowledge and methods to fit diverse ideas into nursing care actions, with care knowledge and skill being re-patterned for the interest of the patient. Leninger (1988: 156) developed new terms for the theory:

- Care is to assist others with real or anticipated needs to improve a human condition of concern or to face death.

- Caring is an action or activity directed towards providing care.
- Culture refers to learned, shared, and transmitted values, beliefs, norms and lifeways of a specific individual or group that guide their thinking, decisions, actions, and patterned ways of living.
- Cultural care refers to multiple aspects of culture that influence and enable a person or group to improve their human condition or to deal with illness or death.
- Cultural care diversity refers to the differences in meanings, values, or acceptable modes of care within or between different groups of people.
- Cultural care universality refers to common care or similar meanings that are evident among many cultures.
- Nursing is a learned profession with a disciplined focused on care phenomena.
- Worldview refers to the way people tend to look at the world or universe in creating a personal view of what life is about.
- Cultural and social structure dimensions include factors related to religion, social structure, political/legal concerns, economics, educational patterns and the use of technologies, cultural values, and ethno-history that influence cultural responses of human beings within a cultural context.
- Health refers to a state of well-being that is culturally defined and valued by a designated culture.
- Cultural care preservation or maintenance refers to nursing care activities that help people of cultures to retain and use core cultural care values related to healthcare concerns or conditions.
- Cultural care accommodation or negotiation refers to creative nursing actions that helps people of a particular culture adapt to or negotiate with others in the healthcare community to attain the shared goal of an optimal health outcome for client(s) of a designated culture.

(McFarland and Wehbe-Alamah 2019: 550).

There are specific assumptions in this theory that support the theory base and Leininger's (1988: 152-160) use of the terms described above. These assumptions are the philosophical basis of the Culture Care theory. They add meaning, depth, and clarity to

the overall focus to arrive at culturally competent nursing care. The following are taken from Leininger's (1988: 152) work:

- Care is the essence and central focus of nursing.
- Caring is essential for health and well-being, healing, growth, survival and for facing illness or death.
- Culture care is a broad holistic perspective to guide nursing care practices.
- Nursing's central purpose is to serve human beings in health, illness and if dying.
- There can be no curing without the giving and receiving of care.
- Culture care concepts have both different and similar aspects among all cultures of the world.
- Every human culture has folk remedies, professional knowledge and professional care practices that vary. The nurse must identify and address these factors consciously with each client to provide holistic and culturally congruent care.
- Cultural care values, beliefs and practices are influenced by worldview and language, as well as religious, spiritual, social, political, educational, economic, technological, ethno-historical and environmental factors.
- Beneficial, healthy, satisfying culturally based nursing care enhances the well-being of clients.
- Culturally beneficial nursing care can only occur when cultural care values, expressions or patterns are known and used appropriately and knowingly by the nurse providing care.
- Patients who experience nursing care that fails to be reasonably congruent with the patients' cultural beliefs and values will show signs of stress, cultural conflict, non-compliance, and ethical-moral concerns.

(Gonzalo and Kantis 2021: 5)

In synthesising the information contained in these defining terms and assumptions, a broad definition emerges of a culturally competent nurse who*:*

- consciously addresses the fact that culture affects nurse–patient exchanges.
- with compassion and clarity, asks each patient what their cultural practices and preferences are.

- incorporates the patient's personal, social, environmental, and cultural needs/beliefs into the plan of care wherever possible.
- respects and appreciates cultural diversity and strives to increase knowledge and sensitivity associated with this essential nursing concern

(Gonzalo and Kantis 2021: 8)

In summary, nurses who understand and value the practice of culturally competent care can make positive changes in healthcare practices for patients of designated cultures. Sharing a cultural identity requires knowledge of transcultural nursing concepts and principles, along with an awareness of current research findings. Culturally competent nursing care can only occur when patients' beliefs and values are thoughtfully incorporated into nursing care plans, with caring being the core of nursing. Culturally competent nursing guides the nurse to provide optimal holistic, culturally based care. These practices also help the patient to care for themselves and others within a familiar, supportive, and meaningful cultural context.

Technology, religion, kinship, values, beliefs, political, legal, economic, and educational factors influence health care practices. (McFarland and Wehbe-Alamah 2019: 551). Respect for individuals is played out in culturally competent care.

Closely aligned with Leininger's (1988: 156 aspect of cultural secrets is the concept of sub-cultures, which are identified as the homeless, sex offenders, older people, persons with mental or physical disabilities and people with HIV AIDS or patients with drug problems. Culture, in Leininger's (1988: 556) view, has a bigger picture and transcends ethnicity, which enables a nurse to see patients as a unique individual in an environment that contains factors that influence their care and health needs (McFarland and Wehbe-Alamah 2019: 557).

Assessments of each sub-culture must be carried out and the outcome of which is to assist the nurse and patient and sometimes the patient's family who are involved, to come to a solution of a treatment plan (McFarland and Wehbe-Alamah 2019: 557). The Culture Care theory's main contribution is seeing culture as the key to understand and serve. The Culture Care theory is made up of characteristics that are the basis for nursing care.

These caring characteristics are defined as ‘activities’ that assist in improving the patient’s condition. The aim of transcultural nursing, therefore, is to find knowledge and techniques that will help nurses to render care to a patient who does not want to change his /her cultural beliefs. This practice is called culturally congruent care (Değer 2018: 25).

Cultural competence, according to the Culture Care theory is the integration of knowledge, attitudes, and skills to enhance cross-cultural communication and interactions with others. Similar to multicultural education, transcultural nursing education is seen as a process that is evolving on an ongoing basis and hopes to achieve effective care. The Cultural Care theory has three phases:

1. Culture care preservation, where the status quo is maintained.
2. Culture care accommodation, where recognition of different cultures takes place.
3. Culture care re-patterning, where a restructuring of thought and behaviour occurs in such a way as to provide culturally competent care. Values give direction and play an important part in the choices an individual make. (Değer 2018: 25).

The Culture Care theory was used to guide the various steps of this study, with cultural knowledge being used by student nurses in their experiences with patient care situations. The similarities and differences were identified by the researcher and the students in their caring, meaningful ways.

The Culture Care theory also meets the objectives of this study which were to gather information on the experiences of nursing students as well as the student nurses’ competencies and self-efficacy which constituted the data for this study. This was extracted from the focus group interviews. The Culture Care theory is a broad theoretical framework which uses enablers or models to discover complex phenomena, such as human care. The following enablers are models that were designed by Leininger (1988: 152):

- Sunrise Enabler
- Stranger to trusted friend enabler
- Observation participation reflection enabler
- Leininger’s semi-structured inquiry guide enablers to assess culture care and health

- Leininger's acculturation healthcare assessment enabler for cultural patterns in traditional and non-traditional lifeway's
- Leininger's phases of ethno-nursing data analysis enabler for qualitative data
- Leininger's Templin Thompson (LTT) ethno-script coding enabler
- Life history healthcare enabler

(Leininger 1988: 152)

Leininger's (1988: 152-160) semi-structure inquiry guide enabler /model to assess culture care and health and ethno-nursing is a research method for describing, documenting, and explaining nursing care phenomena by studying the beliefs, values and practices concerning nursing care that belong to a specific culture as reflected by the language, beliefs, and values of the members of that culture. This guide is to enter the world of the client/ patients and gain knowledge to provide holistic, culture-specific care. A cultural enabler guide was designed to aid the researcher to assess the degree of acculturation of a person or group to a specific culture. Student nurses were observed and in turn they observed their patients in the clinical setting.

The data was analyzed thematically in the following phases of the Data Analysis Enabler for Qualitative Data

- Phase 1: collecting, describing, and documenting raw data.
- Phase 2: Identification and categorization of descriptors and components.
- Phase 3: Pattern and contextual analysis in which the data was scrutinized to discover saturation of ideas and recurrent patterns for similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry.
- Phase 4: this phase of data analysis, synthesis and interpretation required synthesis of thinking, configuration and analysis, the task of the researcher being to extract major themes.

1.9 Operational definitions

Cultural competence

Cultural competence is the ability of the nurse to provide care to clients of diverse cultures according to their values, customs, beliefs, and practices, and applying the knowledge the nurse has of different cultures.

Self-efficacy

Self-efficacy in transcultural nursing is defined as “a nurse’s confidence when providing nursing care to patients from different cultural backgrounds” (Li and Lou 2020: 4).

Transcultural nursing:

Leininger (1990) defines transcultural nursing as “a formal area of study and practice focused on a comparative study of human cultures with respect to discovering universalities (similarities) and diversities (differences) as related to nursing phenomena of care (caring), health wellness or illness patterns within a cultural context and with a focus on cultural values, beliefs and lifeways of people and institutions” (McFarland and Wehbe- Alamah 2019: 191).

Culture

Culture is defined as material and spiritual values which are handed down through the generations. Culture is diversified in every community and is differently experienced by individuals and understood as phenomena such as health, illness, and feelings (Deger 2018: 5).

1.10 Summary

This chapter commenced the thesis with an introduction to the study followed by a brief background to the study. Next, the problem statement was explained as well as the significance of the study. This chapter concluded with a summary of what the chapter entailed followed by an outline of all the chapters. Chapter Two will focus on the relevant literature pertaining to transcultural nursing, the model used in this study and how this pertains to student nurses’ perceptions and knowledge when skills, confidence and competence are displayed in their experiences in nursing.

1.11 Outline of the chapters

Chapter One: Introduction

In the chapter, the study was introduced followed by background information on the study. Then the problem statement was explained. Next, the aims and objectives of the study was outlined. The significance of the study was narrated followed by the culture care model and this chapter concluded with an outline of the different chapters.

Chapter 2: Literature Review

This chapter presents the relevant literature pertaining to transcultural nursing and how this pertains to student nurses' perceptions and knowledge when skills, confidence and competence are displayed in their experiences in nursing.

Chapter 3: Methodology

This chapter details the methods used to conduct the study and describes the study population, the sampling methods and study sample. It outlines the data collection tools, processes and analysis, with the qualitative data being analyzed using thematic analysis to address the three research questions.

Chapter 4: Presentation of results

This chapter presents the results of the participant observations, focus group interviews, diary entries and reflections of the participants. The different phases of the data analysis were provided.

Chapter 5: Discussion, conclusions, and recommendations

This chapter provided the discussion of the findings off this study. Then this was followed by the conclusion to the study as well as recommendations for future

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to transcultural nursing and transcultural self-efficacy among student nurses. The topic is discussed under the following sections: transcultural nursing, transcultural self-efficacy, transcultural experiences, transcultural competencies, and culturally congruent care. Transcultural nursing theory goes beyond the borders of culture, and examines and appreciates people's philosophies, values, beliefs, and history. Upon patient assessments of values, histories, needs and expectations, nurses can assist them by providing culturally competent care (Webhe-Alamah and McFarland 2020: 337). The search enquiries used to access literature were
CINAHL (EBSCO HOST)
PUBMED
GOOGLE SCHOLAR
COCHRANE LIBRARY
MEDLINE
SCIENCE DIRECT
PROQUEST
SAGE
BIOMED CENTRAL
JSTOR

2.1.1 Nationally

In South Africa, there is a need to educate nurses on transcultural nursing and produce culturally competent nurses or nurses who have confidence in nursing patients of diversity. Nurse educators need to consider cultural competency and theoretical models to promote quality nursing care. Nursing education has identified the need to develop more culturally sensitive graduates in South Africa based on the view that culturally competent knowledge is particularly insufficient in nursing (Matthews & Van Wyk 2018:93). The Constitution of the Republic of South Africa (Manner of reference to the Act, previously "Constitution of the Republic of South Africa, Act 108 of 1996" substituted

by s, (1) for the Citation of constitutional Laws, 2005 (Act No 5 of 2005) (Assented to 10 December (1996) incorporates diversity as a national resource to be enhanced in all aspects of public life, which includes nursing education. Nevertheless, cultural diversity and competency is not sufficient and cultural competence remains a challenge as nurses do not necessarily know the various ethnic knowledge systems (Mhlongo 2016: 135).

2.1.2 Globally

The international landscape is constantly changing, geographically and politically. This brings its own challenges within communities regarding the socio-economic dynamics which affect the health care system and communities. Migration and changing lifestyles challenge nurse educators on preparation of student nurses who must function adequately in the health care environment Wehbe-Alamah 2018:2). This provides opportunities in nursing education to look at paradigms of culture.

A changing society with freedom to move between different parts of world have made interactions with multicultural groups of people possible. The interactions with multicultural groups influence the health care system which highlights the need for transcultural nursing among health care professionals (Martin and Ray 2017, cited in McFarland and Wehbe-Alamah 2018: 3).

The global standards for the Initial Education of Professional Nurses and Midwives advises nursing and midwifery schools to train graduates who can demonstrate culturally competent nursing care. Culturally competent care addresses the social, cultural, and biosocial aspects of health to ensure equitable health outcomes for all (Baker, Cary, and da Conceicao Bento 2021:5 Quality cross-cultural care that specifically targets barriers to health equity are the expected standards of the nursing profession and thus should be the expected components of an undergraduate curricula. The European higher education system is aware of the need to respond to diverse patient populations (Baker et al.2021:6).

Transcultural nursing theory goes beyond the borders of culture and examines and appreciates people's philosophies, values, beliefs, and history. Nursing programmes should therefore include transcultural nursing courses to encourage nurses to be open to other cultures and practices, other than their own (Kailaihen et al. 2019;129).

The researcher defined the value of care as the nurse rendering care to people with compassion and respect cognizant of their cultural expectations. Culturally competent patient care makes provision for the patients' needs in a way that the care and treatment is within the parameters of care or compliments the patient's own cultural belief (Webhe-Alamah and McFarland:337). Transcultural nursing focuses on specific areas and once the patients have been assessed and their history taken, nursing care plans are formulated that considers culture in areas such as diet, prayer, hygiene, and last rites (Webhe-Alamah and McFarland 2020: 337).

2.2 The impact of transcultural nursing on the profession

The profession of nursing is faced with several obstacles and challenges in the 21st century due to changing demographics within the profession and the population. The provision of culturally competent nursing care is an important concept for the future of the nursing profession (Deger 2018:63). The knowledge and self-reflection of one's own cultural context being an essential component in developing the nurse's skill to provide the level of care required in a demographically changing environment (Darnell and Hickson, 2015: 99).

During the 1950s, Dr Madeleine Leininger (2008: 152-160) conceptualized transcultural nursing and founded the Transcultural Nursing Society. Her Culture Care theory established models that address the values of culture which incorporate the following factors:

> age; communication and language; dress; use of space; gender considerations; sexual orientation; ability/disability; occupation; socioeconomic status; interpersonal relationships; appearance; food; meal preparation and related lifestyle (Carlson 2020: 1).

Nurses should be aware of how culture influences their lives as this allows them to become more sensitive to practice transcultural nursing. The nurses should be able to realize the prejudices in their life and the effect this has on their care of culturally diverse patients. The student nurse should gain knowledge of different cultures and how these impact on their behaviours towards patient care. The nurse also needs to be culturally

sensitive to provide the necessary support and reinforcement for clients when there are changes in health practices (Theocharopoulos *et al*. 2020: 323). The client's willingness to participate in healthcare practices that conflict with their values and cultural dietary practices should be identified by nurses. Appropriate communication as well as patient and family participation are important indicators for obtaining success in effective transcultural nursing (Theocharopoulos *et al*. 2020: 324).

Student nurses placed in clinical areas are not merely there to observe patients and different cultures but are participants in a health care team who are making a difference by providing transcultural nursing to individuals and families. The student nurses therefore need to reflect on their responses to patients and their worldviews on culture (Kohlbry 2016:309). To make the student nurses' experience more meaningful, the nursing education curriculum should include cultural knowledge, awareness, and skill as well as transcultural self-efficacy. These experiences provide opportunities for student learning (Kohlbry 2016: 309).

between the nurse and the patient as the core focus area in which this care takes place. Cultural competence in nursing involves:

> The complex integration of knowledge, attitudes, values, beliefs, behaviours, skills, practices, and cross-cultural encounters that include effective communication and the provision of safe, affordable, quality, accessible, evidence-based, and efficacious care for individuals, families, groups, and communities with diverse or similar cultural backgrounds (Andrews and Boyles, 2019: 323).

2.3 Transcultural nursing

Transcultural nursing theory is based on the assessment and analyses of the cultures present in a patient care situation. Culturally competent patient care incorporates all aspects of nursing: social, spiritual, physical, and psychological which considers patients' cultural beliefs. For example, a Hindu patient's belief that suffering is inevitable may influence the patient or the family's reporting of symptoms or lead to a rejection of therapeutic measures. For Muslims patients: prayer times, hygiene, dress, and diet

restrictions as dictated by the Quran (The Holy Book of Islam) may challenge the delivery of western modes of health care (Webhe-Alamah and McFarland 2020: 337).

Transcultural nursing has an aim of formulating a body of knowledge and skills that will assist nurses in providing culturally competent care that is relevant to diverse populations. Cultural competence for nurses assures them that the care delivered is culturally appropriate and accommodating to the client's customs (Değer 2018: 47). Transcultural nursing is viewed as being an approach that allows the nurse to operate efficiently among the diverse cultures in the health care settings (Değer 2018: 52).

2.3.1 Perceptions of Transcultural Nursing

Culture influences a person's perception of health, illness and healthcare practice that is in keeping with cultural aims to improve the quality of healthcare. These aspects assist individuals to adapt to nursing services more easily and enhances the effectiveness of care. A challenge in nursing education is to equip student nurses to become culturally aware and sensitive graduates (Değer 2018: 50). The Nursing education curriculum used to begin with cultural studies, but the practice of skills became hindered by the types of clinical exposure and patient demographics that student nurses may encounter. Diverse cultural groups have a range of various understandings of the causes of disability and disease and this knowledge influences their health and need for health care (Webhe-Alamah and McFarland 2020: 337). Nursing students with cynical attitudes to cultures that are different from their own which is referred to as cultural prejudice, do not have the ability to learn new skills in cultural competence (Webhe-Alamah and McFarland 2020: 337). These attitudes of prejudice may hinder an accurate understanding of culture and the ability to provide effective health care which could affect the health outcomes.

2.3.2 Transcultural Knowledge

Healthcare professionals internationally, provide care for many culturally diverse patients. The emphasis on cultural competence is reflected in the quality of care rendered and new knowledge is required for different educational models that aim to improve cultural competence (Kaihlanen et al. 2019: 1).

Cultural knowledge and lifestyles need to be thoughtfully integrated with patients' physical, psychological, spiritual, and social needs to provide them with culturally competent care. Culture Care theory and knowledge extracted from research findings, comprising of general facts, values and practice is changing nursing care in many areas. The positive patient outcomes are well received by those who practice transcultural nursing and for those patients who receive this care (Wagner 2021: 1). The more nurses experience caring for patients from different cultures, the more eager they are to work with patients that are of a different cultural background to their own (Kaihlanen et al. 2019: 25).

2.3.3 Attitudes about Transcultural Nursing

Student nurses' attitudes towards transcultural nursing are indicated in studies where negative attitudes towards patients, influence the nurse-patient relationship. Nursing students who enter the profession and are biased and prejudiced towards people of other cultures may not understand cultural competencies. The data on attitudes of prejudice among students that provide nursing care is limited with the authors describing prejudice as preconceived judgments, ideas, beliefs or opinions about a culture or minority group (Dunagan *et al*. 2016: 345). Attitudes of prejudice can negativity affect nursing care with self-disclosure of attitudes of prejudice being important as it can serve as a form of discrimination against members of certain groups (Dunagan et al. 2016: 345). Understanding nursing students' attitudes of prejudice may assist educators in the development of teaching strategies to address the biases that lead to prejudice, resulting in a more culturally competent nursing workforce (Dunagan *et al*. 2016: 345).

Obstacles such as bias and prejudices among nursing students are difficult to remove and hinder the nurse from becoming culturally competent. An exercise by nurse educators that will assist them to overcome this hurdle is to get them to reflect on culture in simulated class experiences and clinical settings (Dunagan *et al*. 2016: 347). Transcultural nursing and culturally competent nursing care are processes that are acquired over time and not achieved instantly but acquired through a gradual process of skill and attitude of the various factors that make up competency. These factors will include learning to think differently: act, lead and work productively alongside people of different cultures, styles,

abilities, classes, nationalities, races, sexual orientation, and gender (Dunagan *et al*. 2016: 322).

2.3.4 Beliefs and awareness

Healthcare professionals' lack of cultural awareness may lead to cultural imposition of one's own beliefs, values, practices, and patterns of behaviour on another (Wagner 2021: 1). This practice can be demonstrated when a nurse expects a patient to follow his/her cultural practices or that of the hospitals. The nurse may think that her way is the correct way to carry out practices (Değer 2018: 13). Cultural awareness is also regarded as the cornerstone to being culturally competent, the latter consisting of cultural awareness, knowledge, skill, encounters, and desires with knowledge being a key factor (Kaihlanen 2019: 14). Culture can be regarded in two ways, concentrating on cultural beliefs and values and the other on economic and health inequalities. It is generally easier to address the traditional beliefs rather than the economic and health disparities, which are more political (Matthews and Van Wyk 2018: 112). An increase in exposure to knowledge of the activities of groups of people belonging to different cultures has indicated that health care providers are eager to work with patients from diverse backgrounds (Kaihlanen 2019: 20).

The standard of nursing care can significantly improve when nurses are involved with care of the patient as a central focus and take their culture into account. Transcultural efficiency is a positive aspect that can reach competency and encompass care that is congruent with the patient's culture (Asurakkody, 2019: 625). Cultural awareness is when the nurse explores and reflects on their own beliefs about their culture (Kailahen *et al.* 2019: 13). Regulatory nursing bodies and institutions have also realised the need for culturally competent nursing care. Nurse's reflection about their own verbal and non-verbal communication can be realised through self-awareness (Kailahen *et al*. 2019: 13). Cultural self-awareness takes place when a person actively reflects on their own identity.

