NURSE-EDUCATORS' PERCEPTION OF CULTURAL CONGRUENT NURSING CARE: A MODEL FOR EDUCATION OF NOVICE NURSES

by

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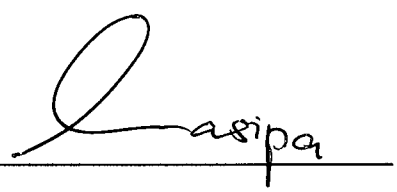

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CHAPTER ONE

ORIENTATION TO STUDY

1.1 INTRODUCTION

South Africa is a rainbow nation (Sunday Times, 8 May 2005). The population of South Africa is multicultural, consisting of Whites/Europeans, Africans, Asians and descendants of interracial marriages. In this multiracial society many cultural orientations like Western, African, Eastern exist; as do mixtures of Western-African and African-Eastern. The multiculturality of the people of the country means that nurses continuously come in contact with health consumers from different cultural backgrounds (Masipa, 1991:4). It, therefore follows that in order to render services that benefit all health care consumers, nurses must be equipped, in their nursing education, with knowledge that will enable them to offer quality care that will be congruent with the expectations of the people of diverse cultures (De Santis, 1992:35).

1.2 MOTIVATION FOR THIS STUDY

The following problem statements underlay this study:

1.2.1 The philosophy grounding Nursing Care

South African Medical Science is based on the biomedical model of intervention into health problems (Tranabranski, 1994:733). In this model, patients are regarded, according to Roberts and Krouse (1995:23) as passive recipients of health care; decisions regarding health and illness are the exclusive domain of the physician and/or the other professional health care providers. Macleod (in

Chalanda, 1995:21) concurs and explains also that this mode (the biomedical model) is based on a narrow belief about patient care, namely that all health/illness problems are embedded in pathological states of the anatomy and physiology of the body systems. Thus all health care (including nursing care) is primarily based on physiological/biological principles to the exclusion of all other dimensions encompassing human beings. According to Macleod (1986:77) the biomedical model is fundamentally based on the principle of looking at diseases from only a physical perspective of pathogenesis, emphasizing physiological symptoms only without any reference to the socio-cultural aspect of diseases (whether in causation or in impact on the person self, family or community). Because health and illness are considered only as physiological phenomena, the socio-cultural aspects of health and illness are very seldom considered (Mashaba, 1995:3 and Marriner, 1970:39). Nursing as a Health Science follows the Medical Sciences with the result that nursing education and nursing practice are also grounded in the biomedical model.

Based on the fact that the bio- medical model dominates the medical sciences, the needs of health care consumers and their treatment are mostly medically assessed. Derived from the assessment, these are primarily based on the prescription of the doctor (Kupe 1993:29). According to Billing and Stokes (1982:60) the medical care assessment is usually physical in nature and includes "skin condition, elimination, nutritional status, and mobility", to mention a few. Even when the "Maslow's needs approach" is applied, the physical needs are the most important because the concept of culturality and cultural health needs in this model are indirectly described. Mashaba (1995:3) further states that because nursing care is grounded in the biomedical model, the nursing needs of health care consumers are mostly based on the medical diagnosis of illness, which in turn is embedded in examining the bodily signs and symptoms of the particular condition that afflicts the patient. Vlok (1979:37) elaborates to show that much of nursing care emphasises routine nursing care like the hygienic care of the body of the patient, the reporting of homeostasis of the body, and taking of vital signs as an indication of the medical prescription (the so-called "Doctor's Orders). Parse (1981:1383) further points out that the

"nursing process" was incorporated into nursing to provide a scientific and rational approach to the nursing care of the health care consumer. Marriner (1970: 39) indicated that because Maslow's hierarchical needs do not form the basis for the nursing process, no assessment of any cultural needs is made given that only the physiological, medical and bio-medical needs of health care consumers are emphasised. Mashaba (1995:3) enhanced Marriner's statement when declaring that in the assessment phase of the nursing process, the focus is only on the physical needs of the health care consumer and environmental aspects in which the health care consumer lives. Since these are the sole consideration planned for, nursing care planning and interventions are based mainly on the medical care structures that are available in the work situation.

The standardization of nursing care based on structured medical records was introduced to nursing during the last few decades (Marriner 1970:88). Morgan (1991:58) attributes the trend to convert nursing care into figures and percentages to the principles of standardization and structuring where standardization committees in hospitals now determine the type of structured health care plans, as well as the categories of care to be given to health care consumers. Attempts at the individualization of care to meet the needs (including the cultural health needs) of the patient in a holistic way are very seldom tolerated by these committees. As Kupe (1993:56) shows under these conditions, medical information overrides all socio-psychological, socio-occupational and socio-cultural information as these cannot be converted into percentages and figures. Therefore, the cultural needs of the health care consumer are not assessed, or if assessed, they become isolated or obscured; the medical information becomes thus, the alpha and omega of care to be rendered. It therefore exclusively determines the direction the nursing care must take, removing the consumer's own needs from all health care decisions.

1.2.2 Nursing as a Cultural and Interpersonal Phenomenon and the biomedical model

The care of the sick was provided typically by women of the family (Ben-Zur, *Yagil and Spitzer* 1999:1433); thus, nursing is a cultural phenomenon which has served all human races by caring for the sick and healthy from the beginning of time. Since nursing takes place between two human beings – the nurse and health care consumer, nursing care is also an interpersonal process (Boyle and Andrew 1989:9). Nursing care also constitutes an interpersonal process between the person expressing the need for help and the helping person (Chao, 1992:182). Therefore, both the nurse and the health care consumer are human beings who have their own cultural orientations that they bring to the nursing setting. According to Hall and Dorman (1988:936), as an interpersonal process nursing is the art of caring and it includes warmth, respect, patience, kindness, sincerity, willingness to listen and the use of interpersonal skills. Sharts-Hopko (1995:343) adds that for caring to be effective, it must be offered in such a way that it brings the recipient comfort. This is not always achieved, however, because as Herbst (1990:23) shows in the African situation nurses (both white and black) tend to assume that all health care consumers, despite their varied ethnocentrisms, have a western cultural view. Mindful of the pitfalls of this situation Leininger (1989:35) explains that nurses should not assume that health care consumers will accept any form of nursing care rendered to them because they have different preferences on care that should be rendered.

Boyle and Andrew (1989:4) as well as West (1993:232) further state that, since nursing is a cultural phenomenon, all nurses must be aware that nursing care takes place in a cultural setting and that each culture is worthy of high esteem and regard and consequently does not need to be modified unless it is destructive to the well-being of the health care consumer, another person or the environment they share. Chalanda (1995:21) notes that nurses often experience problems when giving nursing care in a multicultural setting because of misunderstanding of culturally different life styles, behaviours, practices and perceptions, especially when these are directly related to the concepts of health

and illness, birth and death, and health- illness practices). Thus, cultural bias, nursing socialization and health care policies which do not accommodate culturally congruent nursing care collectively lead to a situation where culturally congruent nursing care will not be rendered to patients of diverse orientations.

Based on the above, nurse educators must ensure that novice nurses will emerge as practitioners who will offer culturally congruent nursing care to the health care consumers (Atieno, 1994:60). Novice nurses must be encouraged to respect health care consumers' values and beliefs, see the consumers as resourceful persons by involving them in their own health care, and help them to take an informed decision by clarifying bio-medical and technical issues with which the health care consumers are not conversant. If nursing care is offered in such a way that it satisfies the person who is giving it and not the person who is receiving it, it is not human care that has been given to the health care consumer by a health practitioner, but technical assistance (Chao, 1992:182).

The allopathic health care system that is grounded on the biomedical model is only focused on the health care practitioner – the health care consumer "the patient is understood to exist" (Brink, 1978). All nursing educational programmes endorse the existence of the health care consumer but novice nurses and nurse educators are very seldom taught what is meant by the concept of "the consumer as a human being" influenced or changed by health, illness, disability, death (Harms, 1981:7-20,30-36).

According to Oberholzer (1964) the Natural Sciences ground the Health Sciences with the results that both the Health Science and health care are robbed of a world view that gives meaning to life. Thus, this orientation to the natural biological view of humanity which posits that a human being is composed of cells or is an illness, not a developing/becoming person embeds nursing knowledge and nursing care in a strong organic/biological view point.

Consequently, although all persons are socio-cultural human beings and nursing an interpersonal and cultural process in which nurses act as brokers, nursing cannot be viewed as interpersonal and cultural phenomena and the health care consumer cannot be understand from the perspective of the human being-model.

1.2.3 Policies and ideologies and their influence on nursing

The political ideologies of ruling parties in government have a far reaching influence on nursing as a profession because nursing has to comply with the laws of the country. The political ideology practiced by the previous government was reflected in the division of the peoples of South Africa in different racial groups (Zaad 1990:21), notwithstanding the idealised statement by Van der Merwe (1983:339) that the concept of apartheid means: "South Africa is a multicultural country with different groups' each with its own culture, and its people reflect that". Because of this political ideology, structures were developed in the South African health care system to comply with the country's political policies. Hence, different hospitals catered for whites only or blacks only. Black and white nurses therefore nursed only persons of their own race. Thus, cultural issues were not important in nursing education. The long separation of people with different cultural orientations led to the phenomenon that nurses became insensitive towards the cultural orientations of the health care consumer (Masipa, 1991:20). After 1994 the political setting changed and nurses now have to nurse all health care consumers irrespective of race, ethnicity, cultural orientation, health-illness perceptions and health-illness practices in the same health care setting. However, because very few nurses have been educated to render culturally congruent nursing care, nurses are now practitioners-in-crisis since they do not know how to render the type of nursing care that is congruent with the expectations of diverse health care consumers.

Health care policies also do not address culturally congruent nursing care as most of these policies were drawn up and designed before 1994. Many hospitals are still not designed to accommodate cultural health-illness practices; health policies still do not include traditional health care practices and practitioners. Thus, as Chalanda (1995:19) indicates, traditional African health care consumers tend to first use their own traditional health care system before coming to the Western health care system. Because the policies and daily routine and procedures in the western health care system are based on western health care models (Spector, 1994:34)), little time is devoted to fulfil the cultural health needs of traditional African health care consumers, a situation which can make a traditional African patient feel unaccepted in the western health care system.

1.2.4 The Educational Setting in the Nursing Profession

Although nursing qualifications are registered with the South African Qualification Authority (1997:13), the curricula of nursing education are regulated and directly prescribed by the South African Nursing Council (Laryea, 1992:167). According to Conley (1997:17) most Nursing Councils worldwide still structure nursing curriculae according to the lines set by the World Health Organization in 1958 even though the World Health Organization revised the role of the nurse during the eighties. According to Ben-Zur *et al* (1999:1433) nurses were and are still seen to be totally dependant on the physician's decisions. Thus, because curricula of nursing are grounded on the biomedical model, these curriculae do not explicitly prescribe the teaching of culturally congruent nursing care; the scope of the nurse follows suite.

Another, often neglected important factor, is the failure of nursing curricula content to keep abreast and in pace with social change. Although the curriculae do include Social Sciences in addition to medical-nursing education, the content of the social sciences is not always relevant to the social setting in which nursing care takes place (Ben-Zur *et al*, 1999:1433). According to Parse (1999:1383), the nursing profession is still composed of the predominant tasks

of nurturing and caring for the physical well-being of the health care consumer, over and above the health consumer's wishes and their cultural health needs.

Nurse-educators play the most important role in imparting knowledge that is utilised in the practice of nursing (Leininger 1994:18). Nurse educators therefore directly and indirectly determine the type of health care delivery that will be rendered to the patient (Clark 1978:12). If nurse educators do not teach novice nurses to cater for the cultural health needs of health care consumers novice nurses will not render culturally congruent nursing care. The reason for this, according to Billings and Stokes (1986:54), is that most nursing students enter nursing career at adolescent stage, a stage wherein the adolescent is a person-in-crisis, neither a child nor an adult (Mohanoe, 1983:2). Kroger (1989:1) adds that the behavioural characteristics of this person are such that, because s/he is in transitional stage and is still finding himself/herself, s/he therefore battles to distinguish between right and wrong, and what is important and not, and therefore tends to take everything that the nurse educator says at face value. McKeachie (1986:54) stresses that it is especially the non-verbal behaviour of the nurse educator that influences the ethical values and behaviour of the student nurse; thus, the novice nurse tends to model the behaviour and values of the nurse educator. On the other hand, Leininger (1988:67) states that if multiculturality and cultural congruent nursing care is taught, only the minimum content is taught to novice nurse practitioners.

McKeachie (1986:54) stated that although the curriculum of nurse-educators creates an impression that the nurse-educator is an expert in nursing knowledge and practice, the curriculum of nurse-educators emphasises mostly cognitive knowledge and skills of educational sciences. The educational foundation of nursing, such as the diversions of the health of the consumers as persons, and the care to be rendered, is never taught. The reason for this is that nurse-educators are mostly taught bio-medical sciences such as anatomy, physiology, pharmacology, as well as educational sciences like curriculum development and the use of educational technology (SANC Regulation R425.).

Because of the fact that, nursing curricula are based on the biomedical model, both Tshotsho (1992:47) and Nyasula (1994:35) enhance Clark's (1978:4) statement when describing how nurses and nurse-educators who are trained according to the biomedical model cling to their educational philosophy which emphasises biomedical and physical needs. This emphasis results in the health care consumer's socio-cultural remaining unfulfilled because nurses were never taught how to address them. Clark (1978:4) notes that nurse-educators tend to teach students the way they have been taught. Further more, most nurse-educators do not give any attention to the values they directly or indirectly teach their students nurses, and because students look upon their teachers as role models and "custodians of wisdom" (McKeachie 1986:56), student nurses model their nursing care on what is directly and indirectly prescribed by their nurse-educators.

1.2.5 Literature regarding the Teaching of Culturally Congruent Nursing Care

Most of the literature in nursing can be divided into two categories: a) literature regarding the practitioner as a provider of nursing care, and, b) literature regarding the nursing care to be provided. Most of the existing literature in the latter category focuses mainly on specialised nursing care (e.g., critical care nursing, trauma nursing care, specialised midwifery, surgical and medical nursing care). Very little material concerned with transcultural or culturally congruent nursing care is published because it is only since globalization started to take place that transcultural and culturally congruent nursing care came to the forefront as an integral part of nursing care in the 21st century.

Thus studies regarding the teaching of cultural sensitivity (including intercultural skills) and culturally congruent nursing care are very limited and most of the articles focus on the type of care to be rendered. A total of eleven articles were found on medline searches, some of which were poorly researched (Boyle & Andrew, 1989:23). With the exception of Leininger's work (1978, 1988, 1989, 1990, 1991, 1995), the following reflect the documentation of cultural care issues: Michael (1994:14), Champion (1989:16), Herbst (1990:24). Literature

regarding the teaching of cultural congruent nursing is scarce because few nursing schools give attention to the teaching of transcultural nursing care. Nursing schools presume the novice nurse knows the science and art of transcultural/culturally congruent nursing care because the novice nurse has completed a module on culture in Sociology

Although there is increasing emphasis on transcultural care among clinicians and educators, according to Davidhizar (1999:14), nurse-educators are not orientated and educated to teach culturally congruent nursing care because of poorly researched articles in journals and scientific books on culturally congruent nursing care. Thus, because nurse-educators are unable to obtain clear information on the subject, they are not able to teach culturally congruent nursing care comfortably and therefore culturally congruent nursing care is not included in nursing curricula.

In summary it can be stated that:

- nurses are not educated to render culturally congruent nursing care; and

- lecturers in nursing are not educated to teach culturally congruent care to student nurses.

Based on the above, the following research questions were thus formulated:

1. How do nurse-educators in South African nursing education institutions perceive cultural congruent nursing care?
2. What are the implications of such perceptions in the education of novice nursing practitioners if cultural congruent nursing care is not taught?
3. Are there any guidelines which enable nurse-educators to teach culturally congruent nursing care to novice nurses?

1.3 THE AIMS AND OBJECTIVES OF THE STUDY

Based on the problem statement above, the purpose/aim of the study is to ascertain how nurse-educators at Universities and Nursing Colleges perceive culturally congruent nursing care in the South African context as well as the implications it has on the education of novice nursing practitioners.

In the light of the overall aim of the study, the objectives of this study are as follows:

1.3.1 To determine nursing lecturers' perceptions of culturally congruent nursing care in a South African context;

1.3.2 To explore the effects of the lecturers' perceptions on culturally congruent nursing care in the teaching of novice learners in nursing;

1.3.3 To formulate a model that will serve as a guideline in the teaching of culturally congruent nursing care in Nursing Education institutions.

1.4 THE POINT OF DEPARTURE UNDERLYING THE STUDY

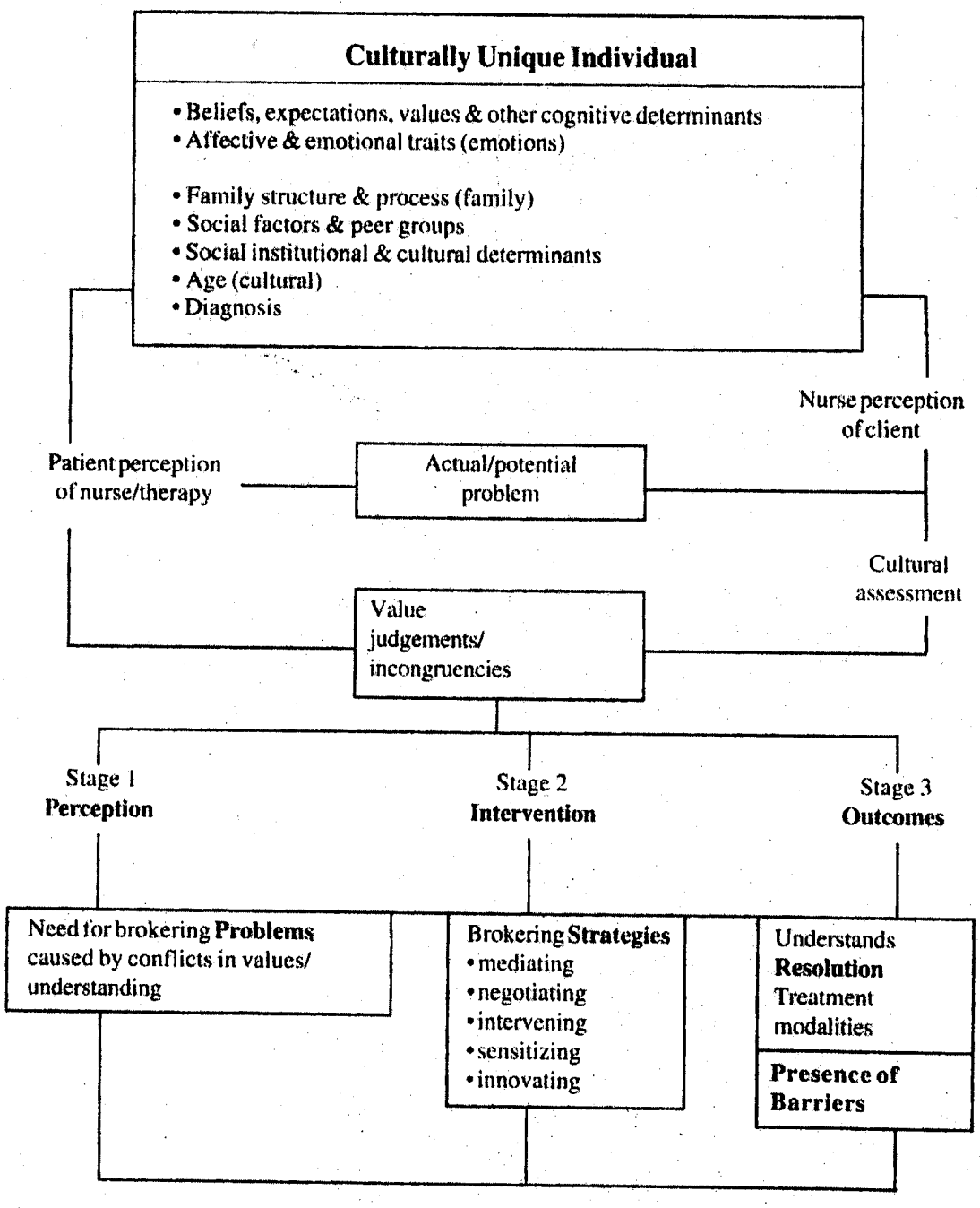
The Culture Brokering Model developed by Jezeweski for Advocacy in Nursing Science is the point of departure of the study. According to Jezeweski (1993:80), culture brokering entails "bridging, linking or mediating between groups or persons with different cultural backgrounds for the purpose of reducing conflict or producing change". The Cultural Brokering Model for Advocacy was later adopted by Chalanda (1995:19-22) as appropriate to nursing and as such described as the Cultural Brokering Model (1995:21); it will be used in this study as the conceptual point of departure since it is relevant to the context. According to Chalanda (1995:20) the broker is a person who mediates between two groups. . The main aim of brokering is to break barriers that cause misunderstanding between two persons, or groups of different

cultural orientations. In the nursing setting the brokering is aimed at preventing misunderstandings between health care consumers and health care providers, namely, the nurses. Culture brokering, therefore, assists nurses to adopt culturally appropriate communication and intervention styles (Chalanda, 1995:20)

The Cultural Brokering Model (see figure 1) focuses on the client and the health care professional thereby establishing brokerage between the provider (the nurse) and the recipient (the health care consumer). The model describes brokerage in three stages in the process: perception, intervention and outcome. The perception stage reveals the need for brokering which must be resolved through cultural assessment. The intervention stage comprises the implementation of strategies by the broker through sensitising, eliciting, negotiating, mediating and innovating with the client to resolve problems and breakdowns. Finally, in the outcome stage the client reaches an understanding through appropriate strategies. If the problems are not resolved, the assessment cycle starts again until the brokerage has taken place. A cultural broker should respect the health care consumer as a unique person and be knowledgeable about both systems, that is, the health belief system of the health care consumer and the system of health care in which the health care provider has been educated. The broker should also be able to introduce and translate ideas into the language understood by health care consumers. As such, the model shows how, despite the differences in beliefs between the nurse and the health care consumer, some form of intervention can be found to achieve care.

Figure 1

Culture Brokering Model



Adapted from M. Jezeweski's Culture Brokering Model

1.5 RESEARCH METHODOLOGY

As the research methodology used in this study is fully discussed in Chapter 4, a short overview will now be given as an introduction.

The research methodology is based on a design that is of a non-experimental, exploratory, descriptive, contextual and phenomenological nature. Reflective inquiry was the main point of departure and included focus groups, a questionnaire and an audit of the nursing curricula as data gathering techniques. Purposive sampling was done of Schools of Nursing in South Africa while the input from nurse-educators was based on voluntary participation to obtain a representative sample. The data collection process consisted of entry into the field, the collection of data and leaving the field. The results were analysed by description on the nominal scale. All ethical aspects were adhered to as set out standards in nursing and medical guidelines. Lastly, a model for the education of Culturally Congruent Nursing Care to novice nurses is described.

1.6 CLARIFICATION OF CONCEPTS

The following conceptual definitions underpin this study:

- Culture

  Culture refers to a system of learned and transmitted values, beliefs, patterns of behaviour and life style practices of particular people (Leininger 1990: 8). The art of culture is not inherited biologically but rather learned, and is transmitted from one generation to the other (Leininger 1990: 48). Culture does not belong exclusively to any individual or groups of individuals, but is acquired through socialization, and it is not race-bound (Kozier and Erb, 1988:56).

- Multiculturality

  Multiculturality embraces the concept of the existence of many cultural orientations as each group manifests certain behaviour patterns according to their own beliefs and values (Leininger, 1988:13). These behaviour patterns are not inherited but acquired through socialization. The behaviour patterns can be transmitted from one group to the other and the transmission is reciprocal (Kinney, 1994: 5).

- Race

  The biological definition of race is a purely categorization of people according to physical characteristics like skin colour, type or texture of hair (Leicester 1988: 16). The sociological perspective of race entails different grouping of population on the basis of not only colour but various ethnic divisions

- Perception

  Perception refers to the ability of the mind to refer sensory information to an external object as its cause (Knopf, 1974:242)

- Cultural Congruent Nursing Care

  Cultural Congruent Nursing Care refers to nursing care that is based on the health care consumer's cultural beliefs and values which basically determine the support to be given by health care practitioners to consumers of health care. This type of care is provided according to what the health care consumer prefers and in line with what is acceptable to the latter individual. Cultural Congruent Nursing Care and Culturally Congruent Nursing Care will be used interchangeable.

- Cultural Sensitivity.

  Cultural sensitivity describes the affective behaviours in individuals, the capacity to feel, convey, or react to ideas, habits, customs or traditions unique to a particular group of people (West, 1993:233).

- Practitioner

  Practitioner means a person engaged in practice in any profession. In this study it means the nurse practitioner registered as such by the South African Nursing Council (Act 50 0f 1978) who practices as such.

- Health care consumers

  Health care consumers refer to those individuals who are recipients of health care. Health care consumers are also referred to as patients or clients.

- Nurse- educators

  Nurse-educators refer to those educators who provide nursing knowledge to learners in nursing (Kupe, 1993:24). In this study it means the nurse-educator is a trained and licensed nurse practitioner who specialised in the teaching of nursing education.

- Novice nurses (Nurse learners)

  Novice nurses embrace all those nurse learners who seek education and knowledge in nursing subjects (Karihuje, 1986:25). They are also referred to as student nurses.

- Brokering

  Brokering refers to the process and strategies used whereby mediation, reconciliation and bridging occur to overcome differences and barriers. This leads to the understanding of the healthy/ill/disabled/dying health care consumer by the health care practitioner.

  - Educational brokering refers to the strategies used by nurse-educators to teach novice nurses the science and art of nursing.

  - Cultural brokering means the science and art of preventing conflict and achieving congruency between persons, groups and communities.

  - Health care brokering which includes cultural brokering, refers to the support (as the science and art of nursing) to be given to health care consumers by health care practitioners. This support must satisfy the health care consumers and lead to self-actualization of health care consumer as a person in his/her family and community.

- Broker

  A broker refers to the nurse-educator and/or the nurse-practitioner who is competent to do brokering because of having the awareness, the knowledge and skills, and uses them during an encounter.

- Doctrinal conversion

  Doctrinal conversion entails the process of empowering novice nurses and novice educators with the science and art of nursing. As such it enables the nurse-educator to teach holistic nursing (science) and nursing care (art) to novice nurses whereby these novice nurses are equipped with the ability to render holistic culturally congruent nursing care to health care consumers.

1.7 OUTLINE OF THE STUDY

The outline of the study is as follows:

Chapter 1 consists of an orientation to the study, which embraces the introduction, problem statement and the purpose of the study.

Chapter 2 draws the contours of the health care consumer and the nurse as human beings.

Chapter 3 consists of a literature review on Culturally Congruent Nursing Care.

In Chapter 4 the methodology of the research process is discussed.

In Chapter 5 the results and interpretation are discussed.

In Chapter 6 the findings, conclusions and recommendations are discussed.

In Chapter 7 a model for teaching cultural congruent nursing care is explicated.

Chapter 8 concludes the study.

1.8 SUMMARY

In this chapter the problem statement, the aims and objectives of the study, the definition of concepts, the point of departure of the study as the conceptual framework and the methodology of the study were discussed. In the next chapter the dimensions of human beings (both health care consumer and nurse practitioner) will be described; a literature overview of culturally congruent nursing care will also be given.

CHAPTER TWO

THE HEALTH CARE CONSUMER AND THE HEALTH CARE PROVIDER: HUMAN BEINGS IN THE CONSUMER-PROVIDER-RELATIONSHIP – A LITERATURE STUDY

2.1 INTRODUCTION

Health care has been commissioned by all cultures since time immemorial, and, as such, takes place between two human beings – the health care consumer in need of health care and the nurse practitioner who provides the necessary care. To render quality care that satisfies the health care consumer by fulfilling his/her needs, the nurse, as the broker, must be knowledgeable on both the health consumer as a human being but also of herself/himself as a human being and professional person. In the light of the above, this chapter will explore the contours of human beings – not only as biological persons but also as persons living multi-dimensional lives.

2.2 HEALTH CARE CONSUMERS AND HEALTH CARE PRACTITIONERS AS HUMAN BEINGS

Nursing, as a form of health care, is commissioned by all cultures, and, as a health care mode, it comes into existence when the health care consumer is in need of a health care practitioner who can provide the necessary health care. Thus, when health care as nursing care is

rendered, the health care provider (practitioner) and the health care consumer (patient, client) form a dyad as soon as the consumer-provider relationship has been established. Both the practitioner and the consumer enter the consumer-provider relationship (nurse-patient-relationship) as unique human beings with personalities, who live a multidimensional life within their own families and communities.

Both are human beings created by God with unique dignity and celestial destination. As human beings, they have a unique structural personality that consists of a systematic dimension (the bodily, psychological and spiritual systems) and a functional dimension (cognitive, will and affective/emotive functions) which indicates a dynamical structural-function multi-unity. According to Oberholzer (1997:28–30), as well as Meyer, Moore and Viljoen (1997:558), in becoming a human being, each party is in relationship with himself/herself, other human beings, his/her Supreme Being, the world, and on the strength of the choices he/she pursues, he/she becomes the person/human being he/she wants to be and can be.

2.2.1 A person in relation to self

From childhood to adulthood (including old age) the health care consumer and health care practitioner each, lives from out of his/her Self and wants to be somebody with his/her own identity. The essence of every person's being is constantly in a process of development because of his/her interaction with other people and the world in which s/he lives. According to Nel, Sonnekus and Gerber (1965:133-136), the choices and decisions of a person indicate how his/her "I" is formed as it is the driving force of all actions that are portrayed. This implies that the health care consumer/practitioner as a person becomes his/her personality. The personality of a person portrays or reveals the type of being he/she has

become, and, as such, comprises all the capacities, qualities and possibilities of that person as an individual.

The health care consumer, as well as the health care practitioner strives for self-fulfillment and his/her personality develops according to a specific pattern of unfolding; his/her inherent ability grows gradually and his/her acquired capacities are learned and undergo changes during his/her life time. This unfolding pattern of the inherent abilities of a personality is subjected to certain restrictions; both the health care consumer as well as the health care practitioner can only become what s/he potentially is while his/her acquired capacities are closely related to the problems and the shortcomings that occur in the environment to which s/he is exposed (Nel *et al*, 1965:117-124, Hurloch,1964:12, Cronje,1969:41-42 and Louw, Gerdes and Meyer, 1984:12).

According to Nel *et al* (1965 :117–1245), within this unfolding elapse all persons go through different developing phases that offer particular challenges and possibilities. Therefore, in every phase of life human beings must master life's developmental tasks. All persons are inseparably involved with their own development or genesis and form themselves because they decide in which direction they want to unfold and how their own limitations will be overcome (Meyer *et al*, 1997:554). According to Cronje (1969:42), and Louw (1984:12), there exist a continuity and alignment within the unfolding of a person's personality, and a person never changes so much that the person is unrecognizable.

The health care consumer and the health care provider each embraces a diversity and complexity of distinguishable, (but not separate) dimensions, namely, the physical, the psychological, the social and the spiritual. The physical dimension embraces the concrete and mortal body and both experience corporeality. The mortal body is the anatomical-physiological

structure which changes progressively in an orderly and logical pattern (Cronje, 1969:42; Nel *et al*, 1965:120)

According to Louw (1984:13–14 and 17-18), a person's duration of life is divided into different stages, characterized by different physical changes which the person is not always aware of. The person changes his/her body image often, as physical changes occur brought on by ageing, illness, being disabled or dying. Because a person's physical changes are always coupled with psycho-social development, the person experiences his/her physical self image and the meaning of his/her body in the relation to the world and his/her fellow-humans. As such, the health care consumer, as well as the practitioner, changes his/her body image often, and this is especially the case when physical changes occur because of illness and disability. Van Peursen (1970:110-126) and Meyer *et al* (1997:523) further state that in his/her relation to the world, a person experiences his/her body as an instrument or mediator (when walking, sitting, and working), and because of the body's perception value or greeting value, the health care consumer as well as the practitioner meets his/her fellow-humans as a person, and opens his/her human nature in a bodily manner.

The psyche of a person embraces his/her will, decision-making and actions, feelings/emotions, aspirations and intellect (thoughts, language, learning ability). According to Van Peursen (1970:110) the intellect dictates how a person relates to other people in the world around him/her and to his/her Creator. Since the person always participates through his/her feelings in any situation, emotions give meaning to his/her experiences, which in turn influences his/her actions and aspirations. According to Nel *et al* (1965:8) and Meyer *et al* (1997:562), the person's feelings also contribute to his/her mood which is the foundation of his/her experiences.

As human beings, both the health care consumer as well as the practitioner are as persons, according to Heyns (1974:81), Murray (SA 81) and Smit (1975:11-23), body-psyche spirit; they thus, have a spiritual dimension, namely a soul. Therefore, the health care consumer and the practitioner always live in relation to his/her Supreme Being and have a conscience with a transcendental nature. All persons (health care consumer as well as the practitioner) are constantly confronted with certain decisions and they have to make choices according to their own values and norms, their consciences for which they must individually take responsibility (Meyer *et al*, 1997:567). Nel *et al* (1965:133-136) maintains that the person's conscience enables him/her to behave in a responsible manner, thus living a responsible life in freedom and with responsibility.

Because all dimensions obtain meaning only in conjunction with other dimensions and stand in a unity with each other, the health care consumer and the practitioner never acts according to one dimension only (although s/he chooses a special dimension at a time). Thus, a person is always intentionally aimed, s/he is involved within something, focused on something as in answer to the appeal that life aims at him/her, and therefore finds the sense of his/her actions always outside himself/herself (Heyns, 1974:151). Thus, both the health care consumer as well as the practitioner lives a fulfilling life; s/he does not exist for the sake of existing, and his/her existence (that is his/her being) is the answer to his/her task commission. According to Oberholzer (1970:28-30 and 32), through his/her choices, a person (the health care consumer as well as the practitioner) becomes that which s/he can become, could become and should become because s/he lives a norm controlled life.

Everybody has his/her own life history (a past, a present and a future) and became what s/he was in the past and what s/he wants to be in the future; because s/he wants to be himself/herself, wants to be somebody, s/he forms himself/herself constantly in the present with the future in mind according to the norms of humanity from what s/he was in the past. Thus, a person will always change as s/he strives to become the person that s/he wants to be in his/her future. According to Nel *et al* (1965:111) there will always be a change in the life that is lived by the person (health care consumer as well as practitioner) as s/he finds himself/herself striving towards the future. This affirms that the health care consumer, and the health care provider, are as human beings, unrepeatable and unique, and each possesses abilities, qualities and possibilities that are different from those of others. Meyer *et al* (1997:566–569) sums this up by saying every person gives meaning to his/her life situations in his/her own particular manner and constitutes his/her own life in his/her own particular way.