Culture provides the rules and guidelines that help people of a certain cultural group know what behaviours and actions are acceptable or unacceptable (Değer 2018: 9). Multicultural education links race and language thereby ensuring that nursing education includes human diversity (Schmidt 2007: 336). Cultural introspection is a continuous

activity and enables people to realize the similarities and differences between cultural groups. Cultural awareness will be most comprehensively understood if people recognize the “diversity of diversity’s” and how different behaviours affect the planning of nursing care (Jeffreys 2021: 198). When nurse educators teach courses in culture, student nurses are given an opportunity to share their experiences, speak their minds and deduce interpretations in relation to the real-life experiences of cultural interactions within nursing practice (Kaihlanen *et al*. 2019: 25). This changing teaching moment enhances each student nurse’s realization of cultural experiences that affects the health care system and highlights the influence of culturally congruent nursing care. Increased awareness enables nurses to be prepared for patients with different cultures and experiences in the healthcare settings (Dunagan *et al*. 2016: 320).

This learning experience enhances the gaining of information and changing of attitudes and perceptions in the practical setting. This provides an opportunity for culturally competent nursing care and expands the definition of diversity, which incorporates the uniqueness of and differences among persons, where people and organizations grow to not only tolerate diversity but to accept the richness of different cultures (Değer 2018: 58).

2.4. Transcultural self-efficacy

Self-efficacy is defined as “people’s judgements of their capabilities to organise and execute courses of action required to attain designated types of performances (Brehanu et al. 2021: 1). For an individual to attain a desired outcome, they need to have the ability intrinsically to carry out an action. If it is thought to be beneficial but the individual is not sure of their ability to carry it out, it is unlikely that the behaviour will be altered in any way (Li et al. 2020: 5). Self-efficacy can be influenced by one’s own personal experience, by being persuaded or through the experiences of others. Self-efficacy is a basic concept in nursing education and can influence the narrowing of the theory-practice gap. Self-efficacy is a continuously changing process that is evolving with new experiences and education and is a means to predict performance behaviours. As nurses have greater exposure to diverse cultures, it is essential for nurse educators to prepare students to work effectively in diverse environments (Brehanu et al. 2021: 11).

2.5 Transcultural experiences

When entering the profession, student nurses have different experiences of life with regards to culture. Most nursing education programmes do not prepare students to deal with negative attitudes and discrimination, whether it is towards themselves or others, with little information being available on nursing students' views on transcultural nursing education. The focus has mainly been on nursing students' experiences on learning activities with a lack of research on nursing students' preparation in practice settings for nursing in a diverse population (Li et al. 2020: 6).

2.6 Transcultural competencies

Cultural competence information can be provided to nursing students by including a multicultural learning experience in the nursing curricula. A curriculum that includes skills and knowledge in cultural competency must ensure that student nurses acquire the necessary knowledge and skills that enable them to have an effective relationship with their patients, patients' families and the community (Harrison, Walton and Leonne 2019: 13) Cultural competence includes attitudes, knowledge and skills and is important to provide quality health care to people of diversity, requiring on-going learning for nurses that are delivering patient care. Culturally competent health care workers are required to have several traits such as being fully aware of their own culture through self-reflection and self-awareness, their values, beliefs, attitudes, and behaviours. The process of cultural competence starts with self-awareness, also referred to as self-exploration or self-reflection. Student nurses should possess the skills to assess patients from different cultural backgrounds and talk to them. Student nurses should acquire knowledge and information about the specific cultures of patients to avoid stereotyping (Zarycka 2020: 16). Cultural competence in nursing is about the ability to care for patients by considering the patients' culture (Zarychka 2020: 1).

Zarychka's (2020: 8) observation in relation to transcultural nursing was that nurses seldom feel culturally competent. The concept of caring and diversity provide experiences that assist and increase student nurses' reflection of themselves and their own culture and then understand and respect individuals for their diversity. Holistic nursing care that is taught in the nursing curriculum will be more applicable to student nurses when they are nursing patients of diversity. Nurses come into the system assuming that nursing care is physical and find it difficult to understand that nursing goes beyond the physical aspect

and incorporates emotional care, spiritual, mental, social, and cultural care that is holistic (Değer 2018: 7).

Nurse educators should be dedicated to moulding student nurses in possessing professional values that are aligned to the professional nurses' responsibilities, making it essential for nurse educators to include cultural competence knowledge, skills, and attitude in the nursing curriculum to shape successful nurse practitioners to make provision for culturally sensitive care to culturally diverse patients (Smith 2018: 20). In the study by (Smith 2018: 20), nursing students possess a lower level of self-efficacy in their ability to provide high quality transcultural nursing care. This deficiency in cultural competency creates a gap between the nurse and safe patient-centred care (Kohlbry 2016: 304). The findings from Kohlbry's (2016: 308) study indicate that teaching methods using student immersion in different cultures contributes to their cultural experiences, understanding, technique, self-awareness, sensitivity, self-efficacy, and cultural barriers. Certifying future student nurses who are experienced in cultural competence will improve nursing practice and care (Kohlbry 2016: 309).

2.7 Culturally congruent care

Culturally congruent care refers to making provision for nursing care that is beneficial and aligned to the belief system and lifestyles of the patient. Professionally, the use of emic (local cultural) knowledge and lifestyles is meaningful and creates ways that are suited with etic (outsiders) knowledge to assist people who are ill, disabled, facing death or other human conditions (Clarke 2017: 1) The definition of culturally congruent care is that which benefits and is substantial to the people who are being provided with it and to avoid health care providers from imposing their own prejudices onto patients. Student nurses need to be knowledgeable about people being diverse in areas of physical appearances and speech and to show that they can respect people and provide them with transculturally congruent, competent care as everyone needs a unique kind of care (Gonzalo and Kantis 2021: 3).

2.8 Summary

As nurses engage in increasing diverse cultures due to the movement of people, healthcare workers need to gain confidence in their ability to liaise with diverse patients

and recognise the importance of culture in health care. The nursing profession is challenged with the changing demographics in the profession and providing competent nursing care is an important component (Değer 2018: 20). In transcultural nursing, competent patient care is care that incorporates all aspects of nursing. Culture influences people's perceptions of health and illness. The challenge is to equip student nurses with cultural awareness and sensitivity towards patients. Many student nurses have stereotypical views on transcultural nursing hence nurse educators need to understand student nurses' attitudes when developing teaching strategies to address the biases and thus develop a more culturally competent nursing workforce (Kaihlanen 2019: 5).

The lack of awareness and beliefs may lead to nurses imposing their own values and belief systems on patients. Self-efficacy is a concept in nursing education and is evolving with new experiences and education. Therefore, nurse educators need to prepare students to work effectively in diverse environments. Student nurses enter the profession with their own life experiences and culture and there has been a lack of confidence of student nurses' preparation for nursing diverse populations (Değer 2018: 25)

The nursing curriculum should therefore include skills and knowledge in cultural competency to ensure student nurses gain the necessary knowledge and skill to care for diverse communities and make provision for care that is meaningful and in line with the patients' lifestyles. In this study, the Culture Care theory is used which is based on the differences and similarities in a culturally caring, beneficial, and meaningful way of nursing culturally diverse patients (McFarland and Wehbe-Alamah 2019: 25).

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter describes the research methodology and design used in this study. According to Doyle, McCabe, and Keogh (2019: 443) qualitative descriptive designs are common in nursing and healthcare research because of its simplicity, flexibility and is used in diverse healthcare research. However, sometimes it is criticized for its lack of rigor or inconsistency, lack of transparency and credibility. The research design maps the way in which the researcher engages with the research subjects to obtain the desired results required to fulfill the study objectives (McCombes 2019: 1). The ethno-nursing approach was adapted in this study to explore the practice of transcultural nursing and promote 'culturally congruent' care. This approach requires the knowledge and information obtained to be accurate and correct for that situation. In the ethno-nursing methodology, the researcher objectively and truthfully portrays the culture of the subjects under study, which adds to the body of transcultural nursing theory and practice (Wehbe-Alamah 2020: 1). The methodology is presented with respect to the research design, research approach, study setting, population and sampling, recruitment, data collection, data collection instruments, data analysis, trustworthiness and rigor and ethical considerations.

3.2. Research design

A qualitative ethnographic, narrative descriptive design was used in this study to obtain qualitative data. The term ‘ethno-nursing research’, which is defined as a study of people’s views, cultural practices, and behaviours was coined by McFarland and Wehbe-Alamah (2020: 97). (Bhandari 2020: 7).

Qualitative research design has emerged as a reputable paradigm of research inquiry within the field of health sciences. Qualitative research aims to elaborate, explain, and describe social phenomena such as relationships between patients and the healthcare providers and how health care can affect the care and quality of lives. Qualitative research seeks to answer the “why” and the “how” of phenomena as opposed to the “what” and “how much” (Jameel, Shaheen and Majid 2018:1).

A narrative study is used for more than one approach, and relies on the writing, speech or visual pictures of people that emphasize the life experiences of their culture, as narrated by them. Qualitative descriptive design is a widely used research approach and is appropriate when an accurate description of a phenomenon is required, or information is gained to form a review of interventions (Kim, Sefcik and Broadway 2017: 23). Several data collection methods can be used in narrative studies such as focus group interviews, diary and journal entries, participant observations and reflections were included to obtain various levels of participants' experiences (Creswell and Poth 2018: 347). Participants were studied as front-line workers and the researcher sought to understand the social determinants of their everyday experiences.

In this study, the qualitative research method was used to answer the research questions which were concerned with the opinions and beliefs of the individuals and the importance was based on the exploration of the data and the explanation of the data rather than the effectiveness. The use for this method also relates to the sensitivity of the topic where individuals shared their personal beliefs and lifeways of their culture (Jameel et al. 2018: 2).

Ethnography is a qualitative approach where you look at people in their natural cultural settings with the intention of constructing a narrative account of that culture against a theoretical background, actions done and choice of words used, interactions with each other and with their social and cultural surroundings. It also includes what is not said as much as what is said, language and symbols, rituals and shared meanings that fill their world (Jayathilaka 2021: 91).

Ethnography is involves immersing yourself in a particular community or organisation to observe their behaviour and interactions closely. The word ethnography also refers to a written report of the study that the ethnographer produces after the research is done. Ethnography is a flexible research method that allows one to deeply understand a group's shared culture. Ethnography originated from the field of anthropology and is a common approach in the social science field to study specific communities within the researcher's own society. The choice of this method gave the researcher direct access to the culture and practice of the group of nursing students who were the participants in this research study. it was an open and flexible method, and it offered a rich narrative account and

allowed the researcher to explore many different aspects of the cultural diversity of the student nurses (participants) at the private nursing college (Caulfield 2020: 1).

3.2.1 Research Approach

Ethnography is a research approach where the researcher studies the behaviour patterns, language, and actions of a particular cultural group in their natural environment over a period (Polit and Beck 2018: 220), therefore being a study of people and their cultures. It is intended to examine cultural characteristics, with the researcher observing the study group from the subjects' viewpoint. Ethnography is a method that is used to present the culture of the group, the field study reflecting the knowledge and systems of meanings in their lives (Claufield 2021:1). It gives the researcher direct access to the culture of the group and first-hand information of the behaviour and relationships of people within the group (Claufield 2021: 1). Culture refers to the way a group of people live, the patterns of activity, as well as the norms and values that give their lives meaning. Ethnography is the research tradition that is concerned with culture, experiences and shared meanings that shape behaviour (Polit and Beck 2018: 220). It was used in this study to describe the student nurses' experiences of their own culture as well as that of their patients. An ethnographic study is a combination of the lived experiences of the subjects under study, fieldwork, and written text. As culture is unable to be seen or touched, it must be described and narrated in writing, with the culture from this group of participations being inferred from their words and actions (Polit and Beck 2018: 221). An assumption is that all groups of people have a culture that dictates the members of that group's worldview and the method they adopt to engage with their experiences (Polit and Beck 2018: 222).

Ethnographers aim to gain knowledge from members of a group of people to understand their world view, which they refer to an emic perspective, this being when they understand their world within the group. The etic perspective is the outsider's interpretation of the experience of that culture (McFarland and Wehbe-Alamah 2019: 75). Ethnographers aim to gain an emic perspective of the culture of the group of people being studied. Participant observation and structured focus group interviews were used to obtain information from an emic perspective, while an etic perspective was used when student nurses diarized

their nursing experiences on culture and reflected on their diary entries. The researcher in an ethnographic study is known as the research instrument (Polit and Beck 2018: 225).

A narrative study is used for more than one approach and relies on the writing, speech or visual pictures of people that emphasize the life experiences of their culture, as narrated by them. Decisions were made on how long and from whom the data was collected as the study unfolded, this being known as an emergent design, as it emerged when the researcher continued to make decisions due to continued reflection and inquiry into the realities of the participants. Characteristics of this research design include triangulation, which entails merging data collection strategies which includes the flexible, holistic intense involvement of the researcher, who becomes the instrument and requires ongoing analyses.

3.3 Study Setting

The setting for this study was a private nursing college located in the central business district of eThekwini Municipality (Durban), KwaZulu-Natal Province, South Africa. This setting does not provide student accommodation. The nursing college is accredited by the Department of Higher Education (DHET) and the South African Nursing Council (SANC). The college offers the Bridging to Registered Nurse program under Regulation R683 of the Nursing Act No. 33 of 2005. The enrolment figure is thirty students per semester, with nurses coming from across the province to upgrade their qualifications. The college often receives more than thirty applications, but it can only accommodate thirty students per semester and accepts those who qualify for the pre-selection assessments.

3.4 Study Population

A study population is a group of people under study who have volunteered to participate and meet the inclusion requirements (Asimah, Menah and Oteng-Abayie 2017: 1612). The total population of registered students is 141 with ninety-one students being in the first year and fifty students in the second year of study. The student nurses complete a basic enrolled nurse training course of two-years duration to become an enrolled nurse. A small number of enrolled nurses wish to upgrade their skills to enable them to qualify as a Registered Nurse are also accepted at the college. There are two intakes a year,

with the requirements being advertised in the local community newspapers. Potential students are called in to write a pre-selection assessment test. On passing the test, they are interviewed with the total enrolment being sixty students per annum with the duration of the course being two-years. The course entails lectures at the college as well as practical sessions in hospital wards in all the general disciplines of nursing. The students come from across the KZN province, its demographics being largely consisting of African students which constitute 75% of the total enrollment, 23% of the students are of Indian origin, 1% are White students and 1% are Coloured students.

3.5 Sampling and sample size

Sampling is defined as a procedure to choose a sample from individuals or from a large group of a population for a certain type of research purpose. Advantages of sampling include saving time and gaining an accurate result. The disadvantage is that the researcher could be biased. In research terms, a sample is a group of people. There are two types of sampling techniques, one is probability sampling, which is classified into simple random sampling, stratified random sampling, systematic sampling, cluster sampling and multistage sampling. The second type of sampling is non-probability sampling which is divided into purposive convenience sampling, snowballing sampling, and quota sampling (Elliot 2020: 3).

In probability sampling, respondents are randomly selected to take part in research, with each person having an equal chance of being selected to participate in the study. Non-probability sampling is when a sample is selected through a non-random process. This type of sampling is used in the exploratory phase in qualitative research methods.

For this study, non-probability sampling was used with a purposive sampling technique. The selection was up to the researcher and her knowledge of who will be suitable for the study criteria (Elliot 2020: 3).

Ethnographers can start by using a ‘big net’ method to identify potential participants, which entails spending time with the cultural group under study and talking to many members of the group (Moser and Korstjens 2017: 9). While some researchers rely on twenty-five to fifty members, a smaller number of participants are recommended to ensure an in-depth study (Moser and Korstjens 2018: 9). The researcher selected participants from the target population who were willing to participate in the study. Of the 141 students

registered at the college, it was decided to use the final year student nurses as they had been together for training for over a year, which implies a level of familiarity with each other. The annual enrolment figure is sixty, which constituted the target population of final year students, of whom twenty-five student nurses were identified from a range of cultural backgrounds, their selection being based on race and religion.

3.6 Recruitment

There are a variety of strategies to recruit people for research such as recruiting through personal and professional connections when the researchers are part of or insiders to the group of people who are known to the researcher. Gatekeepers are people who have administrative positions or who have access to a particular setting. Recruiting using fliers, newspapers advertisements, emails and letters are done. Sometimes, payment of a fee to potential participant is used as an incentive. A face-to-face interaction was used for this research, as the researcher went into the lecture halls to address students and give out information letters about the research study to recruit students (Roulston 2018: 323).

3.5.1 Inclusion criteria

The following inclusion criteria were applied:

- final-year bridging students
- 18 years and older
- males and females,
- students who consented to participate.

3.5.2 Exclusion criteria

The following exclusion criteria were applied:

- first-year bridging students
- final year students who did not consent to participate in the study.

3.7 Data collection

Data collection was informed by the Culture Care Theory of Leininger (McFarland and Wehbe-Alamah 2019: 94)), which is a broad theoretical framework with enablers or models that are used to discover complex phenomena such as human care. Enablers are models that are used to enable a trust to be established with the students. Three

enablers were used to guide the data collection process: the first being stranger-friend model, the second was the observation- participation- reflection model and the third being the acculturation healthcare assessment. Each enabler consists of various methods of data collection:

- **Stranger-friend model**: this guides the researcher's interaction with the participants to map their progress from a stranger to a friend. The researcher spent time with the participants on the college premises, where they were observed in the classroom and during their breaks. The researcher engaged in conversation with the students in groups as they attended their lessons during the day and spent time with them during their meals at the table. During this period, the researcher was made aware of their feelings, behaviours, and responses in transition from being a stranger to becoming a trusted friend, after sharing their experiences with their fellow colleagues and the researcher. This stage required participants to be more protective of themselves and others in the group–they were guarded, a bit suspicious and asked questions. They later became more trusting of the researcher and less suspicious and questioning. The participants were initially reluctant to share cultural secrets and views but became more willing to share cultural secrets spontaneously. In the beginning, the participants were uncomfortable with being a friend to the researcher and later became more relaxed. The change in behaviour from being uncomfortable to be relaxed occurred after the researcher shared her cultural beliefs and practices with the participants. It was anticipated that the researcher needed to move from a stranger or distrusted person to a trusted and friendly person to obtain meaningful and credible data. This stage enabled the researcher to reflect on her own behaviour as well as observing those being studied. The researcher became reflective of and honest about her own behaviour, the researcher remained sensitive of the responses received from the student nurses. This allowed the students to become more trusting as they progressed (McFarland and Wehbe-Alamah 2019: 77).

- **Observation-Participation-Reflection Model**

The Observation-Participation-Reflection Model is divided into four stages as follows:

1. Basic observation of the group of people and listening attentively to the people. In this study, this entailed observing the participants without actively

participating but just listening and watching participants, listening to their conversations, and observing their behaviour.

2. Basic observation with minimized participation, which entailed conversing with the participants with limited interaction with them.
3. Basic participation with continuing observation, primary reflection, and reiteration of results with the participants. This entailed questions being asked and the participants volunteered information to the researcher on how close they have become as a group and the support they provide to each other.
4. Basic reflection entailed the researcher reflecting on the participants and her own behaviour and role in the research, which occurred throughout the study (McFarland and Wehbe-Alamah 2019: 80).

- **Leininger's semi-structure inquiry guide enabler /model to assess culture care and health**

When using this enabler, several open-ended semi-structured questions are used to extract certain data which closed structured questions do not elicit when conducting interviews. These types of questions are not so rigid and ordered but are more flexible and gave the researcher the opportunity to be respectful to participants during the interview while at the same being engaged in the conversation. The researcher listened to the participants during the interviews and gave the participants a chance to view their opinions without disturbing them.

- **Leininger's acculturation healthcare assessment enabler**

Leininger's acculturation healthcare assessment enabler is for cultural patterns in traditional and non-traditional lifeways. This entailed observing a group and identifying the traditional and non-traditional manifestations of culture to identify differences and similarities in a group of participants. Different languages were identified by the researcher. The participants experience in their ward as well as patients' symbols and signs were noted by the researcher. The patients and participants were observed and identified regarding their apparel, religious beliefs and their values and norms were identified.

3.8 Data collection instruments

Four instruments were used for this study to address the objectives, as guided by the enablers described above (stranger-friend model, observation- participation- reflection model, acculturation healthcare assessment), and consisted of participant observations, focus group interviews, discussions, journals, and reflection of the journal entries. All twenty-five student nurses were observed and participated in focus group interviews. However, only ten (10) participants returned their journals with their entries and reflections. The researcher recorded where data was missing or not completed by the participants.

3.8.1 Participant Observation

Participant observations took place over a period of a month in September of 2018. Participants were observed at the college, in the class during lectures and during their breaks. They were observed on their dressing and how they interacted with each other during the activities that took place at the college**.** The reason for observing their dressing was to ascertain whether they abided by their traditional requirements in their style of dress code. Some of the participants were observed during the activities that they engaged in, for their language of communication and their reactions and responses to each other during conversations. The researcher also observed the student nurses' daily activities, interactions, and events in a group. This lasted for a month with the researcher observing participants by walking around the college, watching the participants during the lectures, breaks and college activities. The researcher was actively involved and engaged in observing the participants. This type of data collection is crucial for the ethnographic researcher because a rapport was established with the participants. The researcher entered the students' (participants) spaces and sufficient time was spent obtaining the necessary data on the participants. The cultural practices of the students were observed to have an understanding an insight about the diverse cultures (Gibbs, Tremlett and Iglesias, 2020: 1).

3.8.2 Focus group interviews

Focus group interviews were conducted during the months of October and November 2018. Two sessions were held on the 24 October 2018, two sessions on the 29 October

2018 and one session on the 6 November 2018. Each session lasted two hours with a group of five participants.

Focus group interviews is a qualitative research method in the social sciences with particular emphasis and application on the development program evaluation sphere. It is a re-determined semi-standard interview led by a skilled moderator. The moderator asks questions, and the goal is to generate the maximum amount of discussion or opinions with the group within the time (Prasad and Garcia 2017: 5).