2.2.2 A person in relation to his fellowmen

According to Oberholzer (1970:30), a person as a human being (the health care consumer as well as the practitioner) is in his/her origin, inseparably concerned with his/her fellow-humans and yearns for a community in whom s/he finds an alliance, fellow suffer and a fellow-assistant, and to whom s/he can be connected. Through and in his/her fellow human being, a person discovers himself/herself. Thus the self-esteem of a person develops in his/her relation to others, and through the process of socialization, a person becomes a member of a social group and acts according to the values and norms of that group. According to Louw *et al* (1984:54–64), it is through this socialization that a person learns the norms and values, roles, attitudes, beliefs, habits and customs that are acceptable in his/her society.

From birth, all persons (both the health care consumer and practitioner) are members of a variety of groups. Within his/her household circle, marriage and family life-circle, a person lives an intimate life with others. In his/her marriage affinity, a person becomes a husband or wife, and is as wife/husband more than what he/she previously was and in parenthood his/her being unfolds as a father/mother, becoming more than just a husband/wife and spouse. Parenthood brings a permanent bond and relationship in life between father and mother, on the one hand, and among father/mother and children, on the other hand. Parent and child mould each other's personalities and the parent-child-relationship is an important formative element in the development of the child's personality (Congalton, 1976:82-89).

From the time of birth, a special social status is being imparted to a person and throughout his/her life the person stands in a certain position to other people. About his/her credited statuses (sex, age, household and family status) the person cannot change much, although to his/her gained statuses the person can bring changes through of his/her membership to voluntary groups. Within these secondary groups the person forms his/her own being because s/he can identify with the group(s), conform to the norms of the group and copy them. All persons explore the world in the milieu/environment of their specific social class, and they learn class specific ideas (concerning illness and health), values and norms, and they focus their conduct in life according to standards and prescriptions of their respective groups. While all interpersonal relationships and interaction patterns in all social situations, proceed according to the prescribed codes of conduct of the cultural group, and all role-playing in every status is patronized, all persons address their particular roles from within individual manifestations of "I" and thus unlock their being human through individualized role-playing. (Congalton, 1976:141-158; Cronje, 1969:98-100). According to Roode (1968:63-78), because a person directs his/her

possibilities through his/her focus on the ethical-normative aspects being carried and directed by other people, all persons are exposed to a process of socialization. In this process of socialization each human being internalizes the core aspects of the norm pattern of his/her community as being his/her own personal value and norm system that serves as a reference framework of his/her conducts and actions.

2.2.3 A person in relation to the world

The health care consumer, as well as the practitioner, lives in both the physical/concrete world and in the socio-cultural world constituted by the members of the group he/she belongs to. S/he also lives in the psychological world of his/her own making. Since a person can only actualize himself/herself in the living world, the area where his/her life drama takes place and his/her existence is executed, every person constitutes his/her own psychological world. This psychological living world is the totality of all the relationships that the health consumer and the health care provider ties. The constituted living world grounds the becoming of a person as s/he actualizes himself/herself as a human being in conquering the world with horizons that ripple further and further outwards. The health care consumer's and the health care provider's living world is always multi-dimensional in nature because the person experiences his/her life in a historical way (past, present and future), in spatiality (boundaries and horizons) and in a positive or negative way while his/her living-space is and stays securely, recognizably and possessively interpretable to him/her. The health care consumer (and the practitioner) actively inhabits his/her living world; according to the contents of the landscape of his/her living world, s/he is a family person, a recreational person, a professional person, a church person, a cultural person, an ill person, a healthy person and a dying person (Corsin, 1979:143; Procheska, 1979:114 and Rogers in Hansen *et al*, 1982:95).

According to Nel *et al* (1965:107-113) the health care consumer and the practitioner, as human beings unfold their respective self-beings in their living world and enrich their respective personalities through all the relationships that they participate in shaping.

In their being busy with the cores of life, the health care consumer and the practitioner are always focused on the concrete world. Through learning, thinking, and being perceptive, the health care consumer and practitioner each conquers the unknown and creates his/her own living world by using the things of the concrete world while interpreting and giving meaning to it (Heyns, 1974:109-110; Kotze, 1979:102-103). According to Oberholzer (1970:76-77), a person continuously creates and recreates his/her own specific cultural possessions (material as well as non-material cultural goods of his/her group) and through the socialization process the community conveys this culture as a specific way of life to him/her, so that s/he can grow as a human being while living an organized existence.

2.2.4 A person in relation to a Supreme Being

Both the health care consumer and the health care practitioner live in relation to their God/Supreme Being. The Supreme Being speaks to a person and in this address, the Supreme Being claims him/her in full and s/he has to answer in faith, obedience and love or with slander. In this dialogue between (or relationship with) God and a person, the Supreme Being touches the person in his/her deepest being and therefore a person directs and surrounds his/her life and being from an orientation point that soars above him/her (Heyns,1974:81-89; Dreyer, 1970:33-35). Therefore, according to Labun (1987:315), a person's relationship with his/her Supreme Being is the only primary relationship of the human being; all other relationships that the person establishes find their sense in this

primary human-God-relationship. As such, Labun (1987:315) declares that "religion brings meaning and fulfillment to life itself and provides a purpose of living".

2.3 THE HEALTH CARE CONSUMER AND HEALTH CARE PROVIDER AS CULTURAL BEINGS

As human beings, both the health care consumer and health care provider, live in a socio-cultural world, living a value orientated life according to the ethos of their specific culture. Culture, according to Poggenpoel (1993:39) is the specific world-view in which a person's way of life is rooted. According to van Staden and du Toit (1995:31) the way of life (knowledge, faith, art, customs, laws, practices and other skills and habits) of a social group in a social environment constitutes its culture. Thus culture encompasses both the material cultural goods (money, equipments, art and clothing) as well as the non-material goods (definition of what is right and wrong, forms of communication, knowledge of environment, as well as the manner of behaviour and actions) and is, since time immemorial, conveyed from generation to generation. Therefore, every person's faith, values, language, non-verbal acts as well as his/her ways of conduct towards others, his/her view of illness and health, and how his/her children should be brought up, is defined by the culture he/she lives in. Hence, the values, attitudes and convictions of both the health care consumer and the practitioner, the way they think about, and experience the world, and the way they live in their world, are constituted by the cultural patterns that they have acquired (Samovar and Porter, 2000:58). Every person internalizes from childhood onwards, cultural and spiritual phenomena like ideas, thoughts and feelings, as well as behavioural phenomenon like appearances/behaviour as his/her own (Peoples and Bailey, 1991:17). It can thus be said that culture is a human

product that is not inherited genetically, but taught/transferred from generation to generation by means of socialization and education (Bond and Bond (1994:89). Furthermore, according to Peoples & Bailey (1991:20) cultural knowledge (a specific cultural group's world-view, shared social norms, values and categories within which realities are classified) is of utmost importance to the community because it is shared communally; it ensures that the group members will get along with each other and helps to prevent misunderstandings further assisting in the survival of the community.

As a member of a specific group, the health care consumer or the practitioner directs his/her behaviour according to rules (norms) that were laid down by the culture of the community he/she lives in (Boyle & Andrew 1989:13). As such, the normative component of culture embraces all norms, values and punitive measures, as well as the prescriptions of what type of social behaviour is acceptable and important, and how a person as a community member should behave. According to Peoples & Bailey (1991:21) these norms can be sub-divided into formal and informal norms. Formal norms refer to all written and formalized rules, regulations, prescriptions and laws that serve as a measure to create and maintain order within the society. On the other hand, van Staden & du Toit (1998:41) refer to unwritten conduct requirements as the social habits and customs, national habits, traditions, morals, taboos and etiquette of the culture. The informal norms are more permanent and change very seldom. These informal norms are as binding as the formal norms; deviation from these is met with specific punitive measures applied by the community. The group may ostracize anybody who demonstrates socially unacceptable behaviour. Therefore, cultural norms serve to gauge how a person's (the health care consumer's and the practitioner's) behaviour towards members of the group/community is formed and reconciled, but

cultural norms also guide the expectations from the person as a member of the community.

Since norms together with the necessary punitive measures do not always guarantee subjection, the values of a culture (in other words what is right and what is wrong, what is desirable or undesirable) are of extreme importance to any particular social group. The difference between norms and values can be explained. Thus: norms dictate the rules of behaviour, while values are the common idea/ideology about life-styles and goals that are acceptable for the person self, his/her cultural group and his/her community as a whole. Values provide a set of acquired rules/measures that enable the health care consumer and the practitioner to make choices and resolve conflicts, as well as to regulate the person's behaviour (Samovar & Porter 2002:57). When the social norms and values have been internalized by the health care consumer and the practitioner, a person automatically reacts in relation to them so that a sense of guilt or shame may develop if the other person's behaviour/manner is in conflict with his/her own and/or-shared system of values.

Because members of a particular community share a culture, the members in the community continuously interact with one another. Based on this interaction, specific social structures are set. According to Popenoe (1995:78) these positions and roles within the culture are determined by specific interactions that take place between members. As such, status is a socially determined position in a group, and a person is born into it or can be married into it. Based on the status of a person, a person must fulfill specific roles.

Culture is not static and unchangeable. In as much persons and communities are constantly confronted with new situations and problems, the culture continuously undergoes changes as people and communities make changes to handle these problematic situations. Pederson (1999:197) professes this by saying "Cultural boundaries are not static, but rather dynamic reflections of accelerated change, and interact through contact in bi-directional ways where each party learns from the other." Change, like urbanization, for instance, causes that one culture accepts another culture's values, convictions and behaviour. Cultural diffusion often occurs selectivelly, since cultural assets are occasionally not fully taken over by one culture from the other. According to Ferraro (2001:357) and Raphael and Davis (1978), the rate at which such changes take place often depends on whether the members of the group see this as superior to that which already exists. Alternatively, Pederson (1999:68) points that although certain cultural customs can change, the behaviours often stay traditional because cultural practices are habitual and certain deep rooted values and convictions change very slowly. For example, there still exist deep rooted values about circumcision by the Xhosa ethnic group. For the Xhosa people, even though hospitals avail themselves to render the surgical aspect of circumcision, the real circumcision can only be performed by male elders during initiation by the initiation school held at the mountain or in the bush. Another important aspect that should not be lost sight of is the fact that convictions that are culturally based form the basis of human thoughts, and are reflected in human actions/behaviour. As such, convictions are the concepts that a person, the health care consumer as well as the health care provider, honour regarding what is true and what is false. Pederson (1999:46) also indicates that convictions play a very powerful role in the determination of conduct and beliefs. Furthermore, convictions and beliefs seldom change and judgement of another person's behaviour occurs on the basis of the concerned person's own beliefs.

Notwithstanding the uniqueness of the culture of every society regarding customs, traditions, conducts, ideas and symbols that define the acceptable social conduct, similarities do exist in all cultures in a trans-cultural manner. As such, every culture determines its own spoken language, as well as the specific marriage- and family systems, the specific system of government, specific health-, religious-, economical and value–systems and the recreation activities to fulfill the needs of humanity. Chalmers (1990:67) also points out that, although different cultures give different meaning to health and illness/disabilities/death, all cultures show one collective quality, namely the conviction that illness is overcome by the provision of health care.

Culture, according to Peoples & Bailey (1991:25) and Boyle & Andrew (1989:21) also creates a specific perspective of the world, a world view by which is attempted to understand nature and give meaning to all events and processes in the world, as well as to explain and understand life in general. This world-view reflects every aspect of life within the culture/group, like the culture's orientation towards the Supreme Being, humanity, nature, the right of existence, the universe, life, illness, suffering, death and other philosophical aspects of importance. Because the world-view directs humanity's understanding of the world, it is reflected in the cultural convictions, the cultural patterns that are being followed and in the conduct of its members.

Although humanity's world–view is communicated through a variety of ways, religion exercises the most dominant influence on humanity's world-vision. According to Meyer *et al* (1997:646) the African world–vision is grounded in a holistic and anthropocentric ontology whereby people form an inseparable unity with the cosmos – not only a unity with the Sovereign Being but also with nature and therefore Africans from Africa live a life that is grounded in religion and can be distinguished in the daily life of the

African person. Three cosmos orders, namely the macro-, the meso- and micro-cosmos exist. The macro-cosmos is the domain where the Sovereign Being is found, as well as the ancestors and the spirits of specific chosen deceased. As such, the ancestors are important interim mediums/agents in the contact with the Sovereign Being. The meso-cosmos is the sort of a no man's land where coincidence rules. It is seated in the world of human imagination, and involves the living reality (human and animal) as well as the natural physical reality (forests, trees, rivers and so forth). The micro cosmos is influenced by the macro-and meso-cosmos and involves the domain of the individual person in his/her daily collective existence. Meyer *et al* (1997:647-649) states that the important African principles concerning the interdependence and collective responsibility of the community and the unity with nature is grounded in this domain.

According to Bond & Bond (1994:89), there exist in every cultural orientation, important life events/social events (like marriage, birth and death) that lead to a change in a person's social position which are portrayed in rituals or the so-called right of ways (rites de passage). "Rites de passage is ritualistic ceremonies which have religious significance, help both individuals and the society to deal with important changes" (Ferraro 2001:315). According to Philipin (2002), the importance of these rituals is to help a person to adjust to his/her new role while important cultural values are being emphasized and protected at the same time. Therefore, according to Mbiti (1997:110) the father, in certain cultures, names the child as it is believed that a name has to indicate how the person will bear the strains of life and as such determine the future state of the health of this person. Mbiti (1997:110) further states that every rite of way (rites de passage) consists of three stages: leaving behind the previous status (payment of lobolo/engagement), crossing to the next

phase (marriage ceremony), and finally re-admittance of a person in the community (married person).

The health care consumer as well as the health care provider is socialized by internalizing the cultural values of his/her culture. During this socialization process the health care consumer (as well as the practitioner) learns the cultural view/orientation to health, illness as well as the role behaviour regarding being healthy/ill/disabled/dying. Leininger (1978:35) concurs with the above by stating that "health and illness are strongly influenced and often primarily determined by the cultural background of an individual". From the African cultural perspective, according to Meyer *et al* (1997:648) illness is not only seen as caused by natural factors, but also caused by supernatural forces, ancestral spirits, taboo-transgressions, the violations of social rules and the omission of religious obligations. Therefore, events like illness and death are from the meso-cosmos (the world where coincidence together with the forces of evil spirits and magicians rule) where a force or power exist that penetrates the entire universe and the Supreme Being, as a creator and maintainer of humankind is the source and regulator of this force. Hence, only specific people like the priests and traditional healers may use this power/force to the benefit of the community (Van Rensburg, Pretorius and Fourie, 1992:324). Therefore, according to the traditional belief, it is of utmost importance not only to diagnose the illness, but also to determine and address all causative factors. Thus, persons who hold a more traditional view regarding illness and health give preference to traditional healers over professional health practitioners.

Furthermore all health and illness behaviour that the health care consumer and the practitioner display is also determined by their culture. According to Gilbert, Selikow and Walker (1998:48), health behaviour reflects all those activities that a healthy person will participate in, with the exclusive

purpose of preventing illness or identifying disease during the a-symptomatic stage. Illness behaviour, according to Boyle & Andrew (1989:47), refers to those specific behaviour patterns that a person who feels ill will display to define the state of his/her health while looking for an effective treatment thereof. When a person (the health consumer) experiences that something is wrong with him/her (the stage of symptomatic experience) he/she will decide that s/he is ill and then start to seek help from specific care givers. According to Mechanic (in Boyle & Andrew 1989:49) there exist a variety of determinants that influence the manner in which the health consumer will seek help. The more serious the symptom(s), the greater the chances that the person will seek help; if the symptoms upset the person's life rhythm, the person will look for help quicker. Continuous symptoms are considered more serious and the way family/friends experience the situation (their tolerance) if important; other factors that also influence the health care consumer's behaviour are the person's previous experience, knowledge as well as cultural values, all of which determine the person's experience of being sick. If a person has no money for care, s/he is inclined not to acknowledge the seriousness of the disease. His/her motivation, then, as well as the accessibility of treatment and the more stumbling blocks there are (economic, physical, cultural, psychological) influence the likelihood that the person will ignore the symptoms.

Since a person's reaction to his/her illness is mainly determined by his/her culture, the African health care consumer for whom balance between humankind and the environment is important, will therefore do anything to restore life's balance as quickly as possible when an illness or health problems occur. The sick role with its specific behaviour that the African health care consumer will display after s/he has decided that s/he is ill is acquired through the process of cultural socialization and interaction. Thus, the African health care consumer will, according to Gilbert *et al*

(1998:49), after a symptom has been recognized as abnormal, first consult his/her family, friends or neighbours (popular sector) and thereafter the traditional healer and/or professional health care provider. The popular sector includes lay care that is being delivered by non-professional people and self-care, where the person uses traditional remedies/medicines or changes his/her diet or behaviour so that his/her health can improve. If the consumer's own treatment does not help, additional aid will be looked for, either consulting a professional health care practitioner or the traditional healer. After the health care consumer is diagnosed as ill by the practitioner (either professional or traditional), the person accepts the sick role and display the sick role behaviour. Van Staden and du Toit (1995:185) state that the sick role implies that the health care consumer is exempted from his/her social responsibilities; these are now to be taken over by others, while medical advice has to be sought from experts in health care.

Based on the fact that both the health care consumer and the health care provider as human beings live within a specific culture, all cultural goods are internalized by them through education, rites de passage and socialization. The health care consumer and the health care provider during their lifespan, continuously change roles (like leaving their parents to be married and becoming parents themselves) and have to fulfill the responsibilities of the roles and statuses they have gained. Since the culture determines the rules regarding what responsibilities adhere to the status the person should execute, an African woman has no power to take decisions regarding health care because the African culture has sanctioned the patriarchal family-system valuing the husband as the head of the family in making all decisions (Rosman and Rubel, 1981:47). Furthermore, according to Bloom and Ottong (1987:100) all human beings are brought up within the cultural context of roles, ethos, work, norms and values of the specific culture – therefore the health care consumer as well

as the practitioner as cultural persons are educated persons within cultural norms. But, because literacy demands formal school tuition, the literacy of boys in most African cultures has been put over and above that of girls. Kachiwe-Sisya (2000:65) stresses this point even further when declaring "daughters' schooling is suspended to care for the ill people at home or to take charge of the house-hold". Therefore this kind of cultural orientation has put the female folk, especially among the old, into disadvantage when it comes to decision making. As this disadvantage led to dependence, a tendency has been established to delay the seeking of health or medical assistance even when it is vitally necessary.