The advantages of focus group interviews are that it provides flexibility to the interviewer, a better response is gained rather than mailed questionnaires, the non-verbal behaviour can be judged, the place can be chosen by the researcher for the interviews and the interviewer can control the questions. The disadvantage of conducting interviews is that: it can be costly, interviews can cause bias, there is less anonymity and respondents can be difficult to access. The researcher chose focus group interviews to gather students' opinions, ideas and beliefs on transcultural competency and self-efficacy. The responses were broad and open-ended and provided depth for this qualitative study. Focus group interviews allowed the researcher to gather information in a shorter space of time (Copley 2021: 1)

This step of the data collection process took place after the observations and before the journal entries and reflections. Five focus group interviews were conducted with five participants shortly after the observation stage was completed, with the researcher making sure to combine people of different races to enable a combination of cultures. The questions were designed to understand their perceptions, attitudes, and ideas about culture from their clinical experiences with nursing transcultural patients. Focus group interactions allowed for opportunities to clarify and modify their responses to issues associated with the objectives through discussion and challenging other participants. The participants were seated in a circular fashion in a classroom and the session began once the researcher had obtained written consent from each participant, who was provided with a copy of the information sheet and their agreement to participate. Each interview lasted for thirty to forty minutes and was recorded using an audio recorder and the recording was later transcribed verbatim (Stage and Manning, 2017: 28). The

transcriptions were done by the researcher. All the recordings were played and written down word for word. The discussions during the focus group interviews allowed the participants to share information and insights that might not be gained from an individual interview, including the common terminology used by the participants to speak to each other. A high level of trust was gained and maintained during the focus group discussions (Polit and Beck 2018: 384).

The researcher was the interviewer (moderator) who asked the participants to comment on the point in discussion. Because of the diversity in the group, there were similarities and differences, similar genders, and similar cultures. Groups of five were chosen due to the sensitive nature of the topic. The information was solicited, and participants were forthcoming with their information because they were familiar with each other. There were one or two dominant participants in the group (Polit and Beck 2018: 394). Common terminology was used by the participants to speak to each other. A high level of trust was gained and maintained during the focus group discussions (Polit and Beck 2018: 384).

The following ground rules were set for guiding the participants. The participants were advised that the researcher would like all participants to participate by talking and they were told that the researcher would call on them if the researcher noticed when they did not contribute towards the discussion. Participants were informed that there were no right, or wrong answers and the researcher stated that everyone's experiences and contributions towards the discussion were important. Participants were assured that all information discussed was treated with the strictest confidentiality and was not heard outside the room. This was to make participants comfortable when sharing information. All conversations and discussions were recorded, and all participants were to remain anonymous as no names was mentioned as an alpha-numerical code was used to identify participants (Prasad and Garcia 2017: 4).

3.8.2.1 The role of the moderator

The moderator was the researcher who ensured that all participants were comfortable and contributed to the discussion and that their opinions were acknowledged (Prasad and Garcia 2017: 4). The moderator remained neutral by not contributing to the main points of discussion by the group and refrained from displaying any expressions or body

language that suggested agreement or disagreement with the discussion. The moderator elicited information from shy or quiet participants by using phrases such as: “Help me understand what you mean?” or “Can you give me an example?” There were one or two dominant participants, who were controlled by acknowledging their opinions and soliciting other opinions by saying to them, “Thank you for that response, what do the others think about that question?” (Prasad and Garcia 2017: 5).

The researcher/moderator paraphrased or summarized any unclear comments by the participants which showed the participants that the researcher was actively listening, and this assisted the moderator/researcher in understanding what participants were saying. The moderator acted spontaneously but probed deeper to trigger new discussions and obtain the necessary date on the participants. Also, the culture of the students was observed by the researcher/moderator (Smith 2018: 19).

3.8.2.2 Bracketing

The researcher set aside her own assumptions so that she was not prejudiced when interpreting the data observed and collected. The researcher actively engaged in the research, had informal conversations with the participants and spent time with students during their recess time. The researcher integrated herself within the culture of the participants (Smith 2018: 20).

A set of semi–structured and open-ended questions were prepared to address the three study objectives (Dejonchheere and Vaughn 2019: 9). This semi-structured interview encouraged interactive conversation between the interviewer and the participants, and the participants felt comfortable, and the method was useful to obtain data from the participants. The questions were compiled based on the objectives, planned according to the length of time of the interviews and guided by the suggestion of Creswell and Poth (2016: 55) to have fewer than twelve questions. This flexible form of data collection enables the researcher to identify areas of interest and direct participants’ attention to what they want to know more about the subject matter. After a brief introduction to the study and its purpose, nine questions (Appendix 6) were divided into sections to address the study objectives. Not many probing questions were asked as the interview questions

were semi-structured and students responded to them. There were only five students per focus group which allowed them to speak freely without the need for much probing.

3.8.3. Reflective Journals

Diaries were given to students to write down their experiences in the clinical field related to cultural care or nursing patients who had a culture different to their own during their two months in the ward for clinical training (Lutz and Paretti 2019: 2). They were requested to include information relating to the patient's race, gender, religion and to ask questions about their culture. Student nurses were encouraged to record as many events as possible. These events were to be related to culture and their thoughts on nursing diverse patients related to the three objectives on their experience, competence, and self-efficacy. The diaries were handed to the student nurses and returned after two months of being in the wards.

3.8.4 Participants' Diary Entries, Reflections and Discussion

At the end of a month of ward duties, the participants returned to the college where discussions took place on the experiences written down in their diaries (Hyers: 2018: 284). During the discussions, they reflected on the various diary entries, engaged in discussions about what had transpired and made suggestions on how to treat patients better according to their culture and commented on their experiences regarding knowledge and experience of cultures. The sessions were digitally recorded and later transcribed for thematic analysis. The diary entry, reflection of participants on their diary entry and discussion is provided below.

I nursed a Jehovah's Witness, and she just came back from theatre, lost a lot of blood, and died, they don't believe in receiving blood, and I am catholic, it's hard (FG3 P5): 2 December 2018

***Reflection**:*

I don't want to say, but for me it was a dilemma to see someone die because they didn't want to receive blood. In my religion I believe in life, and in nursing I believe in sustaining and preserving life. This was hard (FG3 P5).

Discussion

This participant showed caring, compassion and empathy for her patient who died. She found it difficult to understand that a religion could allow someone to die when there was an option to live by receiving blood, a simple procedure. The person could have been saved had they agreed to receive blood, despite their religious beliefs. This incident was an ethical dilemma for the participant who believed in the preservation of life, according to her religious convictions and core nursing values.

3.9 Data saturation

Data saturation is defined as information redundancy or the point at which no new information is gained. This research study used five focus group interviews, participant observations, reflective journals, and discussions with the four methods used to collect data. Saturation of data was reached when participants began discussing the same points. Data that was already collected became redundant during the interviews when the researcher began to hear the same comments repeatedly.

3.9.1 Probing

The focus group interview questions were semi-structured so there was not much probing required and students contributed to the questions that were asked.

3.3.10 Data analysis

The demographic data was analysed and presented descriptively in the narrative. In an ethnographic study, data analysis commences from the time that the researcher enters the study setting and begins to observe and compare the participant's behaviour patterns, thereby establishing a deeper understanding of the various cultures (McFarland and Webe-Alamah 2019: 314). The qualitative data from the focus group discussions, journals and reflection sessions were transcribed verbatim into a word document where it was thematically analysed to extract themes for each of the objectives.

3.3.10.1 Extraction of themes

The data from the four tools and discussion sessions were analysed as follows:

3.10.2. Observations

Participants were observed and notes were taken and narrated. Descriptors were identified and categorized, and repetitive patterns were identified and analyzed.

3.10.3 Focus group interviews and discussion

The focus group interviews were audio recorded and transcribed verbatim**,** with descriptors being identified and categorized, repetitive patterns identified and analyzed.

3.10.4 Reflective journals

The data in the diaries was identified and categorized into descriptors, repetitive patterns were identified and analyzed, and major themes extracted.

3.10.5 Triangulation of data

The data was thematically analysed from all four research tools in order of how each was done and triangulated to identify their similarities to address the study aim. The type of triangulation that was used was data triangulation where more than one method of data collection was used to deepen the researcher's understanding of the participants' experiences in nursing culturally diverse patients and maximise the study findings. This method was also used to enhance the validity of the study. Owing to the diversity and quantity of data, this gave the researcher confidence in the research findings.

The transcribing of data from all four tools was done by the researcher and this was verified with the participants and discussed with the researchers' colleagues at the nursing college.

3.11 Trustworthiness

Rigour is a defined as a state of being exact or careful and precise or the quality of being accurate, it is also the strength of the research method or design and the appropriateness to answer the objectives (Cypress: 2017: 4). In this research study, four tools were used to obtain data, and this was then analysed thematically.

Trustworthiness is further divided into the following sections:

3.11.1 Credibility

Credibility refers to credentials and other qualities that indicate whether a source is reliable and authors credibility helps support ideas and arguments in a research paper, if sources lack credibility, it undermines the effectiveness of the paper and perhaps the authors won credibility (Firestone 2021:1)

In this research project, the truthful depiction of the participants' experience was achieved through the various methods of data collection. To achieve this, the researcher spent a month observing the participants, conducted focus group interviews, issued diaries to participants to make entries on their experiences of treating culturally diverse patients. Triangulation took place by cross checking the data. Data was consistently checked and interpreted with the participants

3.11.2 Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. From a qualitative perspective transferability in research is synonymous with generalizability, or external validity (Cypress 2017:4).

Transferability was enhanced using the purposive sampling method and the provision of a wide range of information from the participants about their experiences with the culturally diverse patients. Data collection continued until data was saturated (Cypress 2017: 5). Transferability is the application of the study findings to other contexts or other participants (Cypress 2017:5). In this qualitative study, the researcher achieved openness through clearly articulating the study methods.

3.11.3 Dependability

Dependability emphasizes the need for the researcher to account for the changing context within which research occurs. The research is responsible for describing the changes that occur in the setting and how the changes affect the way the research approached the study (Polit and Beck 2018: 580).

Themes and subthemes were identified as well as categories and descriptors according to the ethno-research method. Dependability establishes stability about time and the

study conditions. Dependability is the extent to which similar findings would be obtained through repeated research (Polit and Beck 2018:585).

3.11.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others, there are several strategies for enhancing confirmability. The researcher can document the procedures for checking and rechecking the data (Cypress 2017:3).
Confirmability was met by keeping notes and documentation. The data was collected and analysed, and interpretations made. Self-awareness of my role as a researcher and as the instrument of this study was emphasised (Cypress 2017: 3). Through reflexivity and bracketing, the researcher was aware of her own bias, assumptions, and beliefs that she could bring to the study but was also aware that not all presumptions could be reduced. Confirmability corroborates with the consistency of the study's findings (McGarry, Allen-Collinson and Evans 2019:9).

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The trustworthiness of this study is considered in terms of its credibility, dependability, confirmability, transferability, and authenticity. Several different procedures were utilized to ensure methodological rigour and credibility was ensured through the relationship between the researcher and the participants. At the beginning of each focus group discussion, a standardized introduction was used. An environment of trust and respect was ensured by reminding participants that the research study and focus group interviews was confidential and continuously extending my gratitude to the participants for their contributions towards the discussions. All data that was recorded was captured word for word in writing. Credibility, dependability and confirmability were gained when journal entries of the participants were reflected upon (Halle' et al. 2021: 1311).

3.12 Ethical considerations

Ethical considerations refer to the rights of the participants that must be respected in the study. The following ethical considerations were observed:

3.12.1 Ethical approval

The research proposal was approved by the Institutional Research Ethics Committee (Appendix 1) to conduct the study. A letter requesting permission was sent to the Head of the Joint Medical Holdings to conduct the study at the college (Appendix 2) and to the Research Committee of the Joint Medical Holdings that granted permission to conduct the study (Appendix 3).

3.12.2 Self-determination

The right to self-determination is based on the principle of respect for persons as free agents (Barrow, Brannan and Khandhar 2021: 1) who have the freedom to live their lives as they choose without being coerced. The principle of autonomy is that individuals have control of their lives therefore they should be treated as autonomous agents (Khandhar et al.2021:2). The researcher explained the nature and scope of the study and informed the participants that participation in the study was voluntary and that they had a right to withdraw at any time.

3.12.3 Anonymity and confidentially

Anonymity is when the identity of a subject remains a secret. In this study, the participants' experiences of their patients in transcultural nursing in the clinical setting was diarized, with the researcher not knowing who the patients were, as their names were not recorded. Confidentiality is when the researcher knows the identity of a research subject but protects that identity. In this study, the students' identity was protected. It required an agreement with the participants to ensure that the information is kept confidential. The participants were not known by their names in the research study but rather by a code or number (Barrow, Brannan and Khandhar 2021: 1).

3.12.4 Fair treatment and protection from harm

Researchers must protect participants from exploitation, and they should not be coerced to participate. All participants have a right to fair treatment and privacy. In this study, the participants were given an information sheet detailing what the study was about with the students being requested to inform the researcher if they were comfortable. All the participants were treated fairly by being given an equal opportunity to answer their interview questions throughout the study (Barrow, Brannan and Khandhar 2021: 1). The ethical principles that guide nurse researchers particularly in relation to protecting

potential research participants, are essentially the same as those that guide nursing practice. These principles include:

Veracity: The principle of truth involved telling each participant the truth regarding the research, what it entails and what part they would play. Truthfulness was maintained throughout the research in the collection of data, the recording and writing of data (Amer 2019:7).

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Justice: Justice is the principle of being fair, with all participants being treated fairly and being given a fair chance to be observed and interviewed in the focus group interviews. All participants were issued with diaries and were given an opportunity to reflect on their diary entries. The participants are vulnerable, and every effort was made not to abuse them in any way (Barrow 2020:8 et al. All participants in this research study were observed and listened to carefully.

Non-maleficence: Is the principle of doing no harm, without any participants being harmed in any way or made to feel uncomfortable (Barrow et al 2020:3). No harm befell any participants or their patients on the clinical environment during the research study.

Beneficence: Is the principle of doing good. Each participant's interest was taken into consideration and they were treated equally. Confidence was maintained as the identity of students were not revealed. An alpha-numeric code was used for each participant (Fleming and Zegwaard 2018: 211).

Confidentiality: All data gathered during the observation, interviews and entries written in the diaries were treated with the strictest confidentiality (Barrow, Brannan and Khandhar 2021: 1)

Reflexivity: Reflexivity is when the researcher becomes aware of herself and her behaviour during the data collection (Cypress 2017:3). In this study, the researcher reflected on her own behaviour, as this can impact the data collection.

3.13 Summary

This ethno-nursing study entailed inviting twenty-five second-year nursing transition students at a College of Nursing in eThekwini District (Durban) Kwa-Zulu Natal, to participate in research that explored their cultural experiences, competency, and self-efficacy. The data collection methods involved observation, focus group discussions,

journal/diary entries and journal/diary reflections. Data that was captured was analyzed into different thematic categories. These represented the differences and similarities and the transcultural behaviour of participants and their patients that enabled the aim of the study to be addressed. In such a study, the researcher becomes part of the study, having to prevent their own opinions and bias from interfering in their ability to accurately understand what they were seeing and extract what was relevant to record. This chapter details the methods used to understand what data was collected and how it was analyzed and provides insight into how the results are presented in Chapter Four.

CHAPTER FOUR
RESULTS OF THE STUDY

4.1 Introduction

This chapter presents the outcomes of the data collection from the study in the following areas: participant observations, focus group interviews, diary entries and reflections. The aim of the study was to explore the competencies and efficiencies of student nurses when rendering transcultural nursing in a private nursing school. The three objectives were to explore transcultural self-efficacy, explore their experiences and describe the competence of student nurses in transcultural nursing. The results are presented by the four stages of data collection:

Stage 1: Participant Observations

Stage 2: Focus Group Interviews

Stage 3: Diary Entries

Stage 4: Reflections

4.2 Demographic profile of the participants

Most of the participants (64%) were under the age of 30. Thirty-two percent were between the age of 31 to 40 and 4% between the ages of 41 to 50. Twelve per cent of the participants were males and 88% females. The racial profile of the participants was 68% Black Africans, 28 % Indian and 4% White. The first language (home language) of most participants (60%) was isiZulu, 36% English and four percent isiXhosa. The religious affiliation was 48% Christian, 28% Hindu, 16% Traditional African and 8% Jehovah's Witness. While instruction at the college is provided in English, sixty % of the students' home language is IsiZulu. The marital status was 76% single, 20% married and 4% widowed.

4.3 Stage 1: Participant Observation

The start of a lecture day at the college begins with students arriving at the main hall and some waiting in the classrooms (Lecture Halls). On arrival, the students are noisy and talk a lot, mainly in English and IsiZulu, with some being more talkative than others. They

speak about their weekends, work on the wards, have general discussions about their lives, families, friends, and colleagues at college as well as hospital staff.

Some students dress smartly, others wear brightly coloured clothes, with the dress code of the college generally being jeans and tee shirts with sneakers, or skirts below the knees. On the mornings when tests and examinations are scheduled, they are stressed and anxious, as is indicated by the expressions on their faces and sometimes they ask the nurse educators to postpone tests. The researcher observed anxious students by the way they twiddle their thumbs, fidget while writing or shuffle their feet and sometimes shuffle their papers.

Some students arrive late due to challenges with travelling long distances and transport. Several students do not make eye contact with their nurse educators when they are reporting that they are late and their heads are lowered, with fear often being expressed. From an African cultural perspective, it is disrespectful to make eye contact with elders or people in a higher position/status and is considered impolite to look at senior persons directly when speaking to them. This cultural practice shows respect and is inculcated in childhood, being a way of life that is practised by their parents and other members of the family. Nurse educators sometimes get the impression that students are shy or have an attitude, but then realise that it is due to their cultural beliefs that there is no direct eye contact.

The college provides students with tea, and they bring their own lunches, which they often share with their colleagues. Others leave the college premises to buy their meals at the take-aways or fast foods outlets. A concern and point of discussion amongst students are the exorbitant fees at the private nursing colleges, which they have difficulty paying as no bursaries or learnerships are available. The students also complain about various issues, such as the allocation to clinical facilities, their work experience at different hospitals and units and that they are not treated professionally by the registered nurses. The students are unhappy about the college operating times as it previously closed at 13h00 on a Friday and now closes at 16h00. It is inconvenient for students to commute over the weekends as some live a distance from central Durban and they do not like to stay until 16:00 on a Friday, as it creates transport problems.

During orientation, students are advised about the various activities and events that take place at the college and their required participation. A free diabetic clinic is organised by students on a Thursday morning, at which health education, vital signs, blood pressure and blood glucose tests are done on people from the local community. This clinic is set up in the college hall and students are required to act professionally, to dress in full uniform, greet the patients, and make them feel comfortable, check their vital signs and record their findings on the patients' clinic cards.

On the socio-cultural day, which is a college event for each group, students must present role-plays and prepare meals for presentations according to different cultures either their own or other cultures. The students are given an opportunity to enact their different cultural practices and traditions and share a cultural meal. This event is part of the role-play activities for the course in sociology. This takes place during the year and the students are assessed and given marks for presentation. Students are divided into groups of five and for their role-plays they enact actual cultural rituals or festivities, such as exchanging gifts for a marriage proposal, the rituals associated with a child reaching puberty and practices after death.

Students narrate their role-plays from a cultural perspective, enjoy this event, and have lots of fun. They prepare their own cultural meals and share their meals with each other at which they explain the nature of the food, its nutritional value, and the special occasion for which the meal is prepared. Students look forward to the socio-cultural day and are excited to be involved in such an event. Mandela Day, held on the 18 July each year, is an event planned and executed by the students. This activity gives students an opportunity to display teamwork and community involvement skills in a social investment programme in the private sector and find it rewarding to serve the people from this community. They prepare a meal on the college premises and bring fruit, yogurt and gifts of clothing and serve the local community in the college hall.

During the observation, which was the first stage of the of the data collection process which took place before the focus group interviews and lasted a month, the researcher had feedback from the students on their interaction with each other, their family, children

and spouses. The students assisted each other with resolving social challenges which they encounter while they study. The students that face these challenges in their lives are befriended, advised, trusted, and motivated by each other, and are also assisted with academic work when they have been absent. Due to challenges, students are very supportive of each other, for example, when there has been a death of a family member, the class collects money as a contribution towards the funeral.

4.4 Stage 2: Focus Group Interviews

The focus group interviews consisted of five participants in each group. The focus group interviews were conducted in the classroom, two on the 24 October 2018, two on the 29 October 2018 and one on 6 November 2018.

The researcher used Leininger's four phases of ethno-nursing to analyse the qualitative data from the focus group interviews:

Phase 1: Collecting, Recording and Describing

Phase 2: Identification and Categorisation of Descriptors

Phase 3: Pattern and Contextual Analysis

Phase 4: Major Themes

4.4.1 Phase 1: Collecting, Recording and Describing

In the first phase, the researcher collected the raw data by audio-recording the responses from the participants in the focus group interviews. The recorded data was then transcribed verbatim in writing.

4.4.2 Phase 2: Identification and Categorisation of Descriptors

In Phase 2, the data was arranged according to the interview questions to address the study objectives. Information received from the participants' interview questionnaire were studied for any similarities and differences in the cultural context as depicted in Table 4.1 These descriptors and responses pertained to the following questions which addressed the study objectives:

Objective 1: To explore students' experiences in the cultural context, the following questions were posed:

How do feel about nursing patients of diverse cultures?

- What opportunities did you have in the clinical practice to provide cultural care according to beliefs, values, and practices?
- Have you had sufficient exposure to socio-cultural knowledge?

Objective 2: To explore the student's experiences in transcultural nursing, the following three questions were asked:

- Tell me some of your experiences in transcultural nursing during your clinical practice?
- Explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures.
- Share with us how you would assess the cultural needs of your patients in a congruent and beneficial way.

Objective 3: To describe the competence of student nurses in transcultural nursing was addressed by the following three questions:

- What are your viewpoints in the recognition of cultural needs without preconceived judgements that would help prepare future nursing students to provide culturally competent care of patients?
- Are there changes you would like to suggest in nursing patients of diverse cultures holistically according to their lifestyles and traditions?
- Are you equipped to provide culturally competent care according to your knowledge, skills and attitudes and if not, why?

4.4.3 Phase 3: Pattern and contextual Analysis

The participants indicated that they experienced a lack of complete competence and self-efficacy and made suggestions about how to improve in this area.

For me it is the language barrier, I have picked up a few words to get through; I do find it difficult socially with the older people (FG5 P1). I would like to change people's perception of organ donation and blood transfusion, I respect their cultures, but I believe in nursing we should do everything in our power to save lives,

so I would like to educate people on how their organs, or their blood can save someone else's life (FG4 P3.)