Lastly, both Van Rensburg *et al* (1992:322) and Rosenbaum (1995:189) indicate that African people use both the traditional and Western health care systems. Thus, the African health care consumer will, when s/he feels ill, first visit the traditional healer and when the needs arises accept to be hospitalized. This practice originated because they were disappointed in the quality of care that they have received from the allopathic health care system.

2.4 THE HEALTH CARE CONSUMER AS A HEALTHY/ ILL/DISABLED/DYING PERSON

Health/illness/disability/death cannot be taken out of the life of a person without robbing life of its meaning. Health problems/illness/disability/death influence human beings in the totality of their personhood as it changes the essence of a person's being. To have health problems/be ill/be disabled/to die affects/disconnects a person's dialogues in his/her relations to himself/herself, his/her community, the world and the Creator (Oberholzer, 1964).

As the meaning of the "Self" (personhood) of the healthy/ill/disabled/dying person is locked up in the meaning of health and illness (including disability and death), health and illness as such are conceptualized in different ways and different meanings are given to health and illness. As such, health and illness are dynamic conditions in the life span of every person. A person is not static healthy or static ill, but undulates between being healthy and being ill. Illness, suffering, pain and dying cannot be taken out of life without robbing life of its meaning. Therefore, illness, health, disability and death are all conditions that form part and parcel of the life of every human being. Health is an instrument to self-actualization, enabling a person to be in dialogue with himself/herself, his/her fellow-humans, his/her world and his/her Creator. Illness/ disability/death endanger the existence of a person and disrupt his/her life dialogues. Because of his/her illness/disability/death a person has to change his/her life dialogues and reconstitute a new world of life resulting in new and changed relations to himself/herself, his/her community, the world and his/her Creator, and, because of this, the becoming/self-actualization of the person may become retarded. On the other hand, illness/disability/death may lead to growth and maturation if the person finds meaning in them (Van den Berg, 1985:22).

People are unique persons whether they are healthy/ill/ disabled/dying. As unique persons, the child's and the adult's dialogues, relations/possibilities/abilities and talents are unique to himself/herself. The healthy/sick/disabled/dying person gives his/her specific meaning to his/her life experience and from out his/her "Self", the person has to work through his/her own life situations. Thus, the healthy/sick/ disabled/dying person constitutes his/her own world of life, creating his/her own safe place to live a meaningful life. And as a becoming person, the person therefore becomes the person who s/he wants to be, must be and should be. Because no person is ever without a family, the healthy

ill/disabled/dying person influences his/her family and his/her family influences the healthy/sick/disabled/dying person (from conception to old age) (Ellerbeck, 1961:27-38).

To be unhealthy/to be ill/to be disabled/to be dying constitutes a life crisis – thus, the not-healthy/sick/disabled/dying person is an endangered person, a person (child or adult) confronted with a crisis situation compelling him/her to change his/her relations and dialogues. Therefore the health care consumer enters the health care situation as a human being and as a person-in-crisis – not as a health problem/a disease/ a disability/ a deceased, but as a human being whose personhood has been changed by health problems/disease/disability/dying and reaching out to the health care provider for help. Thus, the health care consumer does not meet the health care provider as a physical body, but as a healthy/sick/ disabled/dying human being/person who must give meaning to health/ disease/disability/death from out of the boundaries of his/her own possibilities in answering the choice of self-actualization by living a meaningful life or capitulation from life (Van den Berg, 1985:209-211).

2.5 THE NURSE AS A HUMAN BEING AND PROFESSIONAL PRACTITIONER

"Nurses are first human beings then nurses" (Wilson, 1971:213-220). Nursing is commissioned by culture and is part and parcel of life itself. As such, nurses are called to nursing because of the call of support from the health care consumer. Grounded on the nurse's knowledge, competency and life task, the nurse answers the call of the health care consumer by using himself/herself therapeutically in rendering the necessary care to the health care consumer. In their togetherness while rendering care, the nurse actualize himself/herself – thus the nurse cannot stand apart from

the health care consumer because the health care consumer is the instrument through which the nurse actualize himself/herself as person and as professional practitioner (Van den Berg, 1985:228-229).

As human beings "nurses are physically and spiritually integrated beings, created to live in harmony with God, themselves and others" (Fish and Shelby, 1978:145). As such the nurse is a person who forever develops and grows, who possesses a multitude of characteristics and possibilities and who lives a diverse and multidimensional life. Through the way the nurse lives and fulfilling his/her professional tasks, s/he reveals his/her uniqueness, his/her core being and his/her humanness as practitioner. The nurse as health care provider is his/her body and his/her humanness speaks through her body – his/her body is the instrument through which the nurse renders the necessary care (Van den Berg, 1985:226-227).

Grounded in the fact that the nurse as a person, stands in relation to his/her fellow human beings, the nurse uses the health care consumer-health care provider relationship to help all health care consumers to actualizes themselves. In the togetherness of their dialogue, the nurse not only cares for the health care consumer but also discovers himself/herself as human being and as practitioner (Van den Berg, 1985:324-371).

As the nurse exists in relation to a Creator, the nurse is an undeniable part and parcel of his/her own human development as a ethical and value-orientated person. As part of self-consciousness, the nurse takes responsibility for his/her own behaviour, acts and omissions and according to his/her own choices the nurse becomes the person and practitioner s/he wants to be, can be and must be. Thus, the nurse as a person and practitioner forms himself/herself in the present from out of his/her past to the future according to the values and norms of personhood (Van den Berg, 1985:227-227).

The nurse is an intentional-task-directed person in the world of nursing and uses the objects of health care to render the necessary health care. The nurse also creates a safe nursing world for the health care consumer and interprets the world of nursing to the health care consumer. Furthermore, the nurse also use the world of nursing to help him/her in his/her own development/growth because he/she uses himself/herself therapeutically in the service of the health care consumer (Van den Berg, 1985:443-561).

As a social and cultural person, the nurse is also husband/wife in his/her own marriage, father/mother to his/her children, member of a specific family and member of a community. Within the milieu of his/her family (born into and married into) and the community he/she lives in, the nurse as person, internalizes the values and norms of the culture s/he adheres to and complies with the rites and passages of his/her cultural heritage as well as fulfilling the roles in accordance to his/her gender, age and status (Van den Berg, 1985:227-228).

The nurse, as professional practitioner as well as nurse-educator, "in choosing an occupation one is, in effect choosing a means of implementing a self-concept" (Super, 1951). Through nursing, the nurse practitioner actualizes himself/herself as a human being/person and as professional person/practitioner because in the rendering of nursing care the nurse uses himself/herself therapeutically (as a person and as a practitioner) while the health care consumer-health care provider-relationship and interactions shape his/her personhood. As practitioner the nurse is a professional care provider, a leader and a formed identity (person). Thus, his/her professional identity is part and parcel of the nurse's Self, his/her personhood (Kotze, 1984).

The personhood of the nurse, as professional practitioner, is moulded by the content and context of the curriculum of the generic nursing educational programme and the curricula of all post-basic educational programmes s/he had studied. As such, the nurse internalize the ethos, philosophy and paradigms grounding those programmes and reflects it in the way s/he renders health care (as nursing care) as independent professional practitioner. Practicing as a member of the multi-professional health care team, the professional personhood of the nurse is also moulded by all interpersonal relationships and encounters with his/her colleagues (professional and non-professional) as well as by all health care consumers in the health care consumer-health care provider-relationship. Thus, the nurse as professional practitioner practices as an accountable and responsible person. As leader, the nurse acts as role model for others (especially the novice nurse) and his/her leading is grounded in the philosophy of value-led leadership thereby creating security for others. As a formed identity (person) and self-directed person, the nurse is responsible for the moulding of his/her own professional personhood (professional self-image) and own being to become what s/he wants to become and must become – an actualized human being and professional practitioner (Kotze, 1982 and 1984).

The norms, values and behaviours of the nursing profession are inculcated by the socialization process of nursing into the personhood of the nurse - a process which continues throughout the professional life of all nurses. Through the professional socialization process, according to Jacox (in Chaska, 1978:13), inculcation of the obligation of service delivery (as the rendering of holistic health care) to the health care consumer takes place. Thus, according to Harding and Conway (1978:146-147) the nurse as person redefines his/her Self (personhood) with the result that changes occur in the nurse as individual, in his/her role set and in his/her interactions in the world of nursing. As soon as the

nurse defines his/her own role and practice and initiate his/her own nursing care while taking responsibility and accountability for it, the nurse functions as a self-directed human being and autonomous professional practitioner. Therefore, the professional socialization of the nurse not only determines the quality of the care that is rendered, but it also influence nursing as a profession because the professional socialization process moulds nurses as persons, as professional practitioners and as leaders (Kotze, 1982 and 1984).

Male and female nurses are different from one another – based not only on their difference in gender, but also in the way they were educated culturally and in the way they were culturally socialized as children and adults. But, although male nurses are seen and experienced differently to female nurses by health care consumers (Braverman *et al*, 1970 and 1972, Bigner, 1979:37-71, Scheffer, 1980:3 -5 and Brenden, 1981), both male and female nurses are human beings sharing in the human conditions of all people. Therefore, all nurses (whether male of female) change continuously as persons and as professionals and become persons-in-crisis when these changes occur. Nurses are only able to accept health care consumers as human beings when they accept their own humanness and vulnerability. **"The acceptance of humanness of self is a permeating type of understanding – an understanding rooted in oneself and as such a part of oneself .... It is oneself. Once such type of understanding occurs, the individual is irrevocably changed ... Thus the crisis of vulnerability .... determine the nurse's capacity to realize her own humanity as well as her capacity to respond to, and care for, the human being in the ill, suffering and dying patient"** (Travelbee, 1966:47).

2.6 THE NOVICE NURSE AS PERSON AND PROFESSIONAL PRACTITIONER

As persons, all novice nurses had to make a conscious choice to become professional health care practitioners (nurses). In choosing nursing as profession, both male and female novice nurses are confronted with many role problems – females to balance the role of an emancipated career woman with the traditional role of woman and mother in a family and males to balance the role of the male within a culturally sanctioned female occupation (Benda, 1981). Furthermore, where the novice nurse enters the world of nursing, both male and female novice nurses become persons-in-crisis because of the transition from a relatively diffused and open collegiate youth culture to one which is age-graded and sexually segregated and from a kind of pluralistic heterogeneous cultural society of undergraduates to a guild-like of colleague apprentices whose occupational identities are largely unformed (Davis, 1972:14-16; Mohanoe, 1983:2). This sudden transition, according to Davis and Kroger (1989:1), leads to an identity crisis – the novice nurse starts to question his/her own abilities and choices and becomes ambivalent towards his/her self. According to Bates (1975) and Bezuidenhout (1982) this identity crisis is heightened by the fact that most novice nurses are still adolescents busy mastering the developmental tasks of adolescence while maturing into a young adult who have to master the developmental tasks of adulthood. Thus, novice nurses are uncertain of themselves, stressed out and undulating between child-like and adult-like. While working through this maturity-crisis, identity-crisis and personhood-crisis (self-crisis), novice nurses are unable to render quality health care and rely heavily on role models (nurse-educators and nurse-practitioners) to help them through this period – a period that may last eight to twelve months or even longer. Thus, personal, social and professional maturity is only reached at the end of the training period (Bates, 1975).

In attaining professional socialization, novice nurses must abandon their lay views of nursing and ascribe to those views accepted by the profession. Through legitimating and adjudication of the professional socializing process, the professional self-image of the novice nurse is developed. Co-students, nurse-practitioners and nurse-educators as well as co-workers and co-health care professionals sanction the student nurse's claim to the role and position of a nurse, while the health care consumer legitimate the novice nurse's claim when accepting his/her as a fully fledged health care practitioner. During adjudication, the role of the nurse in rendering health care, is sanctioned by instructors to be accurate or inaccurate – if inaccurate, the novice nurse is helped to change it. This cycle becomes a full circle, when the student demonstrates his/her awareness of the appropriate altered behaviour in the future. Legitimation of the adjucation process occurs when novice nurses internalize the role of the professional nurse and his/her professional self-image becomes an integral part of his/her own personal Self (Hardy and Conway, 1978:15).

Although very little is known regarding the change of the 'Self' during the socialization process of novice nurses (Burgess, 1981 and Cotanch, 1981) changes do occur. These changes are marked by "... feelings of worry, disappointment, frustration and heightened self-concern" (Davis, 1972:25) as well as ego-alienation or incongruency of the 'Self' as the 'Self' changes from expressive to instrumental (from caring to doing) as expected by the educational and practice settings. "Psyching out now occurs" (Cotach, 1981) followed by role simulation (Davis, 1972:25). Through role simulation the novice nurse internalize the approved role of nursing as inculcated by the nursing school while the professional rhetoric and symbolisms help novice nurses to acquire a professional self-concept. When the stabilization of the professional self-concept of novice nurses has taken place, their professional-identity-crisis clears, followed by the

stabilization of their own self-image. Novice nurses are now able to grow and develop as persons (Hurloch, 1955:1-345).

The professional identity of novice nurses, according to Kotze (1982 and 1984), is also formed by the educational programme s/he is subjected to. As such, the process of doctrinal conversion takes place through the structure context and content of the curriculum, the philosophies and values grounding the curriculum as well as the role behaviour and professional attitude that nurse-educators and nurse practitioners model (Smith, 1968; Burges, 1980; Cotanch, 1981 and Gendron, 1981). According to all mentioned authors, doctrinal conversion leads to a positive professional identity if the educational programme is constructed and used correctly. If this does not happen, novice nurses experience an identity-crisis in their professional self-image as seen by themselves (warm, caring, compassionate nurses) differs from what the nurse-educators and practitioners models to them (objective, scientific-orientated and technological-skilled nurses). The novice nurses' identity crisis is further heightened, according to Judd (in Travers, 1965) as well as Bregg (1958) and Wisser (1974) by the inability of many novice nurses to transfer classroom knowledge to clinical nursing practice – a situation that leads to apathy, fragmented nursing care, inflexibility and rigidity in the exercise of nursing care.

Other factors in the educational situation that also heighten the professional identity-crisis in novice nurses are the lack of role models (both in the educational situation and the practical setting) (Chalmers, 1977 and Darcy, 1980); the conflict between members of the multi-professional team members (Pellegrino, 1996 and Weinberger, 1980); the intra professional role conflict between nurse-educators and nurse practitioners (Corwin, 1965 and Kramer, 1974:11-21); the accentuating of the instrumental dimension of the nursing role (to the exclusion of the

expressive dimension) (Loprata, 1979:127-128 and Van Rensburg, 1980:53) as well as the negation of the nurse as a human being and the transforming of the personhood of nurses to become neutral, cold and impersonal persons as profession practitioners (Travelbee, 1964 and Oiler,1980:36-48) and the fact that nurse-educators educate novice nurses cognitive-scientifically correctly but model skewed values regarding humanness, compassion, rapport (Partridge, 1978). Kotze (1978) and Rabb (1976) further state that the nursing curriculum is structured on the bio-medical model which only teaches novice nurses the values of the natural sciences while Levine (1997) and Tumilty (1980) declare that the unwritten values nurse-educators as well as nurse practitioners model to novice nurses are neither challenged nor written into codes of ethics. Rottkamp (1980) also states all nursing curricula accentuate the knowledge and skills nurses must possess – not the care that has to be rendered. The curricula of nurse-educators mostly focuses on minor (ancillary) subjects and not on the nature and essence of nursing resulting in the inability of nurse-educators to choose the correct learning experience for and to model the rendering of quality nursing care to novice nurses. Kramer (1974:224) notes further that nurse-educators who suffer from "Burn-out-Syndrome" are unable to teach and model human and holistic nursing care.

In the light of the above, nurse-educators play the most important role in the socialization and knowledge empowerment of novice nurses (Leininger, 1994:18). Therefore, nurse-educators directly and indirectly determine the type of health care novice nurses eventually will render to the health care consumer (Clark, 1978:12 and McKeachie, 1986:56). As nurse-educators tend to teach student nurses the way they have been taught (Clark, 1978:4) novice nurses view the health care consumer through the eyes of the nurse-educators as an object, an illness, a problem (Wright, 1993:213, Van den Berg, 1995:117-118) whose illness/

health problem/disability/death "has to cured" – dehumanizing and stereotyping the health care consumer and robbing him/her of a meaningful life (with or without health problems/illness/disability/death) supported by the nurse practitioner (Oberholzer, 1964; Kotze, 1978; Andrea, 1992 and Meyers, 1992).

2.7 THE IMPORTANCE OF THE PERSONHOOD OF THE HEALTH CARE CONSUMER AND PRACTITIONER

The view nurses hold of themselves as human beings and as professional health care providers, and of the personhood of the health care consumer, stand central to the health care consumer-health care provider-relationship because the attitude of nurses towards health care consumers as well as the quality of the health care activities nurses render, are determined by their worldview, their view of human beings and the life philosophy nurses hold (Roger, 1951:19-64). The same principles apply to the educational setting – the view nurse-educators hold of the personhood of the health care consumer and of the nurse practitioner is modeled to the novice nurse. Therefore, because novice nurses are person-in-crisis who they need the assistance of nurse-educators to become fully fledged professional practitioners, and, as nurse-educators use the nursing curriculum to socialize novice nurses to nursing (the science and the art), novice nurses become the health care practitioners they were taught to become. Thus, if nurse-educators themselves are not taught the nature and essence of nursing and cultural congruent nursing care, they very seldom teach novice nurses to render cultural congruent nursing to health care consumers – robbing both the consumer and the practitioner of the opportunity to actualize themselves as human beings.