It was evident that participants were aware of their own culture and sometimes not aware of the associated cultural practices. The participants had limited experiences of certain cultures, for example, the Jewish culture and were not fully prepared to render culturally competent care but recognised their need to nurse patients who were culturally different. Participants became aware of their own culture through their patients and patients' relatives. A participant related that a relative came back to fetch a deceased patient's limb and was unaware of this practice in her own Zulu culture. The participant was also confused about a tradition followed by a Jehovah's Witness patient, who did not allow a blood transfusion but allowed an organ transplant on a child as related below:

I also had a patient of 7 years old, who needed a blood transfusion, and the parents refused the blood transfusion, but they allowed the child to have an organ transplant because she had liver damage (FG1P1)

The participants realised that some cultures are not strictly adhered to. While some participants stated that they were ready to nurse patients of diverse cultures, they were not aware of all cultures, and the shortcomings of being educated on culture as stated below:

"I would say I am not prepared, there are some cultures I don't know unless we, we, we are taught but even if we are taught, we can't be taught everything (FG1 P3)"

Participants stated that they did not have adequate exposure to socio-cultural information and indicated that cultural practices are often not discrete with people adopting aspects of other cultures and that the patients teach them as they proceed in their nursing practice. The need to respect all cultures was evident and repeatedly stated by participants. In having respect for their patients' culture, the participants were able to provide cultural care according to the required beliefs, values, and practices. To provide cultural care to their patients, it was evident that participants first assessed their needs of patients on admission by taking their history and background and asking relevant questions about their religion and language.

Normally I would ask what religion e.g., what religion or language the patient is, e.g., Shembe, even if patients are praying, we know them from the prayers, what religion, sometimes when the nurses are praying, the patients join us, we do assess patient's needs, sometimes we don't ask, they tell us what they eat or don't eat (FG1 P1) t1.1

Some participants' exposures to and experiences of culture was new, and they indicated a lack of competence and a need to learn more and gain experience in dealing with such patients. Some acknowledged that there are several different cultures and that for the Indian and Black/African Zulu cultures, they can provide adequate care, as they were familiar with their practices. However, some cultures, such as the Chinese, German, Russian, Greek, and Jewish were a challenge.

> *" I am familiar with all the Indian religions and languages, I speak many Indian languages, and there are a lot of black patients who speak Zulu, I speak Zulu as well and understand their culture, I am not sure if I am faced with other cultures, like something foreign (FG5 P2)*

The participants stated the need for more education about the various cultures they were likely to encounter to enable patients' needs to be assessed daily and that negative attitudes and bias on the nurses' part should be addressed through in-service training. The participants stated that one culture was adequately provided for compared to other cultures, this being the Muslim culture, and mentioned that this was regarded as a superior culture among Indian people.

Suggestions made by the participants related to student nurses' orientation to the class members, in which they should take time to share each other's culture in the classroom and to improve the lessons in sociology and transcultural nursing. Similarities among cultures were identified by participants, such as the Muslim patients facing north-east to Mecca when praying and the Hindu patients facing east when praying. Similarities among dietary preferences were also identified, such as days of abstaining from certain food among Hindu and fasting among Muslim patients, food preferences and observance of holy days. A participant mentioned that in Human Rights Law, serving patients food that they do not eat, such as beef for Hindu's and pork to Muslims, is sacrilegious and violates patients' rights if it is served mistakenly. The participant also mentioned that in certain institutions, such as hospice, all faiths are catered for and accommodated.

Nurses must be more accommodating because they just don't care for them, it is such a big thing for nurses when they see them practising other cultures, according to the Human Rights, you cannot give patients what they don't eat according to their religion and culture, I think nurse should be more educated on culture, I am Hindu and at the hospital canteen was served Beef instead of Lamb, I was very upset (FG3 P1)

Learn your own culture, I must accommodate all cultures, things can be done differently e.g., set proper menus to accommodate patients' cultures, it is difficult in the wards, as everybody wants their preferences, everybody wants, double portions, everybody wants hot meal and everybody wants everything now, e.g., Muslim patients do not eat pork, the hospital canteens /kitchens must accommodate all religions (FG3 P3) In the Hospice they accommodate all different faiths, e.g., Jewish, Hindu, Christian including Say Baba, that's so good, the hospitals should learn from them (*FG3 P5*)

A participant mentioned that time management was a challenge in teaching new nurses and nurses should be aware of different cultures and nursing diverse patients, as this was stated in the Nursing Pledge of Service. Many participants mentioned an increase in education and that having books on cultural practices would assist them to nurse patients of diverse cultures.

> *I think we need books for students on Transcultural Nursing, students must take down notes, once they get home they must read and understand (FG5P3).*

4.4.4. Phase 4: **Major Themes**

This phase consisted of the major themes, which Leininger regards as the highest phase of data analysis and interpretation and requires a combination of thought processes and arrangements of the elements in a particular form. The three major themes are Awareness and Self-Awareness of Culture: Respect and Caring and Self-Efficacy.

4.4.4.1Theme 1: Awareness and Self-Awareness of Culture

[Participants' awareness and self-awareness of cultures was evident when nursing patients from different cultural backgrounds. Most participants mentioned the importance and the benefit of awareness and self-awareness of culture, with four sub-themes emerging as illustrated in Table 4.1.

Table 4.1 Theme 1: **Awareness and Self-Awareness of Culture**

Theme	Sub-theme
4.4.4.1 Awareness and self-awareness of culture	a. Identifying needs of the patient
	b. Experiences of nursing diverse patients

	Increased confidence and self -esteem
	d. Self-awareness compliments student's competence

a. Sub-theme: Identifying needs of the patient

The participants identified the needs of patients by questioning them on their dietary preferences, spiritual and personal hygiene needs, which made them aware of other cultures as indicated below:

On admission, we would ask the patients their preferences as on some days patients are fasting or they eat certain meals, or they are dry fasting (fasting by not eating any food) (FG2 P4).
The patient was going for a major operation to theatre, so we had to check if they were a Jehovah's witness, just in case they needed a blood transfusion, would that be an assessment (FG2 P2).

Normally I would ask what religion what religion or language the patient is, e.g., Shembe, even if patients are praying, we know them from the prayers, what religion, sometimes when the nurses are praying, the patients join us, we do assess patient's needs, sometimes we don't ask, they tell us what they eat or don't eat (FG2 P1).

On admission, you ask patients preferences on meals or activities, in some cultures males and females are not allowed to stay in the same room, like some Muslim females (FG3 P3).

We assess by dress, identifying e.g., if the patient is wearing a red dot on her forehead, we know she is Hindu, or a red string on her wrist, again it is a Hindu, sometimes we identify by the language they speak or their names and surnames (FG3 P3).

On admission questions are asked to the patient about dietary preferences, religious beliefs, languages etc. Based on these, patients are assessed and treated culturally; when the patient tells us what religions then we ask more questions or patients volunteer the information (FG4 P2).

We also daily do assessments of patient's health needs and sometimes patients share with us their needs or request certain times to pray (FG5 P2

b. Sub-themes: Experience of nursing diverse patients

The participants experienced an increase in their knowledge by observing patients of diverse cultures. Exposure to patients from the same and different cultures increased their understanding of that culture, thus enabling them to nurse them appropriately.

A patient who came to us after an accident on the N2, her lower limb was damaged and she was taken to theatre for an amputation, post-op the patient was ventilated and later demised. After this the relatives came back and wanted her limb, I didn't know that in my culture that they would want the amputated limb, I thought the limb would be taken for cremation, but the relatives wanted the limb to bury the patient with the limb, I am Zulu and so was the patient, this made us aware that they must not get rid of the limb, I think they are more aware of our own culture (FG1 P1).

There was a granny, a 68 year old patient who came in unconscious, bloods were done for her and her HB was low, four packs of blood was given to her, this was ordered by the doctor and signed for, she was unconscious for days, finally the patient came through and we learnt from the relatives that she was a Jehovah's witness patient, we told the patient that we transfused her, she was happy to be awake and alive and did not mind that blood was transfused to her (FG1 P1).

Participants did have trouble in speaking the language of some of the patients they nursed and found it difficult to understand the different languages they were not familiar with and/or could not get anyone to interpret as is evident in the following quotes:

In my experience, I came across a patient who didn't understand English, didn't understand Afrikaans, and can't understand Zulu. He was an Indian, it was very hard to identify the problem, we even called the seniors, it was very difficult, and it was a language barrier (FG5 P3).

This patient was speaking French, I didn't know what she was saying, I was taking her pulse 'cos even the relatives were unable to tell us, they just brought her in, because it was the hospital, but the one word we could understand was Dr, Professor is somebody we know, so we called him and he was able to give us the treatment telephonically and he was able to tell us what was wrong with her, he gave us all the orders on the phone and there was no letter (FG4 P5).

I heard these people in OPD, it was a Chinese persons, chi Chang, with the child carried, chi chi, chie ha sung sa I thought what the hell is going on, so I took the baby from the mothers arms and started to do vital signs only to find out that the child had a very high temperature and these were very anxious Chinese parents, language is a barrier to me, it was hard to decipher what they were saying, but they eventually got one of the relatives to translate for us (FG4 P1).

We had a patient she could speak English clearly but was Russian. She did not want to have a bath that was offered to her, she said she will go home and bath and did not want to give her baby a bath. I am not sure if this was a cultural thing or just a preference or not, she was not telling anybody why (FG4 P4).

Participants discussed cultural practices of the Shembe, Zulu, Muslim, Hindu, and Christian patients:

Yes, there is something like that, all the patients belonging to Shembe, if you want to go to toilet you have to take even the dress code out, which is white, they are wearing, when they go to the temple, which is outside under a tree surrounded with white stones, you have to leave you shoes outside that space, there is another thing while you go to church /temple the women are not wearing panties, I don't know if it is true, another thing is they are eating cold food on a Saturday and the person in the kitchen that is preparing the food must not be menstruating (P3 FG1).

The experience we got is the experience we got from the patients, I wouldn't say at what time we were born, for example, there was this Indian man in Zelly hospital, I think he was a Hindu man, the relatives used to bring things and burn some fires and do a big prayer in the unit (P4 FG4 P4).

In my experience, there was a patient that passed on and the family came and said they must not do anything for the dead person, they came with a branch thing, it was difficult, in a Christian family there is nothing like that, I heard about it. They took two hours; they came to take the spirit away. I knew about it, and heard about it, but I didn't see the actual thing (FG3 P3).

Last month I was allocated to the NICU (Neonatal Intensive Care Unit), I just didn't know which culture they came from, so they came and asked whether the uncle and aunt could come and pray, we allowed them in, in NICU only the mother and father are allowed, I'm not sure whether it was the grandmother, there's a prayer that needs to be done instantly, like as soon as the baby comes from theatre or from the ward into the nursery (FG2 P2).
(This religious practice is applicable to the Muslim culture and is a baby naming ceremony).

I had a patient who asked which direction was east as we didn't know why or what the direction was, so we requested and directed them to the Muslim prayer room, when I asked the patient, she said that Mecca was in the north-east, the Hindu people also pray facing east towards the rising sun (FG 4 P2).

This patient was very sick, she refused the blood transfusion, so the husband came with some relatives and signed for giving permission for the blood to be transfused, the patient didn't mind (FG4 P4).

There was this one patient, first she was pregnant and went to theatre for a caesarean section, she spoke a different language, she wanted her placenta to be taken home with her, she was a Black African woman, I think she was Zulu, I found that strange as I am Zulu, and we don't do things like that (P5 FG5).

In our ward we had a chief for a certain village, this chief was also a Shembe priest at the same time, and we are used in the ward to greet patients but with this man, we had to not only greet but bow down, that was a bit too much for me. Sometimes I forgot and had to apologise (FG5 P5).

Cultural barrier and practices were experienced by a participant regarding spiritual beliefs, as indicated in the following quotes:

I was in the lift coming out of my ward going down to another level, I was talking to another nurse in the lift, I met some people in the lift, a priest, and the relatives, with a tree branch and talking to nothing (spirit). I was chatting to another nurse, when this man told me to keep quiet, I am not sure why (laughs) (FG3 P2).

Participants experienced patient's culture in the assessment and request for meals among the diverse patients that were nursed:

In my experience we had a Jewish patient that came in. He wanted kosher food because of his religion, he didn't want tap water, he didn't want any food that was not Kosher, he wanted only bottled water, so he ate only fruit and veg as he came in at night, at that point there was no food available, it was late, however the next day we were able to provide kosher food (FG5 P2).

There are a lot of cultures I think, the nurse's attitude, we react differently, for instance, we can provide well for the Indian cultures, but for example we are unable to provide for the Black cultures, for example, the Shembe patient, sometimes the kitchen staff have attitude especially about the cold food on Saturday and they provide bread and maas, that attitude should change (P2 FG4 P2).

c. Sub-theme: Increased confidences and self-esteem

Self-esteem is a key feature in a person's perception of their worth, with a high self-esteem signifying a person with self-respect, while an individual with low self-esteem may lack confidence (Mane 2016: 497).

I *feel we ready to nurse patients, but we are not aware of some cultures, we African cultures are different, we ready but we don't know all (FG1 P1).*

We are aware for example that the Shembe patients don't eat hot food on a Saturday, but we don't know the reason why, everybody learns (FG 3 P5).

I see nurse's discriminating against patients, we should be more accommodating, even as we nurse other cultures, even us as Blacks, I wouldn't want this to be done to me, try and be more understanding, we don't know everything we learn (FG3 P2).

The following quotations show the self-esteem and confidence of the participants:

With the different ethnic groups, you learn and adjust to it, and as you are exposed to it more often it becomes easy for you to handle it (FG 3 P2).

We work in a multicultural hospital, I for one encourage them to pray before we start the day, it used to be a norm back in the day, we sang and we prayed, some do, and some don't (FG5 P4).

If we had the time when the staff were there, the kitchen staff and the cleaners and the patients, sometimes the patients' families they pray, which we don't stop, when they are a little bit well (FG5 P5).

d. Sub-Theme: Self-Awareness compliments student's confidence

Cultural self-awareness includes looking at one's own prejudices, exploring one's culture and history, and being aware of making judgements. Participants are required to acquire knowledge of cultures different to their own and to provide quality nursing service to patients. As they became self-aware of their own and other cultures, they were more confident to nurse diverse patients:

Last year in the SICU (Surgical Intensive care unit) , I am a Priest , there was a patient there on CPAP, it was time for the patient to demise, the family was looking for a Hindu priest and they could not get hold of the priest, I said to them I am a Nurse but I am also a Priest will, you allow me to pray for the patient, I opened up the book to check dates and times etc., the family was happy for me to pray as they could not get their priest, I was offered a thanksgiving , as a priest, I will accept it but as a nurse I cannot accept it , please give it to a charity. The patient passed away the next day, this is the last rights prayer for Hindi people especially for people for find it difficult to make the transition from this life to the afterlife (FG5 P2)

Table 4.2 Theme 2: Respect and Caring

Theme	Sub-themes
4.4.4.2 Respect and caring	a. Ability to accommodate different cultural needs
	b. Respecting various cultures
	c. Opportunities for providing cultural care
	d. Acceptance of different cultures

a. Sub-theme: Ability to accommodate different cultural needs

Care is the core focus of nursing and a unifying force, as caring is vital for health, healing, and the ability to face the stage of dying (Değer 2018: 2). The care component is important to healing and there can be no wellness without caring, as indicated in the following quotes:

To cater for the needs and nurse patients holistically, educate the nurses more (FG1 P1).
Every morning when taking over, student nurses must check all the patient's needs (FG1 P1).
Training or in-service training, for example, on the different cultures and common things in the Jehovah's Witness and so on (FG1 P1).
Nurses must be more accommodating, because they just don't care for them, it is such a big thing for nurses when they see them practising other cultures, according to Human Rights, and you cannot give patients what they don't eat according to their religion and culture. I think nurse should be more educated on culture, I am Hindu and at the hospital canteen I was served beef instead of lamb, I was very upset (P3 FG3).
(A Hindu religious practice is not to eat beef as the cow is considered a mother who produces milk, so this is sacri-religious)
We were able to provide kosher food to the Jewish patient (FG3 P1).

At the hospital where I work a prayer room is provided for the spiritual needs for Muslim patients and a chapel for Christian patients. I was able to provide spiritual care by taking the priest and the patient to the chapel to pray (FG5 P4).

b. Sub-theme: Respecting various cultures

Throughout the interviews and discussions, the participants displayed respect for other cultures, which indicates a caring nature. They stated that they should think about their patients as their own relatives when making decision on their care. The participant emphasised knowing about the roots of their cultures to understand patients and their culture and respect patients and their property (amulets). This is evident in the following quotes of diverse cultures:

What changed me was the fact that I experienced many cultures and accommodated them, I cannot understand some of the nurses, why they don't understand other peoples' cultures and accommodate them, instead they behave inappropriately and unprofessionally, sometimes shouting at people, one must just think what if it was your family (FG4 P4).

Even if we are scientific, culture helps patients get better quickly, we don't ask that question, we need to go back to our roots, see where we came from and what we understand in our culture (FG4 P3).

Some patients are so interested when you ask them about some of their habits or rituals, sometimes we throw things away that the patient has, it is so painful for them, just imagine if someone threw something that you held so dearly, so we must give their things back on them (FG4 P4).

c. Sub-themes: Opportunities for providing cultural care

Students displayed a caring and compassionate attitude towards their patients by taking opportunities to provide cultural care. All these acts show compassion and caring, as is evident in the following quotes:

Yes and No, I can provide cultural care in most instances, mainly the patients in the hospitals I work in are Indian. I am familiar with all the Indian religions and languages, I speak many Indian languages, and there are a lot of black patients who speak Zulu, I speak Zulu as well and understand their culture. I am not sure if I am faced with other cultures, like something foreign (FG4 P3).

Yes, sometimes I can call on my own Catholic priest to pray for patients in the ward, sometimes the patients request these prayers, especially when they are very ill, the priest does come and administer communion to the patients (FG5 P1).

d. Sub-theme: Acceptance of different cultures

Participants showed the acceptance of different cultures despite not always understanding them and showed care to foreign patients when they could not understand the language. Acceptance is evident in the following quotes related to religious groups who do not accept some types of medical or western methods of treatment, while others may respond to illness in ways that are different to the nurse.

This lady was speaking French, as I was taking her pulse, I did not understand what they were saying, then I heard a name of a doctor, he is Professor whom we work with, I was able to call him, and he explained what was wrong with this patient and he gave orders for treatment on the telephone (FG3 P4).

Some Shembe patients do not eat meat for three months in a year and I am able to provide a vegetarian meal for them in the ward (FG4 P1).

We cannot be judgemental, but we need to provide for people culturally, we had a gay guy admitted to the ward and he requested to be admitted in a female ward and he was given a bed in the female ward (FG5 P5).

This quotation below refers to the practice in the Muslim faith of cleansing oneself prior to observing a prayer as a required practice. The participant has had exposure to the Muslim practice as his mother is from the Muslim faith, although he is not a Muslim.

I had a dad who wanted to pray for a baby in the nursery and then I asked him did you make "whudu" he was taken a bit back and said oh, you know about "whudu", he said yes, I finish wash myself; the "whudu" is to wash oneself before prayers (FG3 P3).

The baby is not bathed or touched before Muslims pray; they may collect the placenta (FG3 P3).

4.4.4.3 Theme 3: Self–efficacy

In Theme 3: Self-efficacy is presented as two sub-themes in Table 4.3

Table 4.3: Theme 3: Self-efficacy

Theme	Sub-themes
4.4.4.3 Self-efficacy	a. Cultural Competence
	b. Cultural Skill

a. Sub-theme: Cultural Competences

Participants were generally positive about their preparedness, knowledge, experiences, competence, and lessons learnt to prevent culture shock. They acknowledged that they are still gaining knowledge by learning new things through experiences with different cultures, with some feeling that they should learn each other's culture. This is evident in the following quotations:

> *I will say that I am prepared to nurse patients of diverse cultures and I am learning new things (FG2 P4).*

> *Yes, we get more prepared each time we have an experience; it teaches us to learn more about different cultures (FG2 P4).*

> *I think it should be one of the lessons to learn each other's culture, so that we do not get cultural shock (FG2 P2).*

b. Sub- theme: Cultural Skill

Cultural skill is the participants' ability to gather information on the background and history of the patient presenting with problems and make a skilful assessment. Participants are expected to be proficient and culturally competent by interacting with patients from different backgrounds, as indicated in the following quotes:

> *As students we must be open to learn and get knowledge. I think someone should write a book on transcultural nursing for us and for our colleagues and patients, so that we can learn the cultures we are faced with daily (FG3 P2).*

With the different ethnic groups, you learn and adjust to it, and as you are exposed to it more often it becomes easy for you to handle (FG2 P3)

All participants referred to transcultural self-efficacy in terms of their interactions with patients and related having experienced both positive and negative aspects of interacting with culturally diverse patients. They related experiences that enhanced their own cultural self-awareness and knowledge to respect people. The themes often that were discussed in the interviews regarded nursing care and their own personal growth. Their exposure to diversity in patient care allowed for self-exploration of their own beliefs and values related to culture, as well as its application to the real world by enabling them to relate these discussions to the clinical environment.

We are always learning new things everyday

"We learn our own culture, we don't know our own culture, and we do it because our parents do it "(FG3 P5)

Participants not judging patients were the starting point in understanding and respecting individuals, regardless of their backgrounds. They felt better prepared to provide culturally competent nursing care and were comfortable in its delivery. A participant shared that when she came into nursing, she did not understand holistic care and treated patients physically, later realising that when nursing psychiatric patients that little physical care was needed. The participants identified their own plan of care for a patient, which may have conflicted with the patient's ideas, but stated that every patient cannot be treated in the same way. Their awareness of culture changed, as each patient is different and needs to be respected.