2.8 SUMMARY

This chapter focused on the human being as a person in relation to self, to other people, to the world and to a Supreme Bay. Attention was also paid to a person as a cultural being. Other aspects that were discussed related to the nurse-educator and practitioner as a person as well as the education and socialization of novice nurses. The next chapter will focus on the health care system and how it links up with culturally congruent nursing care.

CHAPTER THREE

NURSING AS A MODE OF HEALTH CARE – A CULTURAL AND INTERPERSONAL PHENOMENON: A LITERATURE REVIEW

3.1 INTRODUCTION

According to the Cultural Brokering Model as described by Chalanda (1995:21)[1], it is of for the health care provider to be knowledgeable on both the health care system in which the provider has been educated and in which he/she currently practices, as well as on the health belief system of the health care consumer. This will assist the health care provider, as a broker, to introduce and translate health care (as nursing care) concepts and meanings to the health care consumer to find interventions that satisfy the health care consumer enabling the latter to become self-caring.

In light of the above, it is necessary to explore the concepts "health and illness", the existing health care systems (including the health care models and the paradigms grounding the systems), as well as the nursing care to be rendered based on the humanness and cultural beliefs of the health care consumer.

[1] *Vide supra 1.4 – p11-13*

3.2 THE CONCEPT "HEALTH AND ILLNESS" – THE FOUNDATION STONES OF THE HEALTH CARE CONSUMERS' HEALTH BELIEF SYSTEM

Health/disease/disability/death is life events that exist since the creation of humanity. Health/disease/disability/death cannot be removed from life without robbing life of its meaning; no two cultures describe health and illness/disease similarly or accord the same meaning to it. The different views on health and illness vary in description from a condition, to a process, to an aspect on a continuum which fluctuates between health, illness and death. Health was described by the ancient Greeks as an ideal state which "a sound mind in a sound body require, both contributing to the good of the soul" (Roper, Logan and Tierney, 1990:4) while Galen (130AC) stated that health is a condition of average functioning with no pain experienced. Offering an alternative definition, Strasser (1965:170-177) states that the concept "health" is a normative notion. To be sick or healthy relates not only to a person's physical condition, but also to the person's ability to handle the responsibilities s/he has to execute. For Leininger (in George, 1995:37), health is a condition of well-being defined by culture, viewed as valuable and lived to the full. As such, health reflects the ability of communities/groups/individuals to execute all role activities expected by the culture in their daily living.

Paterson and Zderad (in George, 1995:304) view health as a personal means of survival and as a quality of life and death. According to the authors, all human beings possess the ability to well-being but also to "more-being". "Well-being implies a steady state, whereas more-being refers to being in the process of becoming all that is humanly possible". The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity". (Gilbert et al, 1998:7). Van den Berg (1985:66)

states that health must be viewed within the nature and quality of a person's total well-being in which his/her abilities, relations and personal experiences play a specific role. Therefore, health can be defined as a condition or state and based on the health status of the person, s/he constitutes his/her own living world, actualizes himself/herself while relating in his/her own unique way to himself/herself, to other people, to the world and to a Supreme Being. The way health is experienced cannot be explained in exclusively biological or physiological ways because health is personally and culturally defined as lived fully and experienced in full within a specific socio-cultural context.

According to the biomedical paradigm the concept illness/disease refers to an objective condition of the body whose functioning (biological or physiological and/or anatomical) has been impaired. Illness/disease is described in terms of organ-specific pathology, caused by a specific cause; it can thus be treated. During treatment the patient plays a passive role because the illness is treated and not the person as patient. Only licensed health care practitioners, therefore, may diagnose and treat ailments (Gilbert et al, 1998:7). However, because illness and health are defined by culture, Boyle and Andrews (1989:23) points out that many cultures define illness and disability in terms of and as linked to punishment, witchcraft or sins. The belief in the power of the ancestors and the magical, according to Maelane (2002:123) plays a dominant role in the perception of Africans (and all ancient cultures) regarding the causation of diseases. Traditional Africans alongside all ancient cultures, since time immemorial, had to use natural remedies to survive and, although different cultures define healing in different ways, all cultures hold onto the strong relationship that exists between healing and religion. Mtibi (1997:162) declares "disease and misfortune are religious experiences and it requires a religious approach to deal with them". Maelane (2002:123) maintains that the traditional convictions and practice,

in other words, the influence of the ancestors and the magical, have to be recognized when rendering health care.

Gilbert *et al* (1998:8) on the other hand, suggested that illness can also be defined as a personal and psychological concept as sickness relates to an individual's experience of being sick/feeling ill and because this experience is subjective, it is defined in terms of the person's own pathos. When a person is diagnosed as ill, his/her social status changes to that of a sick/ill person leading to changes in his role behaviour. Travelbee (1964:50-51) defines illness as a human experience that changes the dialogues of a person (with himself/herself, with other people, with the world and with a Supreme Being) and cannot be taken out of life without robbing life of its meaning. Illness/disability/death leads to the self-actualization and the growth of an individual. If the health care practitioner does not respect the health care consumer as a becoming person, health care (nursing care) becomes a sense of mechanical, technical procedures which dehumanize the health care consumer.

3.3 HEALTH CARE MODELS AND HEALTH CARE SERVICE DELIVERY

Based on different world-views resulting in different cultural definitions of health and illness, two specific health care models have been postulated. The professional health care providers practicing in western societies who believe in a scientifically-orientated world-view base their health care on the biomedical health care model while practitioners in societies who believe in a holistic and/or magico-religious world-view base their health care on the psycho-social (holistic) health care model. These two health care models are poles apart regarding the underlying philosophies and orientations (paradigms) that ground them, their views on health and illness the type of care to be rendered and the training of health care

practitioners. The differences in approach to health care between these models can be summarized as follows:

Table 3.1 The difference between the mechanical paradigm and the holistic paradigm

Paradigm: Biomedical care is curative orientated and the primary goal of care is treatment that begins with the assessment of the symptoms of the disease, followed by the treatment thereof. Care is divided into specialist-areas with the result that the unity of the person as human being is lost.	Paradigm: Holistic care is more than just disease and treatment, it focuses on the promotion and maintenance of health through socio-environmental and behavioral changes of persons as human beings.
TYPE OF CARE	**TYPE OF CARE**
• The health care practitioner is inclined to give advice	• The health care practitioner makes suggestions which are discussed with the client
• Care focuses on the treatment of the disease (cure) by means of technology, chemical substances	• Care focuses on the promotion and maintenance of health through socio-environmental and behavioral changes
• Treatment can only be effective if it takes place in a medical environment	• Treatment takes place in the person's own living milieu as it is beneficial to the person
• The client's own feelings and beliefs are subordinate to the expert knowledge of the health care professional	• The client is viewed as an equal partner in the care programme which results in the establish-ment of rapport and co-operation

• The health care professional takes control and responsibility for the treatment	• The client is supported to accept responsibility for his/her own health as the care must lead to self-caring and self-actualization
• Because the health care professional is in control, the client is seen as a passive victim of his disease. This leads to the disempowerment of the client	• The client is an active participant who is empowered to make informed decisions

Most communities sanction only one particular health care model and service delivery system. This results in the repression or negation of the other health care model. However, regardless the fact that only one model and service delivery system is overtly sanctioned, community members can choose to use only one health care system (either the allopathic or the traditional) or both systems, depending on their cultural view of health and illness. Although both systems are used in South Africa, the care rendered and the education of the professional health care providers is based exclusively on the biomedical health care model because the allopathic service delivery system is sanctioned by government.

3.3.1 Services delivery grounded on the biomedical health care model

According to de Villiers and Van der Merwe (1995:62) the biomedical defines health in an exclusively biological context because the nature and causation of diseases is organ-specific; it can be directly traced

back to a specific etiology like germs, virus, etc, and the treatment focuses on the body of the patient. The body of the patient is therefore regarded as a machine, the patient is passive and depended in his/her treatment, and the doctor-patient-relationship is detached. As a result, the nature of medical intervention is based on medical knowledge, technological engineering and chemical intervention because treatment is sufficient to make the patient's body better, since pathology is of central importance. The implication of the above assumption is reflected in the development of a powerful image of the role of medicine in improving health, with emphasis on:

- The treatment of organic diseases,

- An orientation towards cure with chemical substances (based on the perception that disease is an autonomous and potentially manageable entity which threatens personal health in a temporary episodic manner) because the isolated individual is the site of the disease, and

- The belief that the medical environment, whether hospital or consulting room, is the appropriate place of treatment.

The biomedical model, which is scientific in the paradigmatic perspective (Sorenson and Luckman, 1979) is far removed from the interpersonal human arena of life, since it sees life as controlled by a series of physical and biomedical processes characterized by a cause and effect relationship, that life processes can be controlled through machines, and be divided into parts that can be studied separately. Disease is mainly due to the invasion of organisms and chemical intervention is believed to be sufficient to make the patient's body better. Complications in treatment

tend to be tolerated (even if they are harmful) as minimal consideration is given to the prevention of disabilities.

The results of this approach are that the illness, rather than the person as a human being, is treated. Because the biomedical health care model places the health care consumer in the middle of a biological framework of anatomy, physiology and illness, and, since neither the influence of a person's cultural orientation, nor his/her health and illness behaviour can be explained scientifically, the latter is negated as non-existing.

As allopathic health care is based on a strict scientific framework of testing, measuring and observation with chemical intervention and technological engineering as the main form of treatment, the service delivery is only "cure" orientated. The disease/illness has to be treated and the treatment must be in line with the symptoms observed. The health care consumers' feelings, experiences and views are of no importance resulting in the consumer becoming a spectator of his/her own illness and treatment as s/he is kept in the dark. Further treatment is mostly rendered by specialist health care providers resulting in treatment that is subdivided as the health care consumer as illness/disease is viewed compartmentally.

The allopathic health care service delivery system is characterized by the acquisition and application of scientific medical knowledge and skills regarding illness and its cure. Thus, all professional medical practitioners such as physicians, nurses and physiotherapists are trained to apply only scientific medical knowledge and technology to health and healing. Within this framework the sick person is removed from the family/community and placed in a health care setting such as the hospital. The practitioners in allopathic system are recognized and sanctioned by law.

3.3.2 The traditional health care service delivery grounded in the holistic health care model

The underlying paradigm of the holistic health care model exists since time immemorial and conceptualizes health/illness/disability/death as part of life; they cannot be eliminated without robbing life meaning. Under this guise, then, optimal health is not the aim of health care but a person's optimal adjustment to life itself in the environment within which his/her life's drama is enacted, by living according to the social rules and looking after his/her own health/body (Boyle & Andrew, 1987:35). The holistic health care model views health as a balance between a person's social, natural and supernatural world (environment), and, any deviation there from, like deviant behaviour, not complying with religious practices etc, leads to physical and/or emotional unbalance (Gilbert et al, 1998:62). Health care practitioners who render holistic health care view health care consumers as human beings living multi-dimensional lives – persons in relation to themselves, a Supreme Being, their world and other people whose well-being are influenced by physical-, behavioural-, life style- and environmental factors (Gilbert *et al*, 1998:94). The health care to be rendered focuses on the prevention of disease, the promotion of well-being and the preservation of health through changes in the socio-environment and personal as well as group behaviour.

The non-allopathic health care delivery system embraces both the African traditional health care and folk medicine as well as Eastern medicine and is classified under complementary/alternative health care and non-conventional (unorthodox, natural) health care. According to the holistic health care model, health beliefs include disease/illness causation and are based on the prevailing world views held by different groups. Boyle and Andrew (1989:27) identified various health belief systems, such as magico-religious health paradigm, which emphasize supernatural forces

as the dominant factor determining health and illness because it is believed that health constitutes a gift or a reward from God. This view is also held by de Villiers and Van der Wal (1995:61) who distinguished between the magico-religious, biomedical and the holistic approaches.

The complementary/traditional health care system approaches the patient holistically, dealing with all aspects of the patient's life including the person's relationship with supernatural forces or creator, his/her relationship with other persons, the relationship with the natural world/environment as well as his/her relationship with himself/herself (any physical or emotional symptoms). The holistic practitioners provide culturally familiar ways of explaining the cause and timing of ill health and attempt to resolve them with culturally specific rituals or treatment.

The most common type of African medicine in South Africa is that which is characterized by the divine approach which can be addressed on one hand from religious spirit, and, on another hand from the ancestral spirit (Zungu, 2002). The religious approach includes faith healers or prophets as a way of reconciling Christianity with traditional culture (Green and Makhubu, 1984). According to Rothenburger (1987:1205) there is a need to take care of the whole person although this is a complex situation, and, hence, the "need for the development of multicultural sensitivity" (Jabajia-Rush *et al* 1994:350).

3.3.3 The allopathic and the traditional care systems: Two incompatible systems juxtaposed

South Africa retains, according to Foster and Anderson (1997:25), both distinct systems of health care, namely the traditional system of health care alongside the modern allopathic health care system (Chalmers,

1998:12). The two systems differ vastly from each other and very seldom supplement each other (Mellish, 1984:3). The allopathic health care system is sanctioned by the government to serve all population groups. On the other hand, the traditional health care system is popular among the African population because, according to Leininger (1978:21), all cultures in the world have some kind of folk, indigenous, generic or naturalistic lay care system that exists next to the allopathic health care system. In this connection Uys (1987:32) states that utilization of a specific health care system is always determined by the patient's perception of illness, what causes it, and therefore who and by whom his/her health my be restored. However, the traditional health care system is often criticized by professional health care providers because, as Fourie (1994:32) states, the culture of patients is continuously negated in institutions as all professional health care providers are educated and socialized according to the allopathic health care system. The two systems can be used concurrently, as long as both are helpful; if no attempts are made to accommodate whatever the person believes in, these differences constitute a conflict.

Bark *et al* (1995:39) maintain further that when care givers negate the health care consumers' cultural health and illness beliefs, the consumers, particularly those from traditional world background, may feel uncomfortable and hurt to a point where they void the allopathic health care system, and choose, as Spector (1991:79) shows, to only opt for it as the last resort. Because governments tend to sanction only the allopathic system, the health care rendered in health care institutions adheres solely to biomedical health care philosophy which excludes traditional health care philosophies (Mellish, 1984:3) with the result that health care consumers receive the same type of care regardless of their culture, health and life practices (Laryea and Masipa, 1995:10).

Based on the fact that patients' cultural orientations and needs are negated by professional health care providers, Lea (1994:310) suggested that the two health care systems should be wedded, thus allowing health care providers to fulfill the needs of patients based on both models and not exclusiveness to one model. Lea (1994:310) further maintains that the combination has to be legalized to ensure health care providers are knowledgeable on both systems. As such, the government of the day has now legalized the blending of the two systems of health care (*Sunday World*, 2003:1) therefore ensuring that the people of South Africa receive care that is culturally accepted and which is congruent with their ways of doing things. Chalanda (1995:20) also supports the combining of the two systems of health care as a better way of delivering health care services because the care to be rendered to the health care consumers will be relevant and congruent with **their needs and choices**. If this linkage of professional care and generic care do not occur, conflict and imposition result.

3.3.4 The education of health care practitioners

As health care practitioners need to be competent, knowledgeable and skilled to be able to render the necessary health care, different educational programmes for all professional health care providers have been set by the different statutory bodies within the allopathic health care delivery system. The context and content of these programmes for the education of professional the health care providers (including all nurse-practitioners) is grounded in the biomedical model, leading to accentuating of illnesses/diseases and viewing health science as the answer to all health problems. Because of this biomedical background of the professional practitioner, the health care rendered is based on the

educational philosophy(ies) learned, which negate the social-cultural needs of the health care consumer (Nyasula, 1994:35). Thus, according to Tshotsho (1993:20), professional health care providers tend to reject all traditional health care as it implies that the consumer as human being, the illness and the consumer's socio-culture milieu have to all be taken into account. Mulaudzi (2001) states further that nursing educational curricula do not teach the educators to fulfill the needs of health care consumers and communities because the former is based on the biomedical model without taking the cultural orientation of the different people of the community in consideration. Colliére (1980) states that the content of health care curricula (including nursing curricula) describes and accentuate only the knowledge and skills the practitioner must possesses to be able to render care, while **the care that has to be rendered** is seldom defined. Therefore, according to Rottkamp (1980), health care educators (as well as nurse-educators) teach mainly technical skills enabling practitioners to carry out the necessary health care procedures (accentuating the instrumental dimension of care rendering) without fulfilling the expressive dimension of health care (helping the consumer to grow as person and actualize himself/herself as a human being).

Nursing, as a profession, pays homage to specific values and norms which all nurses internalize as their own. These values and norms, which are grounded in the dominant culture in a specific society and supplemented by values from out of the biomedical model, shape the convictions/beliefs/ foundations of nurses regarding the health care to be rendered. Where more than one cultural orientation exists in a specific society, the values and norms (including the values and norms regarding health and illness) of the dominant cultural orientation are taught in the educational programmes – hence, the educational programmes for health care providers show a mono-cultural flavour rather than a multi-cultural inclination. Education is informed by the dominant culture, while the

needs of the consumers with different cultural orientations are not addressed. The result is that all health care consumers, regardless their cultural orientation, receive the same type/form of care (O'Conner, 1996). Although the South Nursing Council encourages culturally congruent nursing care, it is not taught because nursing curricula are based on mono-cultural (western) and biomedical foundations. Furthermore, Ho and Holroyd (2002) state that although the health care consumer and health care provider sometimes share the same cultural background, culturally congruent nursing care is still not rendered because health care practitioners negate their own cultural background, views, beliefs, values, practices in order to follow/adhere to the philosophy of the biomedical health care model.

3.4 NURSING: A CULTURAL AND INTERPERSONAL PHENOMENON

Nursing is embedded in life itself and is commissioned by culture because health problems/illnesses/disabilities/death is part of life itself. As such, nursing developed from out of the practice of taking care of the sick/disabled/dying person by a member(s) of his/her family. Thus, a person (usually a female family member) became a nurse because of her status/position in the family. The care rendered was extremely holistic and personal as it fulfilled all the needs (whether physical, emotional, social, religious, educational, recreative, etc) of the sick/disabled/dying person. With time, nursing care became the concern of the community and the care giving shifted away from the family home to hospitals with religious nursing orders, widows and educated men and women taking over the role of the family nurse. Although nursing *per se* developed independently from medicine, nursing became an integral part of medicine with the dawn of the 20th century (Dolan, Fritzpatrick and Herman, 1983:1-

350). Today nursing is part and parcel of the health care sciences and, like medicine, it is grounded in the biomedical health care model and its underlying paradigm. Professionally educated nurse practitioners now provide the necessary care.

Through the ages, the concept "Nursing" is perceived differently by different theorists. From the beginning of time, nursing was perceived in the terms of the role of a mother caring for her child while the early deaconesses defined nursing in terms of a commission of Jesus Christ. Florence Nightingale and Henderson defined nursing as "a caring and assisting profession" (Marriner, 1988:34-38). As new roles in nursing emerged, the World Health Organization viewed nursing in accordance with the expected changes in the health care system (Ben-Zur *et al*, 1999:1433). Smith (1983:7) views nursing care as relief from pain and discomfort to curing and healing, whilst assisting entails helping the medical practitioner on delivery of the service to the patient (Kupe, 1993:27). Orem (1980:5) views nursing as a service, a mode of helping human beings, a structure derived from actions deliberately selected and performed by nurses to help individuals or groups under their care to maintain or change conditions in themselves or their environment. As such, nursing is a concept made or produced by nurses. According to Boyle and Andrews (1989:13), nursing is mostly defined in terms of the biomedical health care model as the needs of the health care consumer are addressed in a biomedical way without considering the cultural aspects of people. The authors further state that "nurses therefore adopted a particular behavior and a way of practice in accordance with how the profession was viewed" (Boyle and Andrews, 1989:13).

In so far as nursing **always** takes place between two or more persons, the health care consumer(s) and the health care provider (as nurse practitioner), nursing is an interpersonal phenomenon because it takes place within an interpersonal context (Harms, 1981:35). As such, all nursing care situations are initiated purposefully by nurse practitioners because of their responsibility towards the health care consumer as the health care consumer's life is endangered. Thus, nurse practitioners appeal/call to health care consumers to explain life and death to them. The health care consumer answers the call/appeal of the nurse on the grounds of his/her need to be helped, his/her need for security and his/her need to actualize himself/herself, regardless how grey his/her future may be. The nurse uses himself/herself therapeutically in the health care consumer-health care provider relationship to support the consumer and his/her family to become independent and actualize themselves through living a meaningful life (or by supporting the consumer to die a dignified and human death while supporting his/her family in their crisis situation). Thus, all nursing activities are focused on the call/destiny of the life of a person in supporting the health care consumer to actualize himself/herself as a human being (with or without health problems/illnesses/disabilities) or to die a peaceful and humane death. Therefore, nurse practitioners need to be knowledgeable, skilled and normative orientated to render this extremely personal and interpersonal nursing care.

The nurse practitioner and the health care consumer meet one another in their uniqueness of their personhood and do not disclose themselves as bodies to one another but as human beings in the structures and fellowship of the health care consumer-health care provider-relationship because the consumer and the nurse practitioner are co-founders/co-members of the relationship. As such, the health care consumer-health care provider relationship is the only instrument available to the nurse practitioners to render the necessary personal support and nursing care.

Therefore, the nurse practitioner has to use himself/herself therapeutically as well as his/her knowledge and skills to support the health care consumer to live a meaningful life or to die a peaceful and humane death. By using his/her self therapeutically in the service of the health care consumer and his/her family, the nurse practitioner transforms the science of nursing into the art of nursing.

All nursing care activities have to adhere to the norms and values of the profession of nursing, of the culture and of all interpersonal relationships. As such, nursing care is only meaningful if it takes place within the context of health care consumer-health care provider-relationships and is family-centered. Therefore, the role and tasks of all nurse practitioners must be of such a nature and quality that they support the health care consumer and his/her family to live an independent and meaningful life within their limitations.

As nursing is embedded in life itself and commissioned by culture, nursing is also a cultural phenomenon. By being commissioned by culture, nursing (as a form of health care) becomes a non-material asset of all cultures in the world. Thus, the ethos and professional practice of nursing is based on and regulated by cultural norms and values, beliefs, ideas, behavioral phenomenon and traditions. Furthermore, all nursing care to be rendered, has from the beginning of the world also been defined by culture based on the cultural beliefs and practices regarding health and illness.

Although nursing care situations are constituted by nurses, the nurse-consumer dyad is formed by two human beings – the health care consumer, as a cultural human being, who needs care and the nurse, as a cultural human being, who provides and renders the necessary care. If the cultural orientation of the health care consumer and the cultural

orientation of the health care provider are the same or very similar, conflict very seldom occurs. But, according to Uys (1986:16) cultural conflict can occur when the cultural orientations of the health care provider and the health care consumer differ because the kind of nursing care preferable to the health care consumer may be totally different from what the health care provider renders. West (1992:91) also sites that this conflict is strengthened by the fact that every one regards his/her culture as the best – the nurse provider renders care from out of the culture of the nursing profession while the health care consumer's expectations regarding the care to receive, is grounded in his/her specific culture/beliefs, worldview and health-illness-practices. Lastly, nursing as a cultural phenomenon also relates to the fact that nursing as a profession, has a culture of its own. All acts of nursing are rendered in accordance with a prescribed set of values, rules, attitudes and practices. All novice nurses are socialized into the culture of nursing on entering the nursing profession. During this socialization process all novice nurses, because they come from different backgrounds, are expected to shed their old values and ideas and adapt to scientific concepts, new attitudes and new behavioral patterns in line with the culture of nursing (Spector, 1994:18). As such, Boyle and Andrews (1989:50) declare that nursing is said to be "one of the largest health subcultures".

Nursing further consists of a science and an art. The science of nursing constitutes the comprehensively integrated scientifically-based knowledge of health sciences, behaviour sciences and caring sciences. The art of nursing consist of an ensemble of care and cure activities – the care activities aimed to fulfill the needs and maintain the daily life of the health care consumer, whilst the cure therapeutic activities help the consumers to be come self-caring for himself/herself, their families and their communities.

3.5 CULTURALLY CONGRUENT NURSING

To support the health care consumer to become what s/he wants to become, must become and should become it is necessary to render nursing care that satisfies the health care consumer. To achieve this end, the kind of care to be rendered must be preferable to the health care consumer – according to his/her cultural beliefs, convictions, norms and values, health behaviour and multi-dimensional lifestyle/pattern. Thus, all nursing care must be, according to Leininger (1990:36), culturally congruent and culturally acceptable to the health care consumer's expectations. Rosenjack-Burchum (2002:11) defines culturally congruent nursing care as care rendered that is meaningful and fits with the cultural beliefs and life ways of persons. De Santis (1992:36), Mikhail (1981:114), Champion (1984:336) and Mechanic (1987:78) all stress the importance of cultural sensitivity for relevance of care that has to be provided by the nurse practitioner to the health care consumer to avoid any incongruence brought about by impositions and ethnocentrism. By implication, culturally congruent nursing care will not be rendered if the care is imposed on a consumer who is expected to receive it from a provider who is ethnocentric. Ethnocentrism refers to the situation where health care providers regard the culture of their profession(s) as superior to that of the health care consumer (Boyle and Andrews, 1989:53). Cultural imposition due to ethnocentrism is now experienced by the health care consumer leading to cultural shock, culture conflict and cultural clashes between provider and consumer (Leininger, 1978:31).

As culturally congruent nursing care is a specific mode of nursing care it can only be distinguished as a specific form of nursing but cannot be differentiated from nursing. Culturally congruent nursing care is grounded in nursing and is thus an interpersonal and cultural phenomenon.

Culturally congruent nursing care is, furthermore, also embedded in the same set of principles and values as nursing. The science and art of nursing grounds culturally congruent nursing care although specific points of departure are supplementary to the science and art of nursing.

3.5.1 The science of culturally congruent nursing

Since most of the science/concepts of nursing have already been explained, only the most important aspects of culturally congruent nursing care supplementary to nursing will now be discussed. The foundations of nursing such as the ethos and professional practice, philosophies, the act of nursing itself and biomedical and behavioral science knowledge are the same as nursing.

The theoretical grounding of nursing is applicable in totality with the theories regarding the culturally congruent nursing care supplementary to it. Supplementary to the nursing process is:

- The cultural needs assessment;
- The cultural interventions including cultural diagnosis; and
- The cultural outcome(s).

The following must be supplementary to nursing:

- The holistic health care model as primary paradigm and the supplementary philosophies grounding it;

- The contextual nature of nursing (nurse-patient-relationship, use of self, self-actualization);

- The nature and essence of nursing;

- The health care consumer as a human being living a multi-dimensional life;

- Health and illness/disability/death as existential phenomenological and bio-physical concepts;

- The influence of health/illness/disability/death;

- The personhood and family and community of the health care consumer;

- The holistic and biomedical health care models, the paradigm underlying each model, its integration in rendering care and the health care systems underlying it;

- The axiological, agogic and anthropological values underlying the nature and essence of nursing as cultural congruent nursing care;

- The science and art of nursing and culturally congruent nursing care; and

- The vision set by the Nation Department of Health for health care rendering in South Africa.

Culturally congruent nursing is not only scientifically grounded; it also has, as a discipline of nursing, its own models/theories/approaches that ground it. Therefore, it is necessary to describe those models/theories/ approaches that are of utmost importance to the study.

3.5.1.1 The theory of culture care diversity and universality

The theory of culture care diversity and universality, as described by Leininger (1991:35), focuses on the description, explanation and prediction of culture care similarities and differences with the aim of rendering human care. The theory further emphasizes that all nursing care must be based on human nursing care and culturally congruent nursing care knowledge in order to be effective in caring for diverse cultures.

In describing the theory, Leininger uses the sunrise model, which depicts an overall world view of cultural and social structures and the dimensions that influence cultural care in an inter-related holistic way to explain cultural nursing.

As cultural care is influences by diverse cultural and social dimensions such as educating, religious, philosophical and technological factors, and all these named dimensions must be assessed in order to preserve, negotiate and restructure culturally congruent nursing care within the work view and health belief of health care consumers. The linguistic terms in which these dimensions are expressed and the environmental context in which they are seen must also be taken into account because it has an impact on care patterns and the health or well being of individuals, families, groups and institutions that hold diverse health beliefs. Because of the existence of different health care systems, nursing care could either

be of a folk type or a professional type. In adhering to both types of health care, the care provider therefore must make nursing care decisions and taking care actions to preserve or maintain cultural care, to accommodate or negotiate culture care, and to re-pattern or restructure culture care so that the care rendered/offered is culturally congruent to the health care consumer. Leininger (1991:35-36) states that nursing care must be based on human nursing care and culturally congruent nursing care knowledge, as to be effective in caring for diverse cultures. Human care is viewed as nursing care that takes the cultures and individuals into consideration. Furthermore, all nursing care actions and decisions will only result in congruent care if there is recognition and respect of cultures and values of people. Therefore, culturally congruent care considers culture as an important tool in preventing cultural imposition and cultural care conflicts (Leininger, 1991:41). Based on the above, culturally congruent care leads to human nursing care as it prevents negligence of the different cultures of the health care consumer.

In summary, it can be said that the goal of this model is to help nursing care providers to render culturally congruent care that is beneficial and satisfying to all people the nursing profession serves. The context in which congruent care is provided is based on how "different or similar the generic or traditional care system and professional one are" taking into consideration all the dimensions of diversity and universalities of a culture as the basis for the rendering of culturally congruent care (Leininger, 1991:37)

The two major types of health care systems could be capable of providing human care that is personally satisfying, beneficial and congruent with the values and beliefs of the health care consumer. Professional care might not always be congruent with the health care consumer's generic care. Thus, the health care provider would be challenged to recognize that and

make changes that will be appropriate to the health care consumer's care. What is similar or different would have to be discovered by the nurse practitioner.

Summarizing the holistic aspect, the differences and similarities are conceptualized further in that "there are values, beliefs and practices which may differ or be similar" (Leininger, 1991:36), and which can determine the differences and similarities in which care is expressed.

3.5.1.2 The Culture Brokering Model

The Culture Brokering Model, as developed by Chalanda (1995), addresses how differences in culture impact on health and how these differences can be reconciled by using brokering by a cultural broker. A cultural broker is a "person who mediates between cultures" whether as a nurse or in any other capacity (Chalanda, 1995:19). The model addresses strategies that can be used to "break barriers that cause misunderstanding between the patient and the care provider" (Chalanda, 1995:20).

Based on the fact that in a multicultural environment barriers do occur between health care consumers and health care providers, the model focuses on the client, health professionals and the different types of care. The key aspect of the model is based on breaking the barriers by bridging between two diverse health beliefs and types of the lifestyles and then reaching a compromise with a newly formulated strategy (Chalanda, 1995:20). The model emphasizes the process of brokering by using "perception, intervention and outcome mechanism" (Chalanda, 1995:22).

The philosophies which undergird the model include the paradigm that the health care consumer is a culturally unique individual who has his/her own beliefs, expectations, values and practices about causes, diagnosis and treatment of illness. The individual is also a member of a group, be it a family or social group. The individual adheres emotionally to his/her beliefs and values, and these are cherished by the group. The individual's beliefs, values and practices are in turn influenced by his/her family (its structure and process), peer groups, social factors as well as social structures that s/he interacts with, and other cultural determinants like age. As a result of these influences and the accompanying emotional adherence to beliefs, values and practices, the individual develops certain perceptions about health/illness/disability/death and life in general. Chalanda (1995:19-22) conceptualizes further that all symptoms have cultural meanings and that people interpret and respond differently to symptoms. She, therefore, insists that in order to be effective in providing care, nurses should include a cultural assessment as part (including age, gender and ethnicity) of the assessment of the patient (Chalanda, 1995:20). Based on this assessment, the nurse will now use brokering as the main factor to alter dimensions of care that the patient receives and connects the patient with the cultural supports "that enhance coping responses to illness experience" (Chalanda, 1995:22).

Furthermore, the health care consumer's choices and perception of care and treatment may differ from the nursing practitioner's. These differences in perceptions can lead to either a potential or an actual problem since either part views the other person's perceptions as being incongruent with his/her beliefs and values (Chalanda, 1995:22). Therefore, in order for the cultural broker effectively broker s/he must conduct a cultural assessment at the beginning of the treatment, so that the nurse as broker can be able to judge the health care consumer's values and understand the incongruence that could occur.

Brokering takes place in three stages namely (1) the perception stage where the nurse becomes aware of the need for brokering because of problems caused by conflict in values or understanding; (2) intervention where brokering takes place by mediating, negotiating, intervening, sensitizing and innovating; and (3) the outcome stage when the nurse and the consumer reach understanding and resolve treatment modalities.

The following core concepts undergird this model:

- Culture brokering which, according to Chalanda (1995:20), means the act of bridging between or among cultures to prevent conflicts in care and achieve congruency, linking or mediating between groups of persons for the purpose of reducing conflicts or producing change. Brokering, in this model, focuses mainly on "bridging between folk and biomedical care" (Chalanda, 1995:20);

- Bridging which means narrowing the cultural differences between the patient and the nurse;

- Cultural uniqueness, which entails recognition of the culture that is exclusively unique to a particular group; and

- Culturally appropriate care which is the care that is provided according to the values and the beliefs of the patient.

3.5.1.3 The Cultural Bridge Model

The Cultural Bridge Model was developed by West in 1993 and emphasizes cultural bridging. The goal of this model is "to maintain cultural differences and uniqueness while having a relationship with people of different cultures" (West, 1993:232). Bridging between and among cultures takes place through "mutual respect so as to facilitate effectiveness into plan of care" (West, 1993:232).

Hence, West (1993:233) claims that each culture is worthy of high esteem and regard, and does not need to be modified. Thus, respect must be the foundation in nursing care if bridging between cultures to occur. Therefore, to render meaningful and holistic nursing care, ways must be built to bridge gaps between cultures without necessarily changing any culture, or obliterating the cultural uniqueness of any culture.

Lastly, West (1993:234) stresses that before bridging can occur, an awareness of cultures must exist, and this can be achieved through culturo-assessment. Bridging occurs through four avenues:

(i) assimilation that encompasses conformity and allowing absorption of specific cultural traits by a dominant culture, e.g., by allowing the patient the treatment of his/her choice because it is more effective, whilst using other prescribed measures;

(ii) integration which entails the specific traits which are similar, are grouped together, e.g., equal amounts of treatment from each culture must be provided;

(iii) education as learning what happens during the integration of two cultures; and

(iv) tolerance, implying refraining from opposing a particular culture but not necessarily accepting it.