We are aware for example that the Shembe patients don't eat hot food on a Saturday, but we don't know the reason why, everybody learns (FG3P5)

I see nurse's discriminating against patients, we should be more accommodating even as we nurse other cultures, even us as Blacks, I wouldn't want this to be done to me, try and be more understanding we don't know everything we learn (FG3P5)

4.5 Stages 3 and 4: Diary Entries and Reflections

Diaries were issued to the twenty-five students following the focus group interviews and once they had returned to college from the clinical setting, with only ten students having completed their diary entries. Diaries are commonly used in combination with other data collection methods and the frequent disadvantage is noted about its use in isolation. In

ethnographic studies, the use of diaries as a data collection tool creates a better understanding of the subject (Basit 2010: 136). The diary entries provided experiences as is evident in the following entries and reflections:

Diary Entry Date: 04th November 2018

In my paediatric ward, I nursed a 1-year-old child who had measles, he was complicated and had conjunctivitis and pneumonia, he was quite ill. His mum stayed with him all the time. They were Hindu's and did their rituals in Hinduism if a child has measles and the Hindu faith is followed, they put on a turmeric paste for the child on his rash and place "syringa" berry tree leaves (melia azedarach) *on the bed, according to the grandmother, the "syringa" berry tree leaves would cool the body, and yes the child did have a fever, and the turmeric would help the itching and turmeric powder is an anti-inflammatory cleansing agent (FG5 P2).*

However, what complicated this story is that this child got worse, and the father of the child was of the Muslim faith and did not believe any of what the mum and the family have done for the child. There was a lot of bickering around the child's bed and in the ward between the mum and dad, and the mum and dad's families. Sadly, the child had passed on and the bickering about the ritual continued to the funeral plans (P2 FG5).

Reflection*:*

In my opinion, even if there are different faiths in families, they must respect each other, because patients that are ill respond and react to the environment around them, they get anxious when family members are anxious. A loving peaceful family contributes to the healing of patients. Moreover, in this instance, it was a one-year-old infant, the most vulnerable patient in our community (FG5 P2).

The participant noted that the family voiced the differences in their religious beliefs over the care of the child and did not resolve their disagreement. It was important to the participant for the family to agree for the child's care, as she cared for the child. Respect for each other's cultures was lacking and no tolerance was shown towards the two religious' beliefs, despite this being a time of stress when they needed to put the interest of the child first.

Diary entry: 6th November 2018

Whilst nursing Hindu patients I have come across many who wear ash on their foreheads (vibhuti), this is believed to be protective, and has healing properties when applied on the forehead, some of the patients consume this or carry it on themselves in little pouches (FG3 P4).

Reflection:

This was something new for me that I learnt in the wards, I did not know this before nursing Hindu patients (FG3 P4).

The participant reflected on the awareness of another culture, the Hindu belief of wearing ash (vibhuti) on the forehead and/or carrying it in a little pouch for its protective powers against evil spirits or any other dangers. This was not a judgement call on the part of the participant, rather an expression of interest about how others protect themselves, which is not common in other local cultures.

Diary Entry: Date: 12th November 2018

As human beings we sometimes become sick and therefore go for treatment, depending on what we choose - African or Western, some of us Africans believe that there are some diseases that Western medicine cannot treat, and that we need spiritual help. So, people sometimes don't know what to believe, although they come to hospital, but they want a spiritual experience as well, they believe in ancestors, there are traditional healers in our communities where people get their help from (FG5 P3).

Reflection:

Although I personally do not believe in alternative medicine, I am aware that many people seek alternative medicine; some seek medical assistance and alternative medicine (FG5 P3).

The participant identified that some patients have a different concept of what causes illness and how it needs to be treated, and therefore they do not seek medical care alone but want to be nursed holistically, including the need to observe spirituality and their culture in the form of African traditional medicine.

Diary Entry Date: 20th November 2018

My experience was in a paediatric ward on night duty, where I nursed a young boy with a severe septic large wound on his penis after he had a traditional circumcision with the men in the community. He was in so much pain, he complained and cried a lot and didn't sleep for most part of the night, he screamed in pain and said it was burning; he later had to have reconstructive surgery in many stages (FG4 P5).

Reflection*:*

Sometimes I don't want to believe in tradition when I see things like that, I felt very sorry for him, why must culture and tradition be painful (P5 FG4 P5)?

In caring about the patient, the participant realised that some cultural rituals could have negative consequences and that western medical care then has a role to play to alleviate any pain and suffering.

Diary Entry Date: 28th November 2018

I learned many things about Hindu dietary practices, most people do not eat beef or pork, and many follow a vegetarian diet. Fasting is common among Hindus, where they refrain from meat and meat products, there are no rules, the decision is up to the individual, others, some Hindus are very strict and don't eat garlic or onion (FG4 P1)

Reflection:

Hinduism is so vast, there are so many sects of Hinduism, sometimes it is confusing, but mostly the patients explain what they want or need. (FG4 P1).

The participant gained knowledge about a culture that is different to her own, including the dietary practices of a Hindu culture, which in this instance appeared to be non-specific but rather a preference that individuals follow.

Diary Entry Date: 29th November 2019

I am sometimes unprepared for the difficult challenges that are posed by diversity, I didn't think that when I came into nursing that I had to know so much about culture; it was not about treating the culture but about treating the patient (FG3 P4).

Reflection:

I felt much unprepared as a new nurse and was not aware that in nursing one had to know so much about the patient's culture to treat the patient, I just thought that it was about treating sick people (FG3 P4).

This participant highlighted her lack of awareness of the role of culture in the care environment when she started and the need to nurse patients holistically, that healing was not simply about removing a problem, such as an illness.

Diary Entry*: *Date: 2 December 2018

I *worked in a paediatric ward and a patient's mum and grandma were speaking Telegu (an Indian Language) during doctor's rounds. I do not understand Telegu, and the Dr wanted to know what they were saying, and so the mum of the child explained that her mum was saying seeing that the child is so sick, they need to go home and do a specific prayer called the Black Fowl* (black rooster), *whereby a prayer, rituals are done, and a black fowl is scarified in order to appease the Gods that*

are making the child sick. The patient's family is Hindu/Telegu speaking, and the doctor was a White Afrikaner, it was his first time to hear something like this and he joked about it with other parents, asking them if they also wanted to go home to do Black Fowl prayers (FG5 P4).

***Reflection**:*

The doctor assumed that me being Indian I should have understood the language and the culture, I was expected to know the traditions. I am Christian and do not speak any of the Indian languages. I think he was very judgemental and was mocking the family and discussing their practices with other patients (FG5 P4).

The participant felt that the doctor assumed that as the participant was an Indian, they should have known the language and culture of that patient, not realising that there are different dialects. The doctor was culturally intolerant by making derogatory statements to other patients about the ritual practice and showed no cultural-competence or compassion for the family at this difficult time.

Diary Entry Date 2 December 2018

I nursed a Jehovah's Witness, and she just came back from theatre, lost a lot of blood, and died, they don't believe in receiving blood, and I am catholic, it's hard (FG3 P5).

***Reflection**:*

I don't want to say, but for me it was a dilemma to see someone die because they didn't want to receive blood. In my religion I believe in life, and in nursing I believe in sustaining and preserving life. This was hard (FG3 P5).

This participant showed caring, compassion and empathy for her patient who died, she found it difficult to understand that a religion could allow someone to die when there was an option to live by receiving blood, a simple procedure. The person could have been saved had they agreed to receive blood, despite their religious beliefs. This incident was an ethical dilemma for the participant who believed in the preservation of life, according to her religious convictions and core nursing values.

Diary Entry*: *2 November 2018

In the hospital that I worked in, among all the cultures, I noticed that one culture was favoured or respected highly over others in terms of what was provided or what they were allowed to observe, and that was the Muslims, as that is the only prayer room provided in the hospital, no other religions were provided with a special room for prayers, not even a common prayer room, also in their diet the kitchen must have a certification of halaal food (FG3 P5).

***Reflection**:*

I feel the Muslim religion and culture is favoured over other religions and cultures, especially the other Indian religions and cultures, I just think this might be unfair to the other cultures. I think the hospital authorities should cater for all religions and cultures, especially for a prayer room and for dietary practices. It seems that the dominant religion is Muslim (FG3 P5)

The participant felt that it was unfair to favour one religion and culture over others by the hospital authorities. However, it is not known if most patients in this hospital are Muslim.

Diary Entry Date: 3 December 2018

I had a very sick patient who was suffering from bronchopneumonia, when I was speaking to him, he said he had HIV/ AIDS, but his parents took him to traditional healers and a sangoma, believing that he was bewitched. The sangoma said that his neighbours bewitched him, he then realised he is not getting better with the traditional healers' remedies and decided to come to hospital (FG5 P5)

Reflection:

This is such a difficult thing for me, as I am a young African Zulu girl and I don't believe in traditional healers, as they lie, take people's money and people don't get better, they end up in the hospital very sick, it is very sad. Traditional healers are very costly (FG5 P5).

Despite having the same cultural background, the participant was not supportive of the culture of visiting traditional healers, based on her experiences of the role they have played in people not getting better, and the cost. People may belong to the same culture but have similar or different practices.

Diary Entry*: *Date: 5th December 2018

I worked in this one hospital, and it did not have a Halaal certificate but accommodated Muslim patients. Everyday meal orders were taken from the Muslim patients and meals were ordered from another institution that had a halaal certificate, yes, the hospital was accommodating of patients of all cultures (FG1 P1)

Reflection:

But I think that Muslim patients are always privileged for their culture and are strong about it (FG1 P1).

The participant observed that the patients of the Muslim faith did not compromise their culture during their health care stay at the hospital.

Diary Entry*: *6th December 2018

I also had a culture shock in the early years of my nursing career, as there was an influx of Black patients in a traditionally Indian based hospital. I had to adapt to nurse these patients and to cater for them and their meals, the kitchen menus had to change from traditional Indian curries to bland spice free meals and include pap (FG1 P5).

***Reflection**:*

The change was new and not easy to adapt to (FG1 P5).

This participant had difficulty in adapting to changes that involved the intake of patients from a different culture at the hospital, one aspect of which was the dietary practices of the hospital that had to cater for patients who did not eat the spicy food traditionally prepared for the Indian patients.

Diary Entry*: *6th December 2018

Earlier in my small hospitals, there were no policies in place, we were growing and had to put new policies in place. Changing the culture of staff and hospital was difficult, as staff didn't want to change (FG2 P1).

***Reflection**:*

I observed that staff finds it difficult to adjust to change, especially culture change (FG2 P1).

The nursing staff found it difficult to adapt to new cultures and ways of doing things, despite working in an environment that required them to consider cultures other than their own. Resistance to adopting diverse cultural practices did not come easily to some of the nurses, despite the nature of their working environment, which therefore requires that they must be knowledgeable to understand the reasons for the need to adapt.

Diary Entry*: *Date: 14th November 2018

In my experience, the Black patient died, and the relatives came to the ward with branches and leaves and asked for the bed on which the patient died, they literally swept the bed with the leaves out of the ward and asked us not to be standing in the front; apparently it was to take the spirit of the person away (FG2 P2)

***Reflection**:*

I was very scared, as it was my first experience and quite frightening, because this man also had a live black chicken under his arm (FG2 P2).

The participant noted her first experience with this cultural practice and was unprepared and therefore fearful of the encounter as she belonged to a different culture to the deceased patient and their relatives.

Diary Entry*: *21 November 2018

There was a patient who demised, and he was from the Eastern Cape. After two days, the AmaXhosa son came claiming to fetch his father's spirit. The son wanted to be shown the actual bed where his father was to fetch his father's spirits. So, we the nursing staff politely asked the patient who was in that bed to evacuate the bed and move to a private ward. The son wanted one of the nurses to recite the clan names. When he was done, he thanked the nursing staff and took his father's belongings and left (FG2 P5).

***Reflection**:*

What confused me about him fetching his father's spirit is that he was alone, and he was not carrying a so-called tree (Umlalankosi) for fetching one spirit like AmaZulu. For AmaZulu it should be two family members and the one carrying a tree is silent till they reach home. So, I realised that AmaZulu and AmaXhosa culture differ slightly (FG2 P5).

The participant identified and acknowledged a difference in cultural practices among the Black Africans who belong to different tribes and languages. The nurses understood the mans' need to perform certain rituals, such as fetching the father's spirit, and assisted him by making the bed available to accommodate his culture.

Diary Entry*: *21 November 2018

I nursed a young girl in the paediatric ward whose little finger was halfway amputated, and I asked the mum what happened to the child's finger. Mum said at birth, all the Ngubane (tribe, clan, and surname) children's finger is amputated as a tradition to prove that they are true Ngubane's. If the Mum or anyone else in the family protest, then it means that they are not an Ngubane child (FG2 P4)

Reflection:

It's sad that sometimes culture is physically painful for a new-born baby and emotionally painful for a new mum (FG2 P4).

The participant was distressed in her caring for this baby whose amputated finger was part of a ritual and vouched to obtain more knowledge about why such practice must be

carried on a small child. It is sad that cultural practices can bring physical and emotional pain to people

Diary Entry*: *28th November 2018

*I nursed a young boy in the Children's ward, he was burnt on his left leg, badly, he was a Black African boy and he got burnt with firecrackers. I asked the mum why he was playing with this, and she said that he was playing with fireworks with the Indian neighbours and the boys had burnt him while they were celebrating Diwali (*an Indian festival *(FG4 P2)*

Reflection:

I think in this town there is a lot of integration of cultures, different cultures live in the same neighbourhood, and this was purely an accident (FG4 P2).

The participants identified that cultural integration was taking place in some suburbs, which results in people being exposed to new practices, some of which could be associated with risks, as fireworks are not items to be played with by children. In the absence of children being aware of such risks, there was the possibility of them being injured, especially if there was no adult supervision.

4.6 Summary

This chapter presented the results of the study on the experiences and self-efficacy of student nurses in transcultural nursing in four stages, in line with the transcultural theory of Madeleine Leininger.

Stage 1: Participant observation occurred in their environment at the college during which they engaged in dialogue. The participants were observed for cultural issues related to their dress, discussions, mannerisms and behaviour as well as their meals and sharing their food.

Stage 2: Focus group discussions were carried out with five groups of five participants each. Leininger's theoretical framework was used, with the enablers identifying the data to enable thematic analysis, during which major themes and sub-themes emerged.

Stage 3: Diaries were issued to the participants to take with them to the clinical settings to record cultural events and how they understood them. Ten of the twenty-five participants handed their diaries to the researcher on their return to the college after a month's clinical experience.

Stage 4: The diary entries were reflected upon by the participants. The reflections and the diary entries were discussed by the participants and the researcher to find out the outcome of the cultural practices on patient care.

Chapter 5 discusses the findings according to the themes and sub-themes that were drawn from the research study, followed by conclusions and recommendation

CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the study findings with respect to local and international studies, indicates limitations that may have affected the results and presents recommendations. This is done within the context of the study aim that was to explore the level of transcultural self-efficacy among student nurses, nursing at a private nursing school in Durban, KwaZulu-Natal. Nurses are being exposed to people from diverse cultures and need to be able to provide the same level of nursing care to all patients, irrespective of their practices and beliefs, which requires them to be transculturally competent. Nurses must be knowledgeable about cultures, because people have diverse ways of understanding health and healing, which is likely to manifest in the formal health care sector, including hospitals. The findings are discussed with respect to the three objectives, these being to explore the nurses' self-efficacy, explore their experiences and describe their competence in transcultural nursing.

5.2 Discussion

The researcher used the ethno-nursing method as an enabler to address the areas of culture and care, these being used to direct the discussion within the context of the culture care theory Leininger (2004, as cited in McFarland and Alamah 2019: 77). This theory commonly uses the following enablers, each of which is explored:

- Stranger to trusted friend
- Observation-participation-reflection
- Leininger's semi-structure inquiry guide enabler /model to assess culture care and health
- Leininger's acculturation health-care assessment for cultural patterns

5.2.1 Stranger to trusted friend enabler

Discussions around biases and preconceived notions on culture was discussed by the researcher and the participants, notes were taken on this to keep the bias in check throughout the research and this was written in the transcript.

This enabler allowed the researcher to reflect and become aware of her behaviour, as she worked among the participants to collect data to confirm the cultural “truths”. The use of this enabler was to progress from being a stranger to a trusted friend of the participants. At the outset of the research study, the participants were reluctant and shy to speak or give any information but as the researcher observed them, they became aware of the researcher watching them. The researcher had conversations with the participants and spent time in their presence, observed and participated in their events and sat with them during their mealtimes. As time passed, the participants began to trust the researcher and were more open and shared their experiences. This outsider’s position, or etic view of the researcher, gradually changed to trusted friend and enabled an emic, or insider view as used by Leininger in the ethno-nursing method, which was used in this study (Wehbe-Alamah and McFarland 2020: 77).

The participants were observed for their dressing, their behaviour and during all the events that occurred in the college. During this time, the researcher observed the lack of eye contact from the participants of the Zulu culture, which is considered disrespectful. This cultural practice to show respect is inculcated in childhood (Ntuli 2012: 5).

This stranger-to-friend model has been extended to the participants, whereby in the beginning they were strangers of all different cultures and generally close together in groups of their own culture, but during one observation of the socio-cultural event, a few participants dressed cross culturally and played out scenes of other’s cultures. This is evident of cultural integration and the relationship communities have with cultures other than their own. During the observation, two participants from different cultures stated how close they have become as students over time and how supportive they are of each other. This relationship created a bond of friendship. The participants also assisted each other when one of them was absent from lectures with the theoretical component of the work that was covered during that lecture.

The purpose of using this enabler was to facilitate the researcher to move from stranger to trusted friend and for the participants themselves to move from initially being strangers to trusted friends. As the participants became familiar with each other and spent time

together, they began to befriend each other and their families and lent support to each other during their trying times (Wehbe-Alamah and McFarland 2020: 77)

5.2.2 Observation participating reflection enabler

During this stage, the participants observed and reflected on many cultural practices and behaviours of the patients. They noted that patients became anxious when their religious beliefs were not respected as family members present, voice their conflicting perspectives. In a study by Schmidt (2015: 103), a participant stated that “I think there just needs to be an understanding that there are different people out there with different beliefs, and just because you believe something doesn’t make it right and not everybody else is going to understand or believe that way”. According to (Swihart Yarrarapu and Martin 2021: 13) studies indicate that are geared towards patients’ practices will negatively impact the nurse-patient relationship and affect health care plans. In a participant’s diary entry and reflection, the doctor assumed that the Indian nurse should know the language spoken by the Indian patients and family members and made a joke of the practice of the *black fowl* sacrificial ritual.

A participant reflected on cultural beliefs of Jehovah’s Witness, the dilemma she was in was when a patient was not given a blood transfusion when it was required. Although the patient was an adult, she was on a ventilator and the parents decided on her behalf not to accept the blood transfusion and allowed the patient to die. According to their religious beliefs, blood transfusions or blood products are not to be accepted. When Jehovah’s Witness patients require health care that includes blood transfusions, the nursing staff face a challenge when administrating treatment which may lead to legal, moral, ethical and medical challenges (Chae Okocha an Sweitzer 2020: 432).

One participant observed that among the Indian community, Islam and their culture was dominant in the facility, with a prayer room being provided for this religion only, and halaal certified meals being provided. When care is provided to patients who follow specific religions, including Muslims, it is important for health-care professionals and student nurses to understand this aspect of their faith. Healthcare professionals need to be aware of the many practices followed by Muslims, for example, the gender of the nurse who can

care for female Muslim patients, be touched by them, ensure that meals are consumed, and medication and treatment is acceptable (Attum, Waheed and Shamoon. 2019: 1).

A participant observed that one of her patients who had bronchopneumonia and was HIV positive was first taken by his relatives to a sangoma (African traditional healer) and because he was not getting well the relatives had admitted him to the hospital. The participant reflected that as a young African Zulu girl, she did not believe in traditional healers, as they lied and took people's money, and their patients did not get better but ended up in hospital very sick. In this instance, her stance was based on her experience, rather than on uninformed prejudice. Traditional healing practitioners are an important part of the healthcare system in South Africa, with the sangoma being classified as a diviner who is called by African ancestors to become healers and to go through an intensive process of learning the healing practices (Zuma, Wright and Rochart 2016: 304).

Culture shock among staff in the hospital created problems in adapting to and accepting other cultures due to the changes in the racial configuration of patients. One of the Zulu participants observed and reflected on the African tradition where the family comes to fetch the spirit of the deceased relative. That their method of this cultural practice was different to the one she was accustomed to, was possibly the ways of the Amaxhosa clan. This is an example of awareness of own culture and identifying a difference to another. Understanding cultural practices of people from other cultural backgrounds assisted student nurses to accept the differences and become confident in nursing patients of diversity (Kumlien et al. 2020: 6).

The observation of a cultural practice of the Ngubane clan was a shock to the participant, who noticed that the child's finger was amputated and reflected that sometimes cultural practices are painful and questioned why the child had to go through such pain to subscribe to a culture. The mother was emotionally affected to see her child go through such a lot of pain due to the cultural practice. This finding is supported by Magodoyo (2017: 344) as a Xhosa custom to prove that the child is a Xhosa child with the family surname. This was regarded by the nurse as an act of cruelty and torture.

The reflection on the relationship within communities of having exposure to different cultures was evident, as a Black child was burnt when he was with Indian Hindu neighbours who were celebrating the Diwali festival with fireworks, which is not part of other religious customs, although fireworks are used for entertainment. A participant noted that the change of the patients' profile from predominantly Indian to the African patients in the hospitals was a culture shock in managing diverse cultures. The staff found it difficult to adapt to new cultures, dietary requirements and change in menus. According to Givler, Bhatt and Maani-Fogelman (2021: 1), nurses are challenged when faced with cultures that are different to their own, cultural skill being needed when providing care of an acceptable standard to patients that identify, respect, and require different needs (Givler et al. 2021: 1). A participant mentioned that a patient had a circumcision according to African cultural practice that went wrong, which was painful and required him to be hospitalised. Circumcision is practised by several religions, such as Judaism, Islam and some Christian denominations. In African cultures it is practised as a transition of a boy into adulthood. Under the Children' Act 2010 in South Africa, infant circumcision is illegal unless done for religious or medical reasons (Magodoyo 2017: 6).

5.2.3 Leininger's Semi-Structured Inquiry Guide

Three themes were identified from the focus group discussions, these being awareness and self-awareness of culture, respect, and caring, and self-efficacy, each with several sub-themes as experienced by participants nursing diverse patients which is illustrated in Table 5.1.