3.5.1.4 The Cultural Competence Model of Care

The Cultural Competence Model of Care was specifically developed for education because the goal of the model is "to provide nurse-educators with the framework of teaching nurses on how to deliver culturally competent care to patients/clients" (Campinha-Bacote,Yale and Zuck, 1996:22). For nurses (novice and graduated) to be culturally competent, they need instructors who are culturally prepared so that they can guide the students. Campinha-Bacote *et al* (1996:59) define culturally competent care as that which is sensitive to issues relating to culture, race, gender and sexual orientation. As such, the culturally competent care model is structured to take place in four stages, namely:

(i) first cultural awareness;
(ii) cultural knowledge;
(iii) cultural skill; and
(iv) cultural encounter.

Although these components are independently mentioned, they are intervowen and do not necessarily follow one another. The possibility of all components occurring at the same time is not excluded. Based on the model, cultural awareness is defined as the deliberate and cognitive process in which a nurse becomes appreciative and sensitive to the values, beliefs, life ways, practices and problem-solving strategies of the client's culture. Cultural knowledge is defined as the process in which the nurse seeks out and obtains a sound educational foundation concerning

various world views of different culture. Cultural skills are defined as all the dimensions and structures involving the process of learning how to conduct a cultural assessment while the cultural encounter is viewed as the process that allows the nurse to directly engage in cross-cultural interactions with clients from culturally diverse cultural backgrounds.

Lastly, the authors emphasize/stress that this model **must** be taught to nurse-educators because if educators are not culturally competent, they cannot model culturally congruent nursing care to students in the clinical situation (Campinha-Bacote *et al*, 1996:630).

3.5.2 The art of culturally congruent nursing care

The exposition of the content and context of culturally congruent nursing care grounds the aim of culturally congruent care as "the rendering of holistic-cultural nursing care that satisfies health care consumers of different cultural orientations". To render holistic-culturally congruent nursing care, the holistic health care model and its underlying paradigm is taken as point of departure because it acknowledges the influence of cultural convictions, rituals, views and values as well as individual, familiar and societal health care practices in the rendering of health care as nursing care. However, the rendering of holistic nursing care must also take biomedical facts in consideration in order to render comprehensive nursing care. Thus, the exposition of the art (practice) of holistic-cultural congruent nursing care is based on an eclectic approach to different theories/models/approaches to be applied as comprehensively as possible during the data gathering, the intervention and outcome phases. (See table 3.2 for an exposition of the interrelatedness of different nursing care processes).

Table 3.2 An exposition of the interrelatedness of different nursing care processes

	Nursing Process	The Sunrise Model	Cultural Brokering Model	Cultural Bridging
ASSESSMENT	Assessment of: • Biophysical dimension of health; • Psychological dimension of health; • Social dimension of health; • Environmental dimension of health; • Behavior dimension of health; and • Health care systems-factors Diagnostic phase: • Wellness-diagnosis; • Need-focused diagnosis; and • High-risk diagnosis	• Culturo-assessment of the influence of cultural and social structure dimensions like technological, religious & philosophical, kinship and social, cultural values and life ways, political and legal, economic and educational in their language and environmental context on the health of individuals, families, groups and institutions	Culturo-assessment of a culturally unique individual based on the person's perception of • Beliefs, expectations and other cognitive determents; • Affective and emotional traits; • Family structure and processes; • Social factors and peer groups; • Social institutions and cultural determinants; and • Age (cultural) Making a cultural diagnosis	• Culturo-assessment of observed activities; and • Culturo-assessment of different heath care consumers
CARE RENDERING	• Planning and rendering care (care and cure) based on the needs of the health care consumer through prioritizing, setting of aims, criteria for evaluation, selecting of care modalities, individualization of care activities and execution of care activities	• Service delivery by diverse health care systems: Folk, nursing and professional systems; and • Nursing care rendering based on care decisions and actions to render cultural care	• Provider's perception of the need for brokering based on problems caused by conflict in values/understanding and value judgments/incongruencies; and • Intervention based on brokering strategies of mediation, negotiation, intervening, sensitizing and innovating	• Attainment of sensitivity, cultural respect and trust; and • Bridging the gaps that are observed
OUTCOME	• Evaluation of the health care outcomes (verification of consumer satisfaction); and • Nursing process outcome (verification through evidence based care rendered)	• Culture congruent care	• Patient understands the resolution and treatment modalities; and • Presence of barriers lead to repetition of process	• Assessment of outcomes of bridging

As the art of holistic-culturally congruent nursing has not yet been fully described, the following phases have been identified when rendering holistic-congruent nursing care namely:

- The data gathering phase;
- The phase of culturally congruent health care brokering; and
- The outcome phase.

The aim of the data gathering phase is to assess the health care status (including paving the way to facilitate perception of the shared socio-cultural systems of beliefs, behaviours, values and meanings) of individuals, families, groups and communities. Clark (2000:336-339), Leininger (in George, 1995:373-378) and Chalanda (1995:19-22) all state unequivocally that culturally congruent nursing care can only be rendered after a comprehensive assessment has been made of all biomedical facts and socio-cultural facts. The aim of the brokering phase is to help/support health care consumers to become self-caring (whole or partial) leading to self-actualization as human beings. According to Orem (in George, 1995:123) the health care consumer is not a passive receiver of care but an active participant in the care rendering process. The aim of the outcome phase is to evaluate whether the health care consumer has actualized himself/herself as a person; only after this assessment can it be said that the health care brokering and bridging activities as well as the health care brokering activities have been successfully executed and the aim of culturally congruent nursing care achieved. (See table 3.3 for the culturally congruent nursing care process)

Table 3.3 The culturally congruent nursing care process

The aim of the culturally congruent nursing care process (culturally congruent health care brokering) is to render comprehensive holistic care that is congruent with the cultural orientation of the health are consumer.

Phase 1	**DATA GATHERING**
Aim: Assessment of the health status and socio-cultural systems of beliefs, behaviors, values and meanings	Data gathering based on subjective data, objective data, historical data and present as well as data regarding biomedical and socio-cultural dimensions of life of individuals, families, groups and communities. ➥ Biophysical dimension of health • Genetic inheritance including physical differences derived from genetic make-up that have health implications; • Anatomical structure including attitude towards body parts; • Physiological functioning including attitude towards physiological functions; • Maturation; • Age; • Wellness/abnormal functioning/failure of body organs; • Beliefs and attitude regarding health/illness/ disability/death including folk illnesses and mental illnesses; • Beliefs regarding cause and treatment of diseases including preventative, promotive, curative and rehabilitative practices; and • Familial attitudes to health/illness/disability/ death.

	➡ Psychological dimension of health • Internal psychological wellness of individuals e.g., mood, intellect, libido, self respect, knowledge, personal space • Familial health: ➢ Structure of family life; ➢ Individuals versus group goals; ➢ Authority and decision-making; ➢ Attitude to change; ➢ Value of children and their socialization; ➢ Family roles and adaptability; and ➢ Kinship ties, family centeredness, extended family. • External psychological milieu: ➢ Technological factors and their influence; ➢ Religious factors and their influence; ➢ Political and legal factors and their influence; ➢ Economic factors and their influence; and ➢ Educational factors and their influence. ➡ Social dimension of health • Social, cultural and community structures; • Personal, social and cultural values and norms; • Personal and familial relations with the larger society; and • Interpersonal and social relationships and rules governing these relationships. • Language ➢ Spoken and non-spoken, meaning and context; and ➢ Reticence, titles, epithets and gestures.

	• Appropriate demeanor in interpersonal relationships ➢ Acceptable/unacceptable behaviour; and ➢ Modes of address (formal and informal) • Acceptable behaviour regarding health/illness/ disability/death/life events (e.g., pregnancy, labour, childbearing)/passage de rites • Social health ➢ Pathology, competitiveness, subcultures, fads, social isolation. • Time orientation (personal and social); and • Religion and magic ➡ Behaviour dimensions of health • Lifestyle factors that promote health or lead to ill health/disability/death, e.g., consumption practices, occupation, recreational practices, sexual practices, safety practices, embedded in the cultural, familial and personal points of departure; • Way of life and life events in communities and families; and • Attitude and use of alcohol, drugs and tobacco. ➡ Environmental dimensions of health • Endemic and epidemic diseases; • Pollution (air, water, ground); • Plants (poisonous and pollens); • Water (clear, river, dam); • Energy supply (origin of fuel, nuclear energy, wind energy, hydro energy); • Sanitation; • Insects and animals (domestic and wild);

	• Climatic conditions; • Industries and businesses (light and heavy); • Transport; • Buildings (houses, malls); • Mining of light and heavy metals (including radiation); and • Geographic isolation of communities ➡ Health care system • Factors in the health care system that have a positive or negative influence on health, e.g., equity, comprehensiveness, efficiency, acceptability, affordability, accessibility; • Making use/not making use of the allopathic health care system; • Making use/not making use of the traditional health care system; • Economic support mechanisms for service delivery (public sector, private sector, medical aid); • Delivery of services in urban and rural areas; • Perception of care and cure health care modalities (chemical/physical, technological, engineering); • Perception of service delivery and professional practitioners; • Perception of traditional and allopathic health care system; and • Referral practices between the two health care systems.

Phase 2	CULTURAL CONGRUENT HEALTH CARE BROKERING
Aim: To support the health care consumer to actualize himself/ herself by becoming self-caring (die a humane and dignified death)	During this phase the following activities have to be conducted: (a) The data must be analyzed and validated (if possible) to make a culturally congruent nursing care diagnosis. The nursing care diagnosis will consist of two (2) parts/sub-diagnosis namely: • Health care brokering based on the needs of the individual/family/group/community and formulated as: ➢ Wellness diagnosis – the promoting of health and the prevention of ill health; ➢ Need-focused diagnosis bases on curative and rehabilitative care activities to be taken; and ➢ High-risk diagnosis implicating the possibility of health problems based on risk factors. • Socio-cultural brokering diagnosis based on value and judgement incongruences/conflicts/ understanding that needs brokering strategies to be formulated as well as indication of what health care system to be used (allopathic, traditional or both). (b) Planning and implementing the nursing care interventions • All cultural health care brokering interventions must be rendered on primary, secondary and tertiary levels based on the prioritization of the

	diagnosis, the setting of aims (self-care) the setting of criteria to evaluate the outcomes, the selection of the best modality(ies) of care, the individualization of the interventions and the planning for the evaluation of the health care brokering and cultural brokering outcomes as well as the quality of care rendered (process-evaluation); • The cultural brokering interventions must be based on the brokering strategies of mediating, negotiation, intervening, sensitizing and innovation; • The cultural care interventions must include culturally preservative/maintenance actions, cultural care accommodation/ negotiation actions and cultural repatterning/ restructuring actions; and • The health care brokering interventions must be based on care (daily living activities, developmental self-care activities, health care activities to help the consumer to constitute an own living world within the limitations of his/her health problems/illness/disability/death) and cure (therapeutically) activities with/without the support of the health care practitioner. • During the execution of the planned interventions, attention have to be given to the following aspects: ➢ The identification of the most suitable person to execute the intervention (health care practitioner, member of the family, health care consumer self, support person);

	➢ Delegating the necessary authority and responsibility to the assigned person to execute the interventions or refer to other resources; ➢ Identifying the limitations which will have a negative effect on the execution process while taking steps to change or rule them out; ➢ Creating a therapeutic environment for the positive execution of the interventions; ➢ Communication of the interventions to be executed, to all involved with care rendering; and ➢ Execution of the interventions (health care and cultural/bridging activities) and the documentation thereof.
Phase 3	**THE OUTCOME OF THE CARE RENDERED**
Aim: To evaluate whether the aim of the cultural-holistic health care brokering has been achieved as well as to evaluate the quality of care that was rendered	The last phase is the evaluation of the outcomes reached after the interventions have been executed. ➡ Evaluation of both the health care brokering (care and cure activities) and the cultural brokering (understanding by the health care consumer) outcomes has to be done because only the health care consumer can indicate that the care rendered, had satisfied him/her as it helped him/her to become what he/she wants to become, must become and should become (self-actualization of the consumer); and ➡ The process of the evaluation of the quality of the health care that was rendered is based on the evidence reflected in the necessary documentation.

Since nursing is an interpersonal phenomenon, and because the health care consumer-health care provider-relationship embraces all the health care that are rendered, Peplau (1952:16) emphasizes that if the health care consumer-health care provider-relationship (nurse-patient-relationship) does not exist, the nursing care rendered loses its/has no meaning because nursing then has become a conglomeration of mechanical procedures carried out on the patient. Van den Berg (1985:304) declares that the nurse practitioner can only actualize himself/herself as human being and as health care provider if s/he uses himself/herself therapeutically by fulfilling both the instrumental and the expressive dimension of nursing care. According to Chalanda (1995:20) the nurse practitioner uses himself/herself therapeutically when acting as cultural broker for the health care consumer by being culturally sensitive, culturally relevant and culturally accommodating when rendering culturally congruent nursing care that is satisfying to the health care consumer whereby he/she is enabled to actualize himself/herself by becoming self-caring. Another aspect of importance, according to Peplau (1952:290-294) as well as Fitzpatrick and Whall (1996:57), is language as a tool in intercultural communication and care rendering. Ahovan and Potter (2000:23), Dewer (1997:25) and Pederson (1999:64) declare that if the health care provider communicates ineffectively and shows ethnocentrism, the health care consumer-health care provider-relationship disintegrates. All forms of communication (whether verbal, non-verbal or written) are of utmost importance in the rendering of culturally congruent nursing care through cultural brokering and/or cultural bridging because misunderstanding leads to the breakdown of all interpersonal relations between the consumer and the provider. The end result is the disintegration of the personhood of the health care consumer and the untherapeutic use of nurse practitioner's himself/herself (Van den Berg, 1985:403-406).

3.6 THE IMPORTANCE OF THE CONCEPTS DISCUSSED

South African society is multicultural as indicated earlier. There are also a variety of sub-cultures among the people in the country. That means health care consumers of different cultural backgrounds have different preferences and expectations regarding the health care they have to be accorded. Leininger (1991:63) emphasis that nursing is care and care is culture. According to this author care is only relevant if it is offered according to the values and beliefs of the health care consumers.

People tend to cling to their cultural roots, and if they do not receive the health care that is congruent with their expectations, they may recent the type of health care provided to them either in institutions or at community level. It is therefore important for health care providers to understand what health care consumers expect. Health care providers who fail to understand consumers may label these consumers as Leininger (1978:25) states, as being difficult, indifferent and uncooperative. This in turn may result in the failure of health care delivery as the health care consumers may become dissatisfied with the care, thinking that their preferences have been violated.

Care can only be regarded as quality care if it, as Chrisman (2000:22) states, is congruent with the needs of the health care consumers. Leininger (1991:35) further states that it is also unethical to provide a person with the care that is not congruent with his/her values and beliefs. Thus, the knowledge and implementation of cultural congruent nursing care is the only solution to proper health care to consumers of diverse cultural backgrounds.

Based on the above, the concepts such as health and illness, health care systems, based on the underlying paradigms, as well as nursing as an interpersonal and cultural phenomenon and cultural congruent nursing care theory and practice were discussed.

3.7 SUMMARY

The theoretical grounding of the concept health and illness, the description of the different models used as framework for understanding health and illness, the health care systems in which nursing is provided and the relevant theoretical foundation of cultural congruent nursing care to be rendered were discussed in this chapter. The next chapter will address the methodology that looks into the perception of cultural congruent nursing care.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Nurses should act as cultural health care brokers to all health care consumers. They therefore, must be educated to render holistic health care. If nurse-educators do not teach nurses holistic culturally congruent nursing care, nurse practitioners will seldom act as holistic cultural health care grocers. Based on the above, the exposition of the methodology used in the study is now given.

The research design, the research instrument used, the protocol followed during the data collection process and the data analysis process are fully explained. The ethical considerations, problems encountered during the data collection process as well as the value of the study are also discussed.

4.2 THE THEORETICAL GROUNDING OF THE STUDY

The theoretical grounding of the study elucidates the research design, the methodology followed, the protocol followed for collecting the data and the analysis of the data obtained.

4.2.1 The Research Design

The research design is defined as a blueprint for conducting any study that maximizes control over factors that could interfere with the validity of the findings (Burns and Grove, 1997:225). According to Grinnel (1988:115) the research design is a plan which includes every aspect of the research study from the conceptualization of the problem right through to the dissemination of the findings. Mouton (1998:23) states that the research design is either experimental or non-experimental. The non-experimental design must be used if a human phenomenon is explored. It is descriptive in nature when the phenomenon that is being studied is described in detail; contextual in nature when what is being explored is described as it occurs in a particular context and phenomenological when what happens occurs in a natural setting. Thus, in the light of the aim and objectives of the study, a non-experimental (qualitative) design of a descriptive, exploratory, contextual and phenomenological nature was used.

The reasons for using a non-experimental qualitative design of a descriptive, exploratory, contextual and phenomenological nature were as follows:

i) The study focuses on a human phenomenon, namely the perception of nurse-educators of cultural congruent nursing care;

ii) It entails an exploration of the different meanings given by nurse-educators as they perceive culturally congruent nursing care;

iii) A description was given on how nurse-educators perceive culturally congruent nursing care when they guide novice students to integrate theory (the science) into practice (the art);

iv) The contextual nature refers to nurse-educators' teaching in nursing schools in South Africa, a country that is characterized by a multicultural society; and

v) It is phenomenological in nature because nurse-educators are cultural human beings who have their own perception regarding culturally congruent nursing care.

According to Burns & Grove (1997:55) a non-experimental design of a descriptive nature should be used when knowledge is generated about topics that have been limited or not al all researched. As no previous studies have been conducted in South Africa on the nurse-educator's perception of culturally congruent nursing care, the data obtained would be new; therefore, the study was descriptive in nature. Since the description (information) of the perceptions of culturally congruent nursing care are a real life situation (human experience), no other design was applicable. Another reason for using the qualitative/non-experimental design was that the perception of culturally congruent nursing care in South Africa had to be described from scratch, as well as comprehensively, in order to enable the development of guidelines for the establishment of comprehensive culturally congruent nursing care education programmes that are sensitive to the needs of all health care consumers and to help all professional nurse practitioners to become culturally sensitive and relevant when rendering care.