Table 5.1 Themes and sub-themes

Theme 1: **Awareness and Self-Awareness of Culture**	
a. Sub-theme	Identifying needs of the patient
b. Sub-theme	Experiences of Nursing Diverse Patients
c. Sub-theme	Increased confidence and self-esteem
d. Sub-theme	Self-awareness compliments students' competence

Theme 2. Respect and Caring	
a. Sub-theme	Ability to accommodate different cultural needs
b. Sub theme	Respecting various cultures
c. Sub-theme	Opportunities for providing cultural care
d. Sub-theme	Acceptance of different cultures
Theme 3: Self-efficacy	
a. Sub-theme	Cultural Competence
b. Sub-theme	Cultural Skill

Theme 1. Awareness and self–awareness of culture

Through nursing people from a range of cultures, the participants became aware of their own culture and some practices that they did not know about, as indicated in their clinical experiences, diary entries and reflections. In the current study, awareness and self-awareness of culture was drawn out as a major theme. The participant did not know that in the Zulu culture that this was a practice where the relatives of a deceased patient came to the hospital to fetch an amputated limb of the deceased patient. It is a traditional Zulu belief that a person cannot become an ancestor if they had an amputation because their body would be incomplete (Brown and Goliath 2018: 20).

As cultural competence is a complex learning process, nurse educators need to develop and implement strategies to impart knowledge on culture. For nurses to become culturally competent, they must have three characteristics: firstly, be aware of their own culture, as cultural competence begins with self-awareness. Secondly, they must have the good skills in patient assessment and communication. Good communication skills between healthcare provider and patients are necessary for culturally diverse patients, as the inability to transfer information between them could be a major challenge in the healthcare delivery system. Effective communication was decreased when there was uncertainty or anxiety about understanding within different cultural groups (Kaihlanen 2019: 2). Thirdly,

nurses should be knowledgeable about the cultural practices of patients to provide competent care (Lu and Wan 2018: 823)

a. Sub-theme: Identifying needs of the patient

The participants identified patients by their dressing, symbols, language and communication on admission to the hospital (McFarland and Alamah 2019: 81), Leininger developed an enabler called the inquiry guide enabler to assess diversity that will assist in nursing diverse patients.

A cultural assessment competency questionnaire identified factors such as ethnicity, language spoken or preferred language, the need for an interpreter, what the primary language is, a support system, living arrangements, religious practice, emotional responses, special food preference and dietary requirements (Toney-Butler and Unison-Pace 2019: 2). The participants were able to ask the relevant questions about religious beliefs and language preference in accordance with Leininger's theory. When a nurse assesses a patient and attempts to accept the patients' culture to accommodate the patient and work with the cultural beliefs, this can be conducive to a therapeutic patient experience. The patient assessment includes the following factors:

- Communication
- Gender considerations
- Sexual orientation
- Ability and disability
- Occupation
- Age
- Socio-economic status
- Interpersonal relationships
- Use of space
- Appearance: during the assessment of patients: participants mentioned that they were able to identify patients by their appearance for example, a red dot or a red string they identified the patient as Hindu.
- Dress code: participants mentioned the dress code for Shembe patients and the head scarf of Muslim women. Foods and meal preparation and related lifeway's: many examples of foods were mentioned by the participants such as the Hindu

patients fast on certain days and some Hindu patients do not eat beef or pork as stated by a participant (McFarland and Alamah 2019: 6).

b. Sub-theme: Experiences in nursing diverse patients

It was evident that the participants were able to follow modes of guidance according to Leininger's model or theory and were able to provide and maintain appropriate care as well as accommodate patients based on their needs. Participants could make suggestions when caring for patients and changes for nursing students. In a study by Kohlbry (2016: 305), themes in keeping with this concept emerged: cultural sensitivity, cultural efficiency and identification of cultural barriers. In Kohlbry's (2016) study, the theme of self-efficacy was highlighted by a student's response when she explained how it dawned on her that she was making a difference and she stated that "there was a great need and feeling like I was making a difference to me, this need was by working at community clinics" (Kohlbry 2016: 305).

Leininger's theory posits that there are three methods for facilitating nurses' assessments and decisions for providing relevant, fulfilling and useful care: preserving and maintaining; accepting and discussing; re-planning and re-organisation. These methods have assisted the nurses to provide care that is culturally congruent and as well as enabling them to become competent (McFarland and Wehbe-Alamah 2019: 80). According to two participants, some patients do not follow the norm in their culture, for example, Hindu patients fast on some days and not on other days. Fasting in this instant refers to a complete dry fasting, as in not consuming any food or drink and sometimes abstaining from certain foods, for example, meat, fish and eggs. Other types of fasting include eating only fruit and abstaining from any foods that contain salt. For Hindu's food has been classified as spiritually sattvic (positive), rajasic (neutral) and tamasic (negative according to the effect it has on an individual's spiritually (Goel et al. 2021: 3). A Hindu's belief in karma and their respect for all forms of life is common for those who practice vegetarianism, which is considered sattvic (Goel et al. 2021: 3).

The participants displayed acceptance of the diverse cultural beliefs, with a student being morally challenged with her religious beliefs and her role in providing care to a Jehovah's Witness patient who was not given a blood transfusion and died. The participant

expressed her views that in nursing she was supposed to preserve life, this being reinforced by her Catholic faith. Jehovah's witnesses are Christians who believe literally the 'Word of the Lord" in the Bible and pay particular attention to the last Book of Revelation. The Old Testament forbids the absorption of blood, which has become a culture for Hebrews and Jews who therefore consume food that is Kosher (without blood), with Jehovah's Witness's contending that all blood except that of Christ's is a vector of sin (Melton 2021: 2).

A participant expressed her views on nurses not being judgemental about patients, their beliefs, and rituals, nor to talk to a patient in a language they do not understand. The clinical exposure that the participants had to diverse patients helped to prepare them to care for patients of different cultures. Participants expressed the need to care for individual patients with different preferences and that care should be culturally personalised. Appropriate assessments of patients and implementing personal care for individuals could prevent cultural stereotyping. The participants reflected on care given during their clinical experience whereby some patients did not follow expected cultural practices, with the students noting that it was not about treating the identified culture but the patient (Kaihlanen 2019: 5).

c. Sub-theme: Confidence and self-esteem

The participants were at the beginning of their nursing career and lacked confidence, especially with those whose language they did not understand, nor could they communicate. Most of the participants spoke English and Zulu, while some did not understand the latter, often asking their colleagues to interpret for them, as there are many Zulu speaking nurses in the units. Kaihlanen (2019: 6) stated that communication with patients and relatives from different cultural backgrounds, especially where there were language barriers, was challenging. The participants perceived that they could try different techniques to facilitate interaction, as noted in Kaihlanen's (2019: 6) study who found that the climate of communication could afford staff an opportunity to understand each other and resolve problems relating to communication.

It was also evident that the participants lacked the ability to communicate effectively in sign language with patients with hearing impairments combined with a lack of professional awareness, which results in barriers to nursing care services because their

communication preferences were not being considered. Health professionals often do not communicate effectively with patients who are challenged due to hearing impairments and must resort to lip reading and allowing patients to write down their needs (Davies 2019: 60). Some of the participants did not express complete confidence in cultural care but mentioned that the more they nursed patients within the Kaihlanen's (2019: 6) study, a participant felt better prepared to give nursing care and expressed confidence when faced with unfamiliar patient care situations due to her experiences in the diversity classes.

The experience participants gained on different cultures in the wards increased their confidence and self-esteem when caring for patients with similar cultures to their own, for example the Shembe patients. Kolhbry's study (2016: 309) noted that students who are immersed in service-learning benefit from their cultural experiences by gaining knowledge and skill, self-awareness, sensitivity, competence and knowledge of cultural barriers. The students gain insight of their own responses, which contribute to their growth and understanding of cultural differences. Participants were in keeping with (Wehbe-Alamah et al's 2019: 80) definition of cultural congruent care where care was provided that was beneficial and is in accordance with the patients' cultural beliefs.

d. Sub-theme: Self-Awareness compliments student's competence

The self-awareness of their own culture made the participants competent in delivering culture care to those with similar practices, and aware that they needed to be mindful of the practices of other beliefs. Most participants showed a desire to be culturally competent and provided the best they could to meet the patients' needs. This is evident in the experience of a Jewish patient who arrived at night and while the nurse could not provide kosher food at that time, an alternate was given, and the following morning kosher food was provided to the patient. This is culturally acceptable care, where the nurse has a desire to practice in a culturally acceptable manner that provides the care needed by the patient and indicates the desire for nurses to gain the knowledge and skill to ensure cultural competency (Isaacs et al. 2016: 91).

The cultural competencies of student nurses need to be assessed as they may have different levels of knowledge related to cultural competence, attitudes, and skill. In the

healthcare setting, cultural competence is explained as knowledge of how culture affects the patients' health beliefs and behaviours and how this is considered at different levels of healthcare to ensure quality healthcare (Mareno and Hart 2016: 122). In the case of one participant who spoke many languages, she was knowledgeable about the Muslim naming ceremony and performed a prayer for a Hindu patient in the absence of a priest, thereby displaying a diversity of cultural knowledge (Mareno and Hart 2016: 122).

Theme 2: Respect and Caring

Respect was observed by all the participants towards their patients, and this was depicted in the way they cared for their patients.

a. Sub-theme: Ability to accommodate different cultural needs

The participants accommodated the different cultural needs of diverse patients by allowing them to pray in the wards, use prayer facilities for certain cultures and have specific meals at the patients' request. The participants allowed the relatives of a deceased patient to perform a ritual among the Zulu culture where the soul is removed from a deceased patient. In some instances, the participants facilitated the process of prayer by requesting for their priest to pray for the patient and yet in another instance, the participant himself was a priest and facilitated the prayer. According to Kaihlalen (2019: 13), having the knowledge of the cultural practices of people from different cultural backgrounds allowed the participants to accept cultural differences and be confident in their relationships with patients.

Some participants had a positive perception of being well-prepared culturally and suggested that there should be more time for clinical experience, cultural education, and literature. According to Wehbe -Alamah et al. 2019: 80), cultural congruent care refers to the use of emic, which is cultural knowledge of the people and their way of life that is beneficial and relates to the etic perspective, which is an outsider view and knowledge. Cultural care benefits the patients, produces positive outcomes and facilitates wellness and health promotion.

b. Sub-theme: Respecting various cultures

The participants respect for various cultures and individuals increased during their work experiences. Their focus on care demonstrated respect for patients, regardless of the situations, lifestyle, or beliefs, even if it conflicted with their own values. Respect was evident when participants allowed patients to observe their cultures in the various aspects of nursing care, for example in the provision of meals, safe keeping of patients' religious amulets, availability of praying facilities and request for religious leaders to perform certain rituals. Cultural respect had a positive effect on patients' healthcare delivery, practices and communication requirements. This concept of cultural respect has a positive effect on the delivery of service, which enables patients to feel respected and cared for. The participants were aware that a preconceived judgement of patients with a culture different to their own was not acceptable, thus showing respect to all cultures. Student nurses will require knowledge on self-awareness and awareness of other cultures to help them to develop attitudes that are consistent with nursing ethics that are mandatory, for example, compassion, respect, dignity, worth and human rights for all patients (Dunagan et al. 2016: 347). Schmidt (2015: 6) states that to develop cultural competence is to become culturally aware, which entails an awareness of oneself. The participants reflected on diverse aspects of values, beliefs, lifestyles and practices of different cultures and they identified their own biases, attitudes and prejudices. The lessons that participants learnt in their sociology class and the socio-cultural demonstrations assisted them in respecting individuals of diverse cultures. The teaching of cultural content as students' progress in nursing schools leads to an increase in cultural competence, thus increasing their cultural sensitivity and awareness (Dunagan *et al*. 2016: 320).

c. Sub-theme: Opportunities for providing cultural care

The participants were afforded opportunities for the provision of cultural patient care. They displayed caring and compassion in the provision of cultural care in a case where they used their own priest to pray for patients and other times displayed skill and competence in these opportunities for care.

We were able to provide kosher food to the Jewish patient (FG4P1))

In nursing a Shembe patient I was able to provide cold food to him on a Saturday (FG4 P2)

Yes, sometimes I can call on my own Catholic priest to pray for patients in the ward, sometimes the patients request these prayers especially when they are very ill, the Priest does come and administer communion to the patients (FG5 P1)

d. Sub-theme: Acceptance of different cultures

Participants accepted the diversity of the patients' cultures and continued to do so despite them not understanding some cultures and languages. They were conscious of patient's culture and lifeway's and were not judgmental.

"I would say I am adequately prepared, I am prepared, I will respect their needs, I will learn from the patients and take it into consideration all their cultural needs and what I know, I am open to hear whats.t the patients have to say, how they would like to be taken care of, what their needs and cultural beliefs are, (FG2P4)

Theme 3: Self-efficacy

Self-efficacy is described as people's judgements of their abilities to plan and implement activities needed to gain specific results (Bandura 1986: 391). In an effort for a person to receive a positive result, the person must believe in their own internal ability to perform the act, if this is perceived to be of an advantage but the individual doubts his or her ability to perform the action, then there it is unlikely that the behaviour of the person will change. Self-efficacy can be affected by direct experience, indirect experience, or persuasion. Self-efficacy is a basic term in nursing education and can influence the theory-practice gap positively Kuiper, Pesut and Kautz (2009 as cited in Schmidt 2015: 18).

a. Sub theme: Cultural competences

The participants were mainly competent in providing care to Indian and African patients due to their familiarity with these cultures. However, they lacked competence when they encountered patients who were foreigners and their cultures varied, such as Chinese, French, Greek and Russian. According to Değer 2018: 25), a culturally competent nurse has an understanding that a variety of cultures affect the nurse-patient relationship, including the social environment, cultural needs and beliefs which incorporate the plan of care. Challenges such as communication, language and culture were identified as a risk to patients' safety in hospitals, with cultural competence having been given the attention as a guide to provide equal and quality healthcare services for culturally diverse patients. According to Kaihlanen (2019: 3), communication challenges should be addressed through training that focuses on cultural awareness, facts and interpretation of cultures.

The participants were expected to respect and appreciate cultural diversity and strive towards increasing their knowledge and sensitivity. In Kohlbry's (2016: 303) study,

student nurses identified creative measures when considering cultural beliefs and appreciated the values and opinions of others about health and medication. Student nurses are expected to cultivate cultural competence to assess and put into place nursing interventions with positive outcomes. Self-efficacy has been linked to nursing education. According to Schmidt (2015: 9), cultural competence leads to cultural care that addresses the patient's culture, beliefs, values and practices. Nurses who enter the profession with bias and negative attitudes towards diverse cultures will not be competent in cultural care (Dunagan 2016: 345). Health-care professionals should be trained to provide services in a culturally competent manner, considering the social cultural factors that impact on their patients (Kaihlanen 2019: 4). A participant stated that nurses should not speak about the patients or about their cultures in a language that the patient does not understand. Cultural competence is required and is achieved through preparation and nursing education (Dunagan et al. 2016: 327). A nurse that is culturally competent is capable of assessment and implementing interventions that positively impact on the patient's health, thus contributing to quality patient care and meeting the needs and outcomes of culturally diverse patients.

c Sub-theme: Cultural Skill

The participants' skill levels ranged from not skilled to skilled in some areas of cultural care, given the diversity of patients they need to care for. In areas where the participants were partly or not skilled, they sought more information from the patients or colleagues. The participants learnt about culture from patients with similar or diverse cultures, including an understanding of their beliefs particularly about health and healing. Cultural skill entails gaining appropriate practice behaviours that enable adapting to diverse cultures. Student nurses must possess skills in assessing and communicating with patients from diverse cultural background (Norouzinia et al. 2015: 65). In Kohlbry's (2016: 307) study, the theme of knowledge identified in sub-theme (a) reflected students' learning of different languages, customs, and beliefs, and in sub-theme (b), the theme was cultural skill, the language skills essential for student nurses when they are expected to assess clients, gain knowledge of their culture, communicate with them, and understand their stresses and their behaviours– all these being important to provide cultural care. In the study by Mareno and Hart (2016: 121), the participants verbalised an average level of cultural awareness, but reported low levels of cultural knowledge, skill,

and experiences. Participants indicated that cultural diversity training was minimal in their nursing education and in-service training programs. Cultural skill is the skills required for a holistic care assessment and includes the awareness that the nurse cannot be fully knowledgeable and understand another's culture.

5.2.4 Leininger's Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Non-Traditional Lifeway's

The purpose of this enabler is to assist in assessing the extent of acculturation of a person or group of people about their culture, and to identify who is traditionally or non-traditionally following their culture (Wehbe-Alamah et al 2019: 84). In observing the participants in their college environment, students dressed in their traditional clothing on their religious or prayer days. During their socio-cultural events, participants presented traditional meals, wore traditional clothing, and acted out traditional, religious, and cultural events, such as Membeso in the Zulu culture (engagement with the intention to marry), Eid (a Muslim holy day) and Diwali. However, participants were able to request a history from the patients on admission to the hospital wards during which they questioned patients on their culture, food preferences, days that they abstained from eating certain foods and specific dietary requirements. Participants were skilled to identify the common faith-based cultures that they nursed regularly, with religion being the main factor that influenced the practices that the nurses needed to be mindful of during their care planning and interaction with the patients.

1. **Jehovah's Witness**

A participant was in a dilemma when a Jehovah's Witness patient refused a blood transfusion and demised. For religious reasons this group of people do not accept allogeneic blood transfusion. The religious understanding of Jehovah's Witness does not prohibit the use of blood fractions, such as clotting factors and interferons. Each Jehovah's Witness patient decides on their own choice (Chae 2020: 10).

2. **Shembe**

The participants observed that Shembe patients eat cold food on Saturdays and wore an amulet which had to be removed when visiting the toilet. A participant shared that there was a miscommunication between the ward and kitchen regarding provision of cold food

on a Saturday for the Shembe patient. The kitchen provided the meal that was cooked on a Saturday but was left to cool down and this was inappropriate or against the belief of eating cold food (Kumalo and Mujinga 2017:122).

3. Hindu

Participants observed the cultural belief of most Hindu's that fast on certain days of the week, for example a Monday, Tuesday, or Thursday. Some patients observe the dry fast which is abstaining from all food and drink for the day. Some Hindus abstain from eating meat. Vegetarian meals are provided for patients who do not eat beef and pork. Hindu's respect all forms of life and therefore some of them are vegetarians which is recommended for engaging in spiritual penance (Goel et al. 2021: 3). A participant noted that Hindu's face east when praying towards the sun in the morning. Another participant was exposed to Hindu patients being prayed for by relatives in the wards by "burning some fires". According to the participants, Hindu patients were sometimes identified for their culture by their red dot on the forehead or a red string on the wrist. A participant shared how he, a Hindu Priest participated in last rites rituals for a patient who was very ill and about to demise. Most Hindu's preference is to face death in their own homes, however if that is not possible, then the last rites are performed at the hospital, this includes assisting patients to face east or lighting a lamp near the patient's upper body in the presence of the family, singing or chanting from the sacred scriptures (Goel et al. 2021: 3).

4. Muslim

The participants' experiences of the Muslim faith were that some of the patients wore a head scarf and females were not nursed by male nurses. A participant stated that Muslim patients do not eat pork and are provided with halaal meals. Two participants shared the cultural practice of a new-born baby's naming ceremony in the hospital unit by relatives soon after the birth of the baby. A participant experienced a patient requesting to pray facing northeast and he was directed to a Muslim prayer room in the hospital (Attum et al. 2019: 5).

5. Traditional African

Many participants shared their experiences of the African tradition and culture. When a patient dies the relatives come to the unit to take away the soul with a branch of a tree

and sometimes a *live chicken* under their arm. A participant shared how the relatives talk to the spirits during this cultural practice in the unit, all the way home, in the church and the cemetery until the branch of the tree is placed in the grave with the deceased.

In my experience is that there was a patient that passed on and the family came and said they must not do anything for the dead person, they came with a branch thing, it was difficult, in a Christian family there is nothing like that, I heard about it. They took 2 hours; they came to take the spirit away. I knew about it, and heard about it, but I didn't see the actual thing (FG2 P2).

You see even if they come with the Green Tree thing , branch, allow them in to fetch the soul of the deceased patient , I find it strange but I want to learn about cultures and see what they are doing , they talk to the soul , I listen, they talk to the soul, oh we going to the lift now , they have to talk to the spirit, e.g. in the car , at the Robot, until they reach home , A lot of cultures talk to spirits of the dead person, they have to talk and do prayers, you know sometimes you must move out of the way until they reach home , in the Church and the Cemetery they talk to the spirit to the branch and they throw it away into the Grave (FG3 P1)

Two participants shared how relatives come back to the hospital for body parts of the deceased patients. A participant being Zulu herself experienced a Zulu patient requesting to take her placenta home after delivery. The participant states that the *Umhlankosi*, the tree that is used to fetch a deceased patient's spirit from the hospital is a traditional Zulu custom, as the belief in ancestors is part of the African culture. This spirit is taken to the home, then to the church and finally to be buried with the body in the grave.

6. Catholic

A participant stated that if you see a cloth on a Catholic patient after you bath and change the patient, do not throw this away or put it away in the drawer but put it back on the patient. Different colour cloths signify cultural beliefs as one participant stated that a green cloth was a Novena and if the patient were to die, this signifies a place in heaven. A participant shared how her Catholic priest is sometimes called to pray for patients and on a Sunday, he brings "bales of the Host" (Holy Communion) to the hospital or homes of the people that are sick to administer this to them (Carter 2013: 52).

5.3 Limitations of the Study

Several limitations may have affected the results of this study, including that it was conducted at one nursing training college, and did not include either more colleges or other nursing institutions to obtain a broader perspective. However, as this was a

qualitative study, the intention was to focus on the opinions of a small number of participants. In the absence of other ethno-nursing studies having been conducted in KwaZulu-Natal Province, it was intended for this study to form a baseline to inform the content and direction of other similar studies.

Of the twenty-five participants who were issued with diaries, only ten returned them, and with minimal entries. This means that the responses are not representative of the full group of students, but rather of only a few, which may have affected their understanding and reflections related to the cultural aspects of nursing. However, it does indicate that some students were able to identify the need to accommodate different cultures when providing care.

5.4 Recommendations

The following recommendations are made in the areas of nursing education, institutional management and practice, policy development and implementation, and further research.