4.2.2 The point of departure for collecting the necessary data (methodology)

The point of departure for collecting the data was the "Reflective Inquiry methodology". Reflective inquiry, according to Kim (1999:1205) is a process of consciously examining what has occurred in terms of thoughts, feelings and actions against underlying beliefs, assumptions and knowledge, as well as the context in which the specific practices occur. Kim (1999:1207), maintains, further that reflection involves looking back at what has occurred, and emancipating oneself from misunderstandings and moving towards understanding of aims and intentions. As such, "Reflective Inquiry" consists of three phases: descriptive, reflective emancipatory.

- The descriptive phase entailed a description of the actual and specific content of the generic nursing education programme which the nurse-educators teach to the novice nurses, including the description of the thoughts, the feelings and the experience of the nurse-educators about what they offer to the learners in terms of relevance and congruence to the needs of the consumer. This description also entails what they (nurse-educators) perceive as culturally congruent nursing care;

- The reflective phase entailed examination in a reflective mode, of what had been described during the descriptive phase. Thus, what nurse-educators described as their personal beliefs, assumptions and knowledge about culturally congruent nursing care have to be examined. The nurse-educators' reflection on whether culturally congruent nursing care should be or should not be taught to novice nurses were also taken into account; and

- During the emancipatory phase described as the "process of identifying incongruence between values, beliefs, intentions and actins" (Kim, 1999:1209), the reasons for not teaching as well as the problems encountered regarding the teaching of cultural congruent nursing care to novice nurses, was identified. As the goal of this phase is to set guidelines for further action, the guidelines for nurse-educators on the teaching of nursing care that satisfies health care consumers, need to be formulated based on the results obtained.

The main reason for using reflective inquiry is the fact that nurse-educators are unique persons who can reflect on what they know, think and believe. The content of nursing curricula can also be objectively audited to determine how the curriculum is used to obtain doctrinal conversion to practice culturally congruent nursing care. Therefore, the nurse-educators' reflections on culturally congruent nursing care can be used to re-curriculate (Kim, 1999:1207) not only the generic nursing education programme, but also the curriculum for nurse-educators based on the description of a model that enables nurse-educators to become educational brokers to novice nurses in the rendering of cultural congruent nursing care.

4.2.3 The Research instruments used for data gathering

The following research instruments were employed in the study to gather the necessary data:

- Focus group interviews;
- A questionnaire; and
- A checklist for auditing.

4.2.3.1 Focus Group Interviews

According to Brink (1996:157), focus group interviews are interviews with groups of five to fifteen people, whose opinion and experience are requested simultaneously. Two focus group interviews were held with nurse-educators from selected institutions. One group was made up of eight nurse-educators who came from different nursing schools and nursing colleges combined who attended the Standard Generating Body meeting at the Democratic Nursing Association of South Africa offices. The other group comprised of eight nurse-educators from various sections of North-west, including North-west University (Mafikeng Campus) and Mmabatho College of Nursing. Because very little literature in which the perception of nurse-educators regarding cultural congruent nursing care was explored and made available, focus group interviews were held to clarify the questions to be included in the questionnaire.

To ensure credibility and meaningfulness of the data, specific guidelines were set regarding the main question. The main question was framed to elicit information on the perception of culturally congruent nursing care in South Africa, and whether it should be taught to nurses. The main question was then referred to domain experts namely: a nurse-educator, a social worker (expert in multiculturalism) and the question was subsequently accepted by the domain experts. As such, the main question was set as follows:

"You are assigned to teach novice students who have just entered the nursing profession. Discuss how nurse-educators perceive culturally congruent nursing care."

The researcher had to choose a conclusively warm environment (venue where there was no disturbance). The main role of the researcher was to facilitate the process of the interview. The researcher started the session by introducing herself, explaining the purpose of the research and the procedure to be followed and also what the participants were expected to do. The researcher broke the ice by posing the said question. The ice breaking was immediately followed by tape-recording and note taking of what was being discussed. The discussion of the question by participants took a narrative form. During the sessions the group leader and the process manager were identified by the group itself.

Whilst the main question was kick-started by the researcher, other questions arose which directed the purpose away from the aims of the focus group interview. When the researcher realized that the respondents were deviating from the topic, the researcher rephrased the question bringing the respondents in line with the aim of the interview. Although at times the focus groups tended to dwell on culture per se during the narration, further questions brought the group closer to addressing culturally congruent nursing care. The ideas were noted as the participants responded. At the end of the discussion which lasted for twenty minutes, the researcher followed up the discussion for another ten minutes by asking further questions related to what cropped up in the discussion. All the group members were seen to be participating, without anyone feeling intimidated.

- Within the broad aspects of culture, the groups addressed ethnic differences, religious differences, dietary patterns and socio-environmental influences. The groups addressed even the Western Culture and compared it with the African Culture.

- The trustworthiness of the focus groups were effected as follows:

  - Credibility of focus group interviews was ensured by staying with the focus groups during their narrative exercises until their discussions were saturated. Another way of ensuring credibility was through further questioning by the researcher (which lasted for about ten minutes);

  - Focus group interviews were done with groups that were not included in the entire study. Groups were constituted in such a way that there was a fair representation of the institutions (from different institutions). Two focus group interviews of eight nurse-educators each were conducted; and

  - Confirmability was ensured by replaying the rape-recorder to the participants, followed by the researcher replaying the tape-recorder again and again, comparing the notes she wrote down during narration, adding and editing what she has written. These notes were further distributed to all the members of the focus groups so that they could confirm that, what was recorded in writing is what they indeed said. Thus both the replay of the tape-recorder and distribution of recorded information to the respondents served as confirmability and are therefore credible.

4.2.3.2 The Questionnaire (See Addendum A)

The main research instrument used to collect the necessary data was a questionnaire. The questionnaire was formulated after the focus group interviews, on the basis of the themes identified during narration and probing. A questionnaire was used for the following reasons:

- Most nurse-educators could be reached;
- It was the most convenient instrument to ensure self-expression without any constraints (open-ended questions set);
- Anonymity leads to higher response and can be honestly assured;
- Homogeneity stimulus as everybody received the same questions;
- Respondents could state their views regarding how they perceive culturally congruent nursing care, as well as the end results of the lack of education on what culturally congruent nursing care has on the nursing practice in a multicultural society; and
- The questionnaire consisted of closed-ended questions (biographical data collection) and open-ended questions (perceptions held by respondents)

The validity and reliability of the questionnaire were ensured as follows:

- An evaluation of the questionnaire was done by two domain experts at the University of the Free State;

- Conducting a pilot study: After the evaluation of the questionnaire by domain experts of the University of the Free State, a pilot study was conducted to determine the validity and reliability of the questionnaire, as well as to identify problems that might arise during the data collection process. The questionnaire was modified based on the findings of the pilot study. The pilot study was conducted at one of the universities and one of the colleges not included in the study and the fifteen respondents recruited for the pilot study were excluded from the data collection process. All fifteen questionnaires given to nurse-educators for the pilot study were completed; and

- Content validity of the questionnaire was ensured by securing the opinion of externals, that is, domain experts in multiculturality at the University of the Free State (nurse and sociologist in cultural affairs).

4.2.3.3 The checklist for auditing the curriculum and course outlines

A checklist was compiled to audit the content of the curriculum and course outlines in the generic programme of nursing (see Addendum B). The reason for using a checklist was to ascertain whether the curriculum, study guides and course outlines include culturally congruent nursing care.

The validity and reliability of the checklist for auditing was ensured by sending it to two nurse-educators who are main experts in the compilation of curricula. The checklist was also pre-tested by using three nurse-educators at North-West, who checked if culturally congruent nursing care was included. Curricula from two institutions were used to pre-test the checklist. These institutions were not included in the whole study. After

the pre-tesing, the changes that were made included: culture assessment, inclusion of social factors and life events and the deletion of repeated characteristics on culture. After that the pilot study changes were made.

4.2.4 Population and sampling

4.2.4.1 The population

According to Burns & Grove (1997:47), the term "population" entails all those elements that meet the sample criteria for inclusion in the study and is refereed to as the target population. Babbie & Mouton (2001:174), on the other hand, describe the population as an aggregation of elements from which the sample is actually selected. Thus, in this study the population referred to are all nurse-educators in nursing institutions of higher learning in South Africa, namely schools/departments of nursing at Universities and Colleges of Nursing which are affiliated to/associated with schools/departments of nursing at universities. The total population consisted of four hundred nurse-educators in all nursing schools at both universities and nursing colleges. The nurse-educators teach either novice nurses and/or postgraduate/post-basic students.

4.2.4.2 The Sample

According to Crookes & Davis (1998:32), the research sample refers to the subset of the population that is selected for the study. As such, the subset forms a representation of the whole. Uys & Basson (1995:87) define a sample as the number of elements of the population being studied. As such, sampling in this study was done on:

- Nursing schools at universities and nursing colleges; and
- Lecturers who educate novice nurses.

The sampling of nursing schools was done as follows:

Purposive sampling was used to have a representative sample of nursing schools in South Africa reflecting the multicultural nature of the people of South Africa. According to Polit & Hungler (2001:239) purposive sampling means a type of probability sampling in which the researcher selects subjects for the study purposely. The sampling was executed as follows:

- Population level

  All universities and all nursing colleges were used in each of the nine provinces, namely nineteen universities and fifteen nursing colleges. Those provinces which do not have universities, namely the Northern Cape and Mpumalanga, were substituted by two universities: one university in Gauteng Province for Mpumalanga and one university in Eastern Cape for Northern Cape.

- Randomized level

  The following criteria were used for selection of nursing schools:

  Dominant cultural/language stratum:

  - One university and one nursing college that are dominantly English medium;

- One university and one nursing college that are dominantly Afrikaans medium; and

- Universities and nursing colleges that are mixed language medium in South Africa as defined by the provincial culture.

Based on this criteria nine universities and nine nursing colleges in each province were purposely selected. One university department or nursing school and one nursing college from each province in South Africa was selected. For those provinces that do not have a university or nursing college, a substitute was provided from other provinces by purpose selection from other provinces that have more than one university or college.

- Data level

Nursing schools had to be voluntarily included in the study. The heads of schools made final decisions as to whether members of lecturing staff could take part in the study.

The sampling of the nurse-educators as respondents was done as follows:

- Population level

All four hundred (400) nurse-educators employed by 19 universities and 15 nursing colleges were included in the study.

- Randomized level

The registered nurse-educators were selected from each of the selected eighteen nursing schools as follows:

Out of every selected nursing college or university of each of the nine provinces, eight nurse-educators were to be purposely selected manually to sample. These eight nurse-educators had to be specialists in one of the four components of generic nursing education namely: general, midwifery, psychiatry and community health nursing science. The researcher requested the assistance of the heads of the nursing schools or department of nursing at a university and nursing colleges to select the nurse-educators according to their specialities. The total number of purposely selected nurse-educators for the study was two hundred and eight (208). According to Leedy (1997:211), only 104 of the total population of nurse-educators stipulated above would be representative of the total population under study.

- At data level

  Only those respondents who were willing to participate were included in the study. Because not all the identified nurse-educators were willing to participate, all willing nurse-educators were subsequently accepted.

4.3 THE PROTOCOL FOLLOWED IN THE DATA COLLECTION PROCESS

The data collection protocol consisted of the following three steps: Entry into the field, the data gathering process and leaving the field.

- Entry into the field:

  Prior to entering the research field, permission was obtained in writing from the Departments of Health and Heads of Nursing Colleges in all the provinces of South Africa as well as from the Vice-Chancellors, Deans of Faculties and Heads of the Departments of Schools of Nursing at Universities (see Addendum C).

- The data gathering process

  - Focus group interviews were held to clarify in-depth questions to be included in the questionnaire;

  - Collection of data was done by means of a questionnaire in all selected universities and colleges of nursing. All questionnaires were accompanied with written guidelines regarding the aim and the use of the questionnaire. Two hundred and fifty (250) questionnaires were sent out to universities and colleges;

  - Special attention was given to the introduction of the questionnaire and the time allocated for completing the questionnaire per respondent. Two weeks were allowed to each respondent to complete the questionnaire. The questionnaire was mailed by post to all far off (more than 200 kilometres) institutions but delivered personally by the researcher at nearby institutions; and

- Auditing of curriculum and course outlines was done. Only seven nursing institutions were willing to provide their curricula. Two course outlines were received with the curricula.

- Leaving the field

  A maximum of two weeks was given for return of the questionnaire. A follow up letter was sent for return of delayed questionnaires. On completion of data collection process, the management of the concerned institutions and respondents were thanked for their support and willingness to allow the study to be conducted.

4.4 THE ANALYSIS OF THE DATA OBTAINED

The analysis of all data obtained was done on a nominal descriptive level because of the descriptive and exploratory nature of the study. The Department of Statistics at the University of North-West did the data analysis while Bio-statistics Department of the University of the Free State served as a consultant agent. A full description of the analysis process is given in Chapter 5.

The data analysis was done as follows:

- The data of focus group interviews was analyzed according to the method described by Tess (in Creswell, 1994:144-155).

The data obtained through the questionnaire was analyzed as follows:

- The questions were analyzed and described on a descriptive ordinal level as well as on an inferential level. Open-ended questions were analyzed according to Tess (in Creswell 1994:144-155).

- Data obtained from the checklist was only analyzed on an ordinal level.

4.5 MEASURES TAKEN TO ENSURE THE TRUSTWORTHINESS OF THE STUDY AS A WHOLE

The trustworthiness and credibility of the study was assured by:

- Monitoring of data-collection process, as already indicated by the researcher in the focus group interviews;

- Homogeneity (only registered nurse-educators who are licensed to function as nurse practitioners and who are practicing as teachers were included in the sample) as indicated during sampling on randomized level; and

- Heterogeneity was ensured as the subjects had mixed cultural orientations.

The first four criteria are mostly used according to Lincoln and Guba (1985:324).

- Credibility

  This was ensured by the researcher. According to Lincoln and Guba (1985:324) credibility includes activities that increase the probability that credible findings will be produced. This was ensured by the prolonged time with the participants as a facilitator during the focus group interviews. Furthermore, the fact that the respondents were given time to voice their experiences freely during the narrative discussions added to this, as did the fact that the participants were ensured that what they communicated was tape-recorded and replayed to them and distributed for comments. Research was also supervised by experts in both qualitative and quantitative research.

- Dependability

  According to Streubert and Carpenter (1999:29) dependability will be automatic once there is credibility as the researcher depends on what is credible to ensure trustworthiness.

- Confirmability

  The audit trail that is left by documentation, through notes taking and tape-recording, according to Streubert & Carpenter (1999:25), is another way of showing confirmability. The objective of confirmability is to illustrate the evidence and thought process that led to the conclusion. This was facilitated throughout the research by the supervisor of this research.

- Transferability

According to Lincoln and Guba (1985:316) transferability refers to the probability that the study findings have meaning to others in similar situation. Transferability was enhanced by selection of the sample, which was purposive and respondents participated on voluntary basis.

- Reflexivity

This was ensured through consensus discussions with an external independent coder in the Sociology department of the University of North-West who has a doctoral degree in the cross-cultural affairs of society. The researcher also discussed the data with two experts – a nurse and a social worker who are experienced in variables which could be biased.

- Triangulation

After analysis of the data obtained from focus group interviews, the data was compared with the questions on the questionnaire. Data source triangulation was reached by using both quantitative and qualitative research methods in the study.

- Peer group examination

During analysis of the data obtained from the focus group interviews, two colleagues who have conducted research in psychiatric nursing on transcultural issues gave input on the results. The researcher also had a chance to discuss telephonically, the outcome of the research with the author of the model that was used as the point of departure.

4.6 ETHICAL ASPECTS

All ethical aspects were maintained according to the standards set through nursing and medical guidelines. Geyer (1998:7) identified the following guidelines and these were adhered to as follows:

- Permission to do research

  This was obtained in writing from the Ethical Committee of the Faculty of Health Sciences of the University of the Free State and from the Provincial Departments of Health and Heads of Nursing Colleges as well as from the Vice-chancellors, Deans of Faculties and Heads of the Departments or Schools or Nursing at the universities as well as from the willing respondents themselves (see Addendum D).

- Planning

  The researcher planned the study thoroughly.

- Implementation

  The researcher compiled a usable report at the end of the study.

- Integrity was ensured by taking into consideration all ethical aspects such as anonymity.

- Honesty was maintained by fulfilling all aspects indicated to respondents.

- Confidentiality

  According to Searle (1987:45) confidentiality means not divulging any information about a person. This was maintained in the following manner:

  - The subjects were assured that only they and the researcher would know the information they provided.

  - The questionnaire sent by mail was provided with a safe and reliable address. Accommodation for the use of couriers was provided (a form for this was sent with the questionnaire) and in some cases stamped envelopes sufficient for mail registration were included.

  - Anonymity was secured by instructing the subjects not to write their names on the questionnaires.

  - Respondents were informed about the study and only those who gave consent were included.

4.7 THE PROBLEMS ENCOUNTERED DURING THE DATA COLLECTION PROCESS

The following limitations were experienced:

- Constraints of the study were that the sample was exclusively based on the selected nursing schools that had been identified purposively. As some schools had to fall out, the depth of multicultural nurse-educators could not be fully explored.

- Another constraint was that of the distribution of questionnaires to different nursing institutions that are scattered all over the country. In some cases there was a delay of post (delivery especially in rural areas). In some cases the protocol of sending the questionnaire was complicated by the fact that it had to be first sent to the main campus before it could reach its destination. Another