5.4.1 Nursing Education

- There needs to be a greater emphasis on formally teaching the most common cultures that the students are exposed to in the nursing college, hospitals, and clinical practice. This needs to be accompanied by programmes and handbooks to add to the curricula on the diverse cultures that they are likely to encounter.
- Nursing institutions need to develop curricula that facilitate cultural competence in students. The curricula must be adapted to enable the development of competent nursing care knowledge skills and attitudes that will equip nurses to work in multi-cultural environments.
- A nursing curriculum that includes cultural studies must enable nursing students to be able to effectively interact with patients and their families and their communities. Nursing graduates should be able to demonstrate cultural awareness, sensitivity, and competence in cultural nursing care.
- Formal support in the need of preceptors in transcultural nursing needs to be provided in the clinical environment that the students can turn to in circumstances where they have inadequate cultural knowledge. It is unlikely that the curriculum will be able to address all the cultural aspects of care, as people may adapt their cultural

traditions, making it difficult for nurses to know all the rituals and practices they are likely to encounter.

5.4.2 Institutional management and practice

- Healthcare organisations should enable their patients to observe their cultural and religious practices, for example, different prayer rooms for the more popular religions of patients. Dietary requirements need to be accommodated for the recognised South African faiths.
- Formal clinical teaching and learning programmes need to be provided with preceptors for students to be taught on transcultural nursing in the clinical setting.

5.4.3 Policy development and implementation

- Policy on the competency of student nurses in transcultural nursing should be drawn up and students should be assessed on these policies and procedures. Student nurses in the clinical setting need to be orientated to the patient's cultural preferences for example diets for the regular patients that occupy the facilities. In this setting, most patients are from the black Zulu communities and the Indian communities and nurse should be fluent in traditional and cultural requirements.
- Student nurses that are placed in the clinical setting need to be orientated to the patients that are regarded as frequenting each facility as well as the standards of care regarded as appropriate for each one. An orientation to the most common cultures of patients that frequent that health care facility should be carried out.

5.4.4. Research

- Further research is needed to establish the extent of transcultural nursing practice among student nurses at under and postgraduate level.
- Further research on the exposure to different cultures to enable them to be competent nurse practitioners across diverse cultures.

5.5 Conclusion

This study demonstrated that transcultural nursing competency and self-efficacy among student nurses were generally moderate. A few nurses stated and were confident that

they were adequately prepared and competent to nurse patients of diverse cultures especially those cultures that they were familiar with and had experience in nursing patients of Indian and African cultures**.**

Health care workers should be respectful of the choice's patients make in their health care decision-making. Culture encompasses various components, such as diet, dress, food, relationships, and faith, all of which need to be acknowledged when patients are being cared for by nurses and other health professionals.

In the absence of nurses being aware of how to accommodate the country's diverse culture in their provision of care, patients may be offended, and rituals and practices not conducted. Culturally competent care is therefore a necessary reality in a country with a diverse culture, both locally and internationally. Nurses need to be open to understanding how they can best meet their patient's needs by firstly being aware of their own cultures and secondly to not judge those who have practices that are different (Moreno and Hart 2016: 129).

In terms of identifying trans-cultural self-efficacy among the students, the study found that exploring the students' experiences in transcultural nursing, highlighted the need for orientation and facilitation of diversity and culture in the clinical area. The participants indicated that their competence in transcultural nursing was enhanced by their clinical experiences, that they could understand the value of such instruction as part of their training, and how important this aspect of nursing was in providing care to people from diverse culture.

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APPENDIX 1

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Newlands West
4037

Dear Ms Somoloo

Transcultural self-efficacy among student nurses in a private nursing school

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC

APPENDIX 2

07th June 2018

The Ethics Committee
Joint Medical Holding Propriety Limited
83 Ismail. C, Meer Street
Durban
4001

Dear Professor, Adhikari and Dr Chellan

RE: Letter of intention to conduct research activity at the nursing school

I am a student enrolled at the Durban University of Technology for the master's programme in nursing. My research topic is Transcultural self-efficacy among student nurses in a private nursing school. My intention is to conduct research among the Bridging students at the school by way of focus group interviews, the use of diaries for students to record their experiences whilst they are in the clinical area and reflection discussion groups once they are back at the school from the clinical area.

Data will be collected and analysed in a qualitative research methodology.
Students will be issued with an information form and a consent form to complete prior to participating in the actual study.

Kindly grant me permission to carry out this activity
Premalena Somoloo _____Student No: 21646795

Appendix 3

JOINT MEDICAL HOLDINGS PROPRIETARY LIMITED
Registration No. 2011/010448/07

17th June 2018

To: Ms. Somoloo
Durban University of Technology

Research Topic: Transcultural self-efficacy among student nurses in a private nursing school.

Re: Approval granted from Joint Medical Holdings: Ethics Committee approval (IRB)

Dear Ms. Somoloo
We acknowledge receipt of your request for JMH Ethics Committee approval to undertake the above qualitative study at Joint Medical Holdings, GMNA. Permission is hereby granted from the JMH Ethics Committee for the study to be undertaken. The study focuses on Bridging students at the college by way of focus group interviews, the use of diaries for students to record their experiences whilst they are in the clinical area and reflection discussion groups will take place when they are back from the clinical area. We also acknowledge that students will be given an information form and a consent form to complete prior to participating in the actual study.

Kindly provide record of the final IREC approval and the survey questions to the JMH Ethics Committee prior to commencement of the study. On completion the results of the study will be shared with the management of the GMNA Nursing School.

We trust that this is in order.
Good luck with your research

Thanking you

Professor Miriam Adhikari
Chairperson JMH Ethics Committee

APPENDIX 4. INFORMED CONSENT

Research title: Transcultural self-efficacy among student nurses in a private nursing school.

Researcher: Ms Premalena Somoloo
Phone: 0742893140
Work: 031-3093094

Transcultural nursing focuses on holistic care, culturally based beliefs, values and practice to help cultures maintain or regain their health and confront disabilities or death in a caring culturally congruent and beneficial way. The aim of the study is to examine the competency and self-efficacy of student nurses in transcultural nursing

Transcultural nursing concepts, principles and research findings are transforming nursing, health systems and practices. Transcultural holistic and comparative perspectives are challenging nurses to think broadly and to reduce highly technical impersonal actions that fail to help clients (Kuriakose 2011:248)

THIS IS TO CERTIFY THAT I_____ (Full Name).
Hereby agree to participate as a volunteer in the above-mentioned research.
I understand that there will be no health risks to me resulting from my participation in the research.
I hereby give my permission to participate in the study.
I understand that the information may be published but my name will not be associated with the research.
I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

Participants Signature	

Participants Student Number	
Researchers Signature	
Date	

APPENDIX 5. LETTER OF INFORMATION

Title of Research Study:

Transcultural self-efficacy among students' nurses in a private nursing school

Principal Investigator /Researcher:

Ms Premalena Somoloo: Professional Nurse: B. Cur Nursing Science Degree

Introduction and Purpose of the Study:

You are invited to volunteer for this research study. The reason for selection is that you have been exposed to nurse patients of diverse cultures in the hospital wards and your exposure to transcultural nursing in sociology and nutritional activities at the School. The information leaflet is to assist you to decide if you would like to participate voluntary in this study. Before you agree to take part, you should fully understand what is involved. You are not forced to take part in this study. You have the right to participate voluntarily and withdraw if you are not satisfied with the information provided.

The aim of the study is:

To explore the level of competency and self-efficacy of student nurses in transcultural nursing.

Outline of the procedures:

1. Participant observation: The student nurses will be observed in the classroom for their mannerisms and dressing, language used, who talks the most, the researcher will interact in the events of the group
2. Focus group interviews: Face to face discussions in groups will be done beginning by introductions and consent to audio record the discussions which will be transcribed verbatim
3. The use of diaries: student nurses will be given diaries to record their experiences in the clinical setting whilst they are doing their training.
4. Reflection of experience: Reflections of the experiences will be discussed once student return to the school and will be audio recorded

5. All the data will then be analyses

The respondents will be anonymous in the study. No names will be written or mentioned

Benefits: There will be no direct benefit to the participant, but this information when published will contribute to the body of knowledge to the nursing profession.

Reason why the participant will be withdrawn from the study: non-compliance, there will be no adverse consequences should the participant wish to withdraw.

Remuneration: There will be no remuneration to the participant.

Cost of the study: There will be no cost to the participant of this study.

Confidentiality: The respondents will be anonymous in the study.

Persons to contact in an event or query

Please contact the researcher: (031-3093094. /0742893140) B. Cur Nursing Science,

Supervisor: Dr A. Razak (0826530179) PHD

Co-Supervisor: Mrs. P. Pillay 0836520879) M. Cur Nursing

Or the Institutional Research Ethics Administrator on 031 373 2900.

Complaints can be reported to the Director: Research and Postgraduate Support,

Prof.S. Moyo (031-3732577)

moyos@dut.ac.za

APPENDIX 6. DEMOGRAPHIC DATA SHEET.

Biographical Data: (Place a tick in the appropriate column)

1. Age

21-30 Years	
31-40 years	
40-50 years	
Over 50 years	

2. Gender

Male	
Female	

3. Religion

Muslim	
Hindu	
Christian	
Traditional African	
Jehovah's Witness	
Shembe	

1. Race

Black	
Other	
Coloured	
White	
Indian	
Other	

2. Language

English	
Afrikaans	
Zulu	
Xhosa	
Sotho	
Tamil	

Telegu	
Hindi	
Urdu	
Guajarati	
Other	

6. Marital Status

Married	
Divorced	
Single	
Widowed	

APPENDIX 7. Focus Group Interview

Questions

1. Would each one of you like to introduce yourselves?

2. Tell me some of your experiences in nursing patience from different backgrounds and culture during your clinical practice?

3. Do you feel that you are adequately prepared to nurse patients of diverse cultures?

4.Have you had adequate exposure to socio-cultural knowledge?

5. Please explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures.

6. What opportunities did you have in the clinical practice to provide cultural care?

7. Share with us how you would assess the cultural needs of your patient?

8. Are you equipped to provide culturally competent care, if not why?

9. Are there changes you would like to suggest in nursing patients of diverse cultures

10. What experience and knowledge would help prepare future nursing students to provide culturally competent care of patients?

APPENDIX 8:

Durban
South Africa
28 September 2020

To whom it may concern

Title: Self-Efficacy among Student Nurses in a Private Nursing School
Student: Premalena Somoloo
Institution: Durban University of Technology
Supervisor: Dr A Razak

I have provided structural comments and editing services to the student's thesis and am satisfied that the comments have been addressed and the document is ready for submission.

Regards

Ms Carrin Martin
Academic Editor
MSocSci, PGDPH

Appendix 9

YN

CONTACT

Dr Anita Hiralaal
BA, HDE, B ED HONS, B COMM HONS, M ED, PH D, CERTIFICATE IN COPY-EDITING AND PROOFREADING (UCT)
17 Fairfield Avenue
Scottsville
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Your name

Recipient Name

8 November 2021

Master's Thesis

TRANSCULTURAL SELF-EFFICACY AMONG STUDENT NURSES AT A PRIVATE NURSING SCHOOL IN DURBAN KWAZULU-NATAL

has been edited to ensure technically accurate and contextually appropriate use of language, grammar, logical coherency and presentation.

Dr Anita Hiralaal

Data collection

Focus group 1

Question One: The students /participants were familiar with each other and did not need any introductions therefor the questions were followed on and question 2 became question one

Question 1

Tell me some of your experiences in transcultural nursing during your clinical practice?

With me, the patient I nursed a patient who came to us after an accident on the N2 her lower limb was damaged and she was taken to theatre for an amputation, post op the patient was ventilated and later demised. After this the relatives came back and wanted her limb, I didn't know, I didn't know that in my culture that they would want the amputated limb, I thought the limb would be taken for cremation, but the relatives wanted the limb to bury the patient with the limb, I am Zulu and so was the patient, this made us aware that they must not get rid of the limb, I think they are more aware of our own culture (FG1P1))(st1.2)experiences

I also had a patient of 7 years old, who needed a blood transfusion, the parents refused the blood transfusion, but they allowed the child to have an organ transplant because she had liver damage (FG1P1) (st1.2) experiences

There was a granny a 68 year old patient who came in unconscious , bloods were done for her and her HB was low, 4 packs of blood was given to her , this was ordered by the doctor and signed for , she was unconscious for days, finally the patient came through and we learnt from the relatives that she was Jehovah's witness patient, we told the patient that we transfused her , she was happy to be awake and alive and did not mind that blood was transfused to her (FG1P1)

My mum used to work for an old age home, there were only Jewish residents there, they used to eat Kosher foods, sometimes I used to visit my mother and eat this Jewish food, it was very tasty (FG1P1) (st1.2) experiences

At Durban South Hospital where I work, we recently celebrated Diwali with the Indian staff there, the Matron who is black, dressed up in a Panjabi and we ate a whole lot cakes and sweet things (FG1P11)

I didn't celebrate Diwali, I am a Hindu but, in my culture, when someone dies, and you don't celebrate for a whole year after the death (Participant 2)

The Soji (An Indian sweet treat) was tasty and the Burfee (Indian sweet treat), very nice, we need to respect each other's culture even though they are different, It's normal for us (FG1P1) respect

I had a 36year old female patient on the Medical ward she could not speak and used to use sign language, it was a Zulu patient, but he was writing everything down in English, even the doctors were writing and were communicating on paper, so patient was understanding, the thing that I noticed, just giving the chart and just writing everything down "(FG1P13)

There was a patient who followed the Shembe, I was escorting the patient to the bathroom, she was opening this photo from her gown and giving it to me to keep, I didn't know there was something like that "(FG1P44) (

Yes there is something like that , all the patients belonging to Shembe, if you want to go to toilet you have to take even the dress code out, which is white, they are wearing, when they go to the temple , which is outside under a tree surrounded with white stones, you have to leave you shoes outside that space, there is another thing while you go to church /temple the women are not wearing panties, I don't know if it is true, another thing is they are eating cold food on a Saturday and the person in the Kitchen that is preparing the food must not be menstruating (FG1P3)

My mother and all they said that I must wear something across my Abdomen when I got married, apparently it is a Makhatini Culture, but I dint, even though I am married to a Makhatini (FG1P44)

We must respect the ancestors (FG1P4)

There was an old lady in the ward, she was not eating her relatives was bringing food for her, she was a Shembe" (FG1P 4)

There was a Muslim patient who came in at night and she was not wearing a Burkha (head covering) she said she cannot be nursed by a male nurse (FG1P5)

There was a mother and baby who died, the father came and said that the mother and baby must be buried separately, although the baby was not born, this is new to me I didn't hear something like that in my culture (FG1P1)

My sister was pregnant, and the baby died, the doctors took the baby out and they were buried separately, she was 7 months pregnant" (FG1P1)

Question 2

Do you feel that you are adequately prepared to nurse patients of diverse cultures?

I *feel we ready to nurse patients but we are not aware of some cultures, we African cultures are different, we ready but we don't know all (FG1P11)*

I see the situation I nursed already even the Doctors didn't know, I felt sorry for the patient and we were not adequately prepared for the mute patient (Fg1P3) (s.t.2.3 opportunities)

I would say I am not prepared, there are some cultures I don't know unless we, we, we are taught but even if we are taught, we can't be taught everything (FG1P3)

I come across new things, Language is a barrier to me, we don't understand, but we learn everyday" (FG2P4))

Question 3. Have you had adequate exposure to socio-cultural knowledge?

I did have some, but I need more (FG2P1)

Question 4. Explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures?

Some of the things are mixed, they are not true patients teach you as you go along (Fg1P3)

I agree with Charmaine (Participant 1), I learnt a lot from patients, so patients too, they tell each other how to do things FG1P3(3)

It changed me, by me respecting other cultures (FG1P3) (s.t.2.1. respect)

What I have learnt was a good learning experience for me ((FG1P22)

Question 5. What opportunities did you have in the clinical practice to provide cultural care according to beliefs, values and practices?

The relatives sometimes, when it is an accident and the person dies, they go to the street where the accident happens and take the soul away, they put crosses on the street (FG1P1Participant 1)

Question 6. Share with us how you would assess the cultural needs of your patient in a congruent and beneficial way?

Normally I would ask what religion e.g., what religion or language the patient is, e.g. Shembe, even if patients are praying we know them from the prayers, what religion, sometimes when the nurses are praying, the patients join us, we do assess patient's needs, sometimes we don't ask, they tell us what they eat or don't eat (FG1P1) t1.1

Question 7. Are you equipped to provide culturally competent care according to your knowledge skills and attitudes, if not why?

I felt I failed that patient of mine when the relatives came back for the limb, I didn't understand, and it was my first experience (FG1P1) (s.t.2.3 opportunities)

Any body part, they come for it, even the foreskin, we make them sign an n affidavit, before we give, we call the security, and the Unit manager is signing is out (Participant 3)

Not really (FG1P1)

I would say I am borderline; there are too many cultures (FG2P2)

Even the Zulu culture, even though I am Zulu, there are different things, (FG1P4)

Question 8. Are there any changes you would like to suggest in nursing patients of diverse cultures holistically according to their lifestyles and traditions?

we can, it's new to us, and we can try (FG1P2)

Everybody comes with their own things; sometimes we don't know (Participant 3)

There are a lot of cultures I think our, the nurse's attitude we react differently for instance we can provide well for the Indian cultures, but for example we are unable to provide for the black cultures e.g., the Shembe patient, sometimes the kitchen staff have attitude especially about the cold food on Saturday and they provide bread and mass that attitude should change (FG1P1)

The kitchen staff do the rounds to take the orders, but they don't follow through for the Shembe patient, this is wrong they are not catering (FG1P1)

Question 9. What are your viewpoints in the recognition of cultural needs without preconceived judgments that would help prepare future nursing student to provide culturally competent care of patients?

To cater for the needs and nurse patients holistically' educate the nurses more (FG1P1))

Every morning when taking over student nurses must check all the patient's needs" (FG1P2) *(s.t 2.1 accommodate*

Training them or In-service training for example on the different cultures and the common things in the Jehovah's Witness and so on (FG1P2)

There are negative attitudes towards the patients so nurses should be trained according, educate the student nurses more (FG1P 3)

Focus Group 2

Question 1. Tell me some of your experiences in transcultural nursing during your clinical practice?

In my experience is that for instance for example a jug in the toilet was seen, I think it for Muslim patients rinse their hands, I don't exactly know what they use it for, and so when we nurse Muslim patients, we ensure that a jug is always kept in the toilet (FG2P1) *(experience s.t.1.2)*

In my experience is that there was a patient that passed on and the family came and said they must not do anything for the dead person, they came with a branch thing, it was difficult, in a Christian family there is nothing like that, I heard about it. They took 2 hours; they came to take the spirit away. I knew about it, and heard about it, but I didn't see the actual thing (FG2P2) *experience s.t 1.2*

Last month I was allocated to the NICU, I just didn't know which culture they came from, so they came and asked whether the uncle and aunt could come and pray, we allowed them in, in NICU only the mother and father are allowed, I'm not sure whether it was the grandmother, there's a prayer that needs to be done instantly, like as soon as the baby comes from theatre or from the ward into the Nursery. (FG2P1) *experience s.t.1.2*

Question 2. Do you feel that you are adequately prepared to nurse patients of diverse cultures?

Not prepared if we have foreign patients (FG2P2)

I would say that I am prepared here at school we do learn about other cultures, when we come across other cultures, we know how to nurse, how to behave around these patients, we know what to do (FG2P2) *(s.t 1.3 confidence and self esteem*

"I would say I am adequately prepared, I am prepared, I will respect their needs, I will learn from the patients and take it into consideration all their cultural needs and what I know, I am open to hear whats.t the patients have to say, how they would like to be taken care of, what their needs and cultural beliefs are, (FG2P4Participant 4)

There might be times we are (FG2P2) (s.t 1.3 self-esteem confidence.)

Question 3. Have you had adequate exposure to socio-cultural knowledge? Explain

Wouldn't say it was adequate, it was basic in our sociology lessons, and we learnt about culture, but mostly the terms and didn't know how to apply this knowledge (FG2P3)

Sociology was difficult to understand, and I did not have sufficient exposure as I am a Christian black male and have interacted mostly with Christian culture, I don't have experience with Black African Culture, I am aware of it but not exposed to it (FG2P2

Have had some exposure to socio cultural knowledge 'cos in this school in my first course we had socio cultural day and I was exposed to all the other student's culture ((FG2P1)

Question 4. Explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures?

What made me change is that when I realised different things mean different to different cultures for example, I was being scolded by a Unit Manager and in my culture, you do not have direct contact when a Senior person is talking to you, so I was just looking down, but she thought that I was rude, so I realised what something means in my culture is different to someone else's culture (FG2P 1) (s.t.2.1 respect)

Question 5. What opportunities did you have in the clinical practice to provide cultural care according to beliefs, values and practices?

We had this one patient in the ward, and the day staff told us that he was a Shembe patient and that we must allow him to bath at five o clock in the morning, so we allowed him to bath (FG2P1

while we on that topic of Shembe's, we had this one patient who requested that he wants cold food on a Saturday, unfortunately this information was miscommunicated between the ward and the kitchen staff and food was provided but it was cooked on Saturday and was left to cool down, but what I know is that food must be prepared the day before, it must not be cooked on Saturday (FG2) (s.t.2.1 accommodate

Question 6. Share with us how you would assess the cultural needs of your patient in a congruent and beneficial way?

For example, on admission we would ask the patient his preferences, example on some days patients is fasting, or they eat certain meals, or they are dry fasting (FG2P3)

Some patients don't' eat beef or pork and we need to assess what they eat (Participant 4)

the patient was going for a major operation to theatre, so we had to check if the patient was Jehovah's Witness, just in case the patient needed a blood transfusion, would that be an assessment (FG2P1Participant 1) t1.1

Question 7. Are you equipped to provide culturally competent care according to your knowledge, skills and attitudes, if not why?

Yes, If I have enough knowledge and information, I feel equipped (Participant 2)

Yes, in Lorne Cross hospital we provide a room for Muslim patients to pray in food as well is hall for them and those that eat veggies, those Krishna's, we provide for them (FG2PG5) (s.t.2.3 opportunities)

Question 8. Are there changes you would like to suggest in nursing patients of diverse cultures holistically according to their lifestyles and traditions?

Hearing from my colleague there that Lorne Cross hospital has a prayer room for Muslim patients, it would have been amazing if River horse Hospital had a prayer room with facilities, hey just seeing Dr Talia washing his feet in the sink its unhygienic, he uses the sink in theatre, depends which sink he is going to get, I would like to change that, and provision should be made for a prayer room (FG2P2Participant 2)

Question 9. What are your viewpoints in the recognition of cultural needs without preconceived judgements that would help prepare future nursing students to provide culturally competent care of patients?

I think it should be during one of the lessons, students must share their culture, so that they do not get a cultural shock when they go to the wards, for example that doctor that was washing his feet, if we knew we would not be shocked (FG2Pt 1)

We must be open to give knowledge and understand future students, someone should write a book for us on Transcultural Nursing (FG2P2 2) (s.t.2.1 respect)

FOCUS GROUP 3

Question 1. Tell me some of your experiences in transcultural nursing during your clinical practice?

I had a patient who asked which direction was east as we didn't know why or what the direction was, so we requested and directed them to the Muslim prayer room, when I asked the patient, she said that Mecca was in the East, the Hindu people also pray facing east towards the sun (Participant 1)

This patient was very sick, she refused the blood transfusion, so the husband came with some relatives and signed for giving permission for the blood to be transfused, the patient didn't mind (FG3P2 2)

Some of us were nursing in the Apartheid era as some of us are older so we came from our own cultures in school, and it was difficult initially to nurse patients of different cultures" (FG3P3Participant 3)

The experience we got is the experience we got from the patients, I wouldn't say at what time we were we were born, e.g., there was this man who was and Indian man in Zelly hospital, I think he was a Hindu man, the relatives used to bring things and burn some and fires, and do a big prayer in the unit

(FG3P44)

Question 2. Do you feel that you are adequately prepared to nurse patients of diverse cultures?

We are aware for example that the Shembe patients don't eat hot food on a Saturday, but we don't know the reason why, everybody learns" (FG3P5)

"I see nurse's discriminating against patients, we should be more accommodating even as we nurse other cultures, even us as Blacks, I wouldn't want this to be done to me, try and be more understanding we don't know everything we learn" FG3P5(2) *(s.t.1.3 self-esteem and confidence)*

Question 3. Have you had adequate exposure to socio-cultural knowledge?

"*We are always learning new things everyday" (Participant 3)* *(s.t.1.3. self-esteem and confidence*

"We learn our own culture, we don't know our own culture, and we do it because our parents do it "(FG3P5)

Question 4. Explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures

What changed me was the fact that I experienced many cultures and accommodated them, I cannot understand some of the nurses why they don't understand other people's cultures and accommodate them, instead they behave inappropriately and unprofessionally, sometimes shouting at people., one must just think what if it was your family (FG3P2) *(s.t.2.1 accommodate)*

Even if we are scientific culture helps patients get better quickly, we don't ask that question, we need to go back to our roots and see where we came from and what we understand in our culture (FG3P1)) some patients are so interested when you ask them about some of their habits or rituals, sometimes we throw things away that the patient has, it is so painful for them, just imagine if someone threw something that you held so dearly, so we must put their things back on them (FG3P1) *(s.t.2.1. respect)*

Question 5. What opportunities did you have in the clinical practice to provide cultural care according to beliefs, values and practices?

If I see, after the patient's bath that they have a cloth, the Catholic people don't take it out after the bath put it back how it was don't shove it in the drawer (FG3P2)

Some patients are blind or confused, keep their meals for them if they have gone for procedures out of the ward, there was this Hindu man that was served beef, thankfully the caregiver saw this and managed to resolve this, so you know this is an offence and patients can take you up to a criminal court (FG3P1) You see even if they come with the Green Tree thing , branch, allow them in to fetch the soul of the deceased patient , I find it strange but I want to learn about cultures and see what they are doing , they talk to the soul , I listen, they talk to the soul, oh we going to the lift now , they have to talk to the spirit, e.g. in the car , at the Robot, until they reach home , A lot of cultures talk to spirits of the dead person, they have to talk and do prayers, you know sometimes you must move out of the way until they reach home , in the Church and the Cemetery they talk to the spirit to the branch and they throw it away into the Grave (FG3P)(s.t.2.11(accommodate)

Question 6. Share with us how you would assess the cultural needs of your patient in a congruent and beneficial way?

On admission you ask patients preferences on meals or activities, in some cultures males and females are not allowed to be in the same room, (FG3P4)

Like some Muslim females (Participant 5) (t1.1)

We assess by dressing, identifying e.g., if the patient is wearing a red dot on her forehead, we know she is Hindu, or a red string on her wrist, again it is a Hindu, sometimes we identify by the Language they speak or their names and surnames (FG3P3) (t1.1)

Question 7. Are you equipped to provide culturally competent care according to your knowledge skills and attitudes, if not why?

We have some knowledge, we learn everyday (Participant 2)

For example, we don't know all the cultures, we don't have Jewish patients, and we don't nurse them at River Horse Hospital. I have nursed a Greek patient, and I have nursed a French, white patient from Mauritius, we are not familiar with their cultures, no I don't think we are fully equipped (FG3P4)

Question 8. Are there changes you would like to suggest in nursing patients of diverse cultures, holistically according to their lifestyles and traditions?

Nurses must be more accommodating because they just don't care for them, it is such a big thing for nurses when they see them practising other cultures, according to the Human Rights, you cannot give patients what they don't eat according to their religion and culture, I think nurse should be more educated on culture, I am Hindu and at the hospital canteen was served Beef instead of Lamb, I was very upset (FG3P1)

Learn your own culture, I must accommodate all cultures, things can be done differently e.g., set proper menus to accommodate patients' cultures, it is difficult in the wards, as everybody wants their preferences, everybody wants, double portions, everybody wants hot meal and everybody wants everything now, e.g., Muslim patients do not eat pork, the hospital canteens /kitchens must accommodate all religions (FG3P3)

In the Hospice they accommodate all different faiths, e.g., Jewish, Hindu, Christian including Say Baba, that's so good, the hospitals should learn from them (FG3P5)

Even us nurses we would like to be accommodated according to our faith; we would like to Pray" (FG3P33)

In our hospital we cater for Muslim patients when they are fasting and breaking the fast, the kitchen provides for them and the staff the meals to breakfast (FG3P22)

Some are dry fasting; some Christians are dry fasting (FG3P3Participant 3(s.t.2.1 accommodate)

Question 9. What are your viewpoints in the recognition of cultural needs without preconceived judgements that would help prepare future nursing students to provide culturally competent care of patients?

We don't have enough time to teach the new students, the nurses should know this, it is in the Nurses Pledge and they are taught this in College (FG3P2)

Our schooling is limited in culture (FG3P3))

A course in Transcultural Nursing will do (FG3P3))

In lots of workplaces, cultural days are observed and celebrated among nurses, but we in the hospital, this is not done – this is something that would help students understand culture (FG3P11)

Focus Group 4

QUESTION 1. Tell me some of your experiences in transcultural nursing during your clinical practice

In my experience we had a Jewish patient that came in, He wanted Kosher food, because of his religion, he didn't want tap water he didn't want any food if it was not Kosher, he wanted only bottled water, so he ate only fruit and Veg as he came in the night, at that point there was-s no food available, it was late, however the next day we were able to provide Kosher food. (FG4P11) *Experience 1.2*

In my experience I came across a patient who didn't understand English, didn't understand Afrikaans, and can't understand Zulu. He was an Indian, it was very hard to identify the problem we even called the seniors, it was very difficult, it was a language barrier" (FG4P22) *Experience 1.2*

*This patient was speaking French , I didn't know what she was saying, I was taking her pulse, cos vent the relatives were unable to tell us, they us brought her in, because it was the hospital, by the one word we could understand was Dr Ashton, Professor Ashton is somebody we know , so we called him and he was able to give us the treatment telephonically and he was able to tell us what was wrong with her , he gave us all the orders on the phone and there was no letter"(FG4P3*Experence stsss1.2

We had a patient; she could speak English clearly but was Russian. She did not want to have a bath that was offered to her, she said she will go home and bath, and did not want to give her baby a bath, I am not sure if this was a cultural thing or just a preference or not, she was not telling anybody (FG4P4)) Experiencest1.

There was this one patient, first of all she was pregnant and went to Theatre for a Caesarean Section, she spoke a different language, she wanted her placenta to be taken home with, she was a Black African woman, I think she was Zulu, I found that strange as I am Zulu, and we don't do things

In our ward we had a Chief for a certain village, this chief was also a Shembe Priest at the same time, we are used in the ward to greet patient but with this man we had to not only greet but bow down, that was a bit too much for me. Sometimes I forgot and had to apologise (FG4P5) *Experience set 1.2*

I heard these people in OPD it was a China, chi Chang, with the child carried, chi chi, chie ha sung sa I thought what the hell is going on, so I took the baby from the mothers arms and started to do vital signs only to find out that the child had a very high temperature and these were very anxious Chinese parents, - -language is a barrier to me, it was hard to decipher what they were saying , but they eventually got one of the relatives to translate for usFG4P1).Experience st 1.2

I was in the lift coming out of my ward going down to another level I was talking to another nurse in the lift I, I met some people in the lift, a priest and the relatives, with a tree branch and talking to nothing

(spirit) – I was chatting to another nurse, when this man told me to keep quiet, I am not sure why (Laughs) (Fg4P2)) *Experience st 1.2*

I had a similar experience, more or less the same, we had a staff member in my ward, and on most weekends that we work we buy our meals, there is this one nurse who refuse do buy food with us because it was a Saturday and she would not eat food that is prepared on a Saturday, she would rather eat cold food from the fridge she was a Shamble and she was following her religion" (FG4P3)s.t 1.2 Experience

Once we had a patient in the ward, she was ventilated, her HB was 4, she was an adult and if awake could have signed consent for herself for a blood transfusion, but the parents didn't want to sign for her, she was Jehovah's Witness and she died without the blood transfusion (FG4P4)))

We had a psych patient, this patient had refused to procedure, he got ready and stood up and said he was leaving the ward, refused to go to theatre, rather go to his own country and go to theatre, so we prepared him for theatre but he left the ward, he was a foreign patient, I am not sure if he was Russian (FG4P5)st 1.2 Experience

Question 2. Do you feel you are adequately prepared to nurse patients of diverse culture?

We learn from experiences, we learn about the cultures, we are eager to learn (FG4P5))

Yes we get more prepared each time we have an experience it teaches us to learn more about different cultures (FG4P5))

I think we are not adequately prepared but are come with experiences every time you experience you are more prepared (FG4P2)

Question 3. Have you had adequate exposure to socio-cultural knowledge?

"No" responses from the group

Question 4. Explain how your knowledge and experience helped you change your perception of nursing patients of diverse cultures.

We nurse patients and families, learning more about their likes and dislikes, spending more time with them" (FG4P1).

In nursing we come to nurse the patients' health but be able to nurse them respectfully (FG4P1)

When I came to Nursing, I only thought about the physical nursing, but patient is very well, happy, but hot patient is psychological disturbed heath and cultures, respect and culture, perception had been exposed". (FG4P3) *(s.t.2.2 respect)*

Question 5. What opportunities did you have in the clinical practice to provide cultural care according to beliefs, values and practices?

We were able to provide kosher food to the Jewish patient (FG4P1))

In nursing a Shembe patient I was able to provide cold food to him on a Saturday (FG4P2) *(s.t.1.3 self-esteem and confidence*

At the hospital where I work a Prayer room is provided for the needs spiritually for Muslim patients, a Chapel for Christian patients, I was able to provide Spiritual care by taking the Priest and patient to the chapel to pray (FG4P4)

Some Shembe patients do not eat meat for 3 months in a year and I am able to provide a vegetarian meal for them in the ward (FG4P5)). *(s.t. 2.1 accommodate)*

Question 6. Share with us how you would assess the cultural needs of your patient in a congruent and beneficial way.

On admission questions are asked to the patient about dietary preferences, religious beliefs, languages etc. Based on these patients are assessed and treated culturally, when the patient tells us what religion then we ask more questions or patients volunteer the information (FG4P5) t1.1

Question 7. Are you equipped to provide culturally competent care?

We are not fully equipped, as we don't have prayer rooms for all religious groups, Christians, Muslims and other religions, patients do request a place to pray, others ask why we (nurses) do not pray in the wards (FG4P1)

It's an on-going learning process, we learn new things every day (FG4P2)

Question 8. Are there changes you would like to suggest in Nursing Patients of Diverse cultures holistically according to their lifestyles and traditions?

I would like to change people's perception of Organ Donation and blood transfusion, I respect their cultures, but I believe in Nursing we should do everything in our power to save lives, so I would like to educate people on how their organs, or their blood can save someone else's life (Participant 3)

I would like to change the fact that sometimes a priest or people from the church come to pray for patients in the ward, sometimes we have patients coming from theatre and the people who are praying are noisy and this does not respect or disturb the patients who come from theatre, maybe the others can use a prayer room and we don't have a prayer room in or hospital to cater for the Christians or other religions, or maybe a common prayer room (Participant 4))(s.t.2.2. respect)

I would like to change regarding the Nutrition of patients like the Shembe patients or other religious groups diet , should be provided for them, e.g. some people are eating vegetarian diets on certain days, the kitchen staff come early on a Saturday and they cook food for the Shembe patients, and the patients come to know that this food was cooked on a the same day and they don't want to eat it , they starve or eat mass that day, I would like to change this the food should be cooked the day before (Participant 5))

The Shembe have days when they don't eat chicken, so they eat Maas only and they cannot eat bread on a Saturday, I would like to educate them on diet (Participant 4)

Question 9. What are your viewpoints in recognition needs without preconceived judgements that would help prepare future nursing students to provide culturally competent care of patients?

Students may not agree with everything the patients do, but we need to explain to them that we do not have a choice, but to respect their cultures (Participant 3)

We cannot be judgemental, but we need to provide for people culturally, we had a gay guy admitted to the ward and he requested to be admitted in a female ward and he was given a bed in the female ward (FG4P5) (s.t2.2 respect)

Focus Group 5

Question 1. Tell me some of your experiences in transcultural nursing during your clinical practice

For me it is the Language Barrier, I have picked up a few words to get through; I do find it difficult socially with the older people (FG5P1) 1)

Not that I speak German, which is my Mother Tongue, we are sometimes put on the other end of the Line (FG5P1

From a gender base, I would be at a disadvantage as certain words with females from certain backgrounds who didn't want me to nurse them (FG5P1)

It's more of a respect thing, mmm, mm so it the husband is present Nurse you cannot come near me, but if the husband is not there then I can nurse the patient (FG5P1)

when I worked on the 10th floor , I uh, uh refused to go to Room 103 and Room 104, I just could not nurse them, they made me feel so uncomfortable there were things that they say to you , because you a young female, they very, I don't want to say seductive , they try and seduce you, they cross the line and they don't , I don't know what to do, I get so nervous , so now I think I learnt to handle them, it opens you up to the different ethnic groups you learn and adjust to it , and as you exposed to it more often it becomes easy for you to handle it (FG5P1)

The older people when they see me, they like "haibo wena you're a nurse," ok yes, I am a nurse, they would think otherwise, they respect me once they see your professionalism and how good you are at what you do then they say I want that nurse there, but the stereotype is there for some odd reason they they see the clinical side and they appreciate you (FG5P2)

People either love me or hate me, It's a very fine line they ether wonder why I am a nurse what pushed me to become a nurse I do do stand out , I'm fine with that , Other people like children are not used to seeing a whiter person so that I have a lot of challenges in the Paediatric Unit as children are afraid of me , I think it's in their cultural stories, where they associate white person to be a bad person or a witch, In the paediatric ward you sometimes have to hold a child down to give medication or insert and IV, so I had challenges with that, so sometimes If I am taking a temperature, they feel I am going to hurt them (FG5P1)

I had a Dad who wanted to pray for a baby in the nurse and then I said Dad, then I asked him did you make "Udhu" he was taken a bit back and said oh you know about Udhu, he said yes, I finish wash myself; the Udhu is to wash oneself before the prayers (Participant 3)

You don't bath the baby or touch the baby before they pray; they even collect the placenta (FG3P33)

When someone passes on they come with a branch, and they will pray and come and take the spirit away and so I questioned the man on doing that I said to him, with all due respect Sir what are you doing , he replied , I need to tell my Dad (spirit) that I am right here with him in the hospital, he must

come with me, follow me down the corridors, open the car door and put him inside the car, I take him to my house, what I was going to do, so he was having a conversation with the spirit, I accepted it because it his culture (FG5Pt 4)

There was a Catholic priest who came and put a green cloth on a patient and so I asked the the Lazarus Sisters, who are Catholics, what does the green cloth mean, and they said that it was a Novena and it meant that the patient was guaranteed a place in Heaven (FG5P5)

On a Sunday after the Holy Communion is taken at Church, the Priest gets little bales of the Host and distributes this for the people that are sick at home or in the Hospital (FG5P1))

On a Saturday they don't eat hot food, you need to call the Kitchen and order fruit or sandwiches.th 1.2 experience (Fg5P2))

The Jehovah's witnesses, haver other alternatives to blood products are offered but explained where thy come from e.g., venofer and has animal deritives and was refused by a patient (FG5P3)

I am a born free and throughout my schooling I was with all race groups of people so coming into Nursing in a predominantly Indian and Black hospital, I don't feel a cultural shock (Participant 1)

My little sister 8 years old does not see colour, she does not understand why people would say "That Indian Man" she would probably say the man in the blue shirt "or if I say "go sit with the Indian boys, she will say that is not their names (FG5P1)

Question 2. Do you feel you are adequately prepared to nurse patients of diverse cultures?

We might not always agree or see that we can't. stop them and we allow them to practice whatever they believe in, that's human nature, we might not know the reasons behind it, some of them are ready to share, some they rather don't. (FG5P4)

I am a Catholic and was not aware of this, I am learning something in my own faith" (FG5P2) "The Last Rites, no one ever tells us how it's done the Catholic way" (FG5P1))

Question 3. Have you had adequate exposure to socio-cultural knowledge?

"Sociology we touch on, maybe we should go deeper, its jargon that we learn, languages should be included in the course, maybe some basic terminally that follows course so that we can get through so that we can get through to our patients, as much as school does teach us about it, it is not what we need" (FG5P10)

Question 4. Explain how your knowledge and experience helped you change your perception of nursing patents of diverse cultures?

"With the different ethnic groups, you learn and adjust to it, and as you are exposed to it more often it becomes easy for you to handle it" ((FG5P3)

"We work in a multicultural hospital, I for one encourage them to pray before we start the day, it used to be a norm back in the day we sang and we prayed, some do, and some don't "(FG5P4)

"If we had the time then the staff were there, the kitchen staff and the cleaners and the patients sometimes the patient's families they pray, which we don't stop, them, when they a little bit well" (FG5P5)) *(s.t.2.2 respect)*

Question 5. What opportunities did you have in the clinical practice to provide cultural care according to beliefs, vales and practices?

Last year in the SICU (Surgical Intensive care unit) , I am a Priest , there was a patient there on CPAP, it was time for the patient to demise, the family was looking for a Hindu priest and they could not get hold of the priest, I said to them I am a Nurse but I am also a Priest will, you allow me to pray for the patient, I opened up the book to check dates and times etc., the family was happy for me to pray as they could not get their priest, I was offered a thanksgiving , as a priest, I will accept it but as a nurse I cannot accept it , please give it to a charity. The patient passed away the next day, this is the last rights prayer for Hindi people especially for people for find it difficult to make the transition from this life to the afterlife (FG5P2) *(s.t 1.4 self-awareness*

Question 6. Share with us how you would assess the cultural needs of your patient in a congruent and beneficial way?

On admission we ask questions to assess patients' needs and one of them is Cultural care, for example we ask what religion, language or are there any dietary preferences according to their religious beliefs, or just their preferences (FG5P 4) *(t1.1)*

We also daily do assessments of patient's health needs and sometimes patients share with us their needs or request certain times to pray (FG5P3) *(1.1*

Question 7. Are you equipped to provide culturally competent care according to your knowledge, skills and attitudes, if not why?

Yes, sometimes I can call on my own Catholic priest to pray for patients in the ward, sometimes the patients request these prayers especially when they are very ill, the Priest does come and administer communion to the patients (FG5P11) *(s.t.2.2. respect) Yes and No, I can provide cultural care in most instances, predominantly the patients in the hospitals I work in are Indian, I am familiar with all the Indian religions and languages, I speak many Indian languages, and there are a lot of black patients who speak Zulu, I speak Zulu as well and understand their culture, I am not sure if I am faced with other cultures, like something foreign (FG5P2)*

Question 8. Are there changes you would like to suggest in nursing patients of diverse cultures holistically according to their lifestyles and traditions?

In Sociology we touch the surface, we should go deeper, it's just jargon and terminology, it's not practical, yes, we do learn about cultural terminology but it's not application, I would like to change that (FGP 2)

In this hospital there is no provision for a prayer room for other religions, only a room for Muslim patients, they should have a little chapel or a prayer room for other religions, where patients can go privately to pray or relatives (FG5P1) Participant 1)

(s.t.2.2 respect)

Question 9. What are your viewpoints in the recognition of cultural needs without preconceived judgements that would help prepare future nursing students to provide culturally competent care of patients?

I think we need books for students on Transcultural Nursing, students must take down notes, once they get home they must read and understand (FG5P3)).

Maybe languages should be included in the course, some basic terminology that follows our course so that we can get through to our patients as much as school does teach us, and it's not what we need in nursing different cultures and different languages (FG5P4).

I think our Socio-Cultural day at the College was a real eye opener, where the cultures were portrayed and where one of the Indian students played a young black girl in the Memeso (black African cultural event), (FGP 2)

Some, but I need more (Participant 1)

Submission of Dissertation/Thesis for Examination

	Health Sciences			
	Nursing			
Qualification for which registered		MHSci: Nursing		
Offering type	**Full time registration**		**Part time registration**	x
Prior qualification		B. Cur Nursing Science		

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			Dissertation/Thesis	

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I hereby grant the abovementioned student permission to submit his/her dissertation/thesis for examination.				

Signed: **Date: 16 November 2020**

_____

(Supervisor)

YES	√	**NO**	

Signed: _____Date: _____

(Co-Supervisor)

YES		**NO**	

Signed: _____ ___Date: _____

(HoD)

Routing	**Student**		**Supervisor**		**HoD**		**Faculty Officer**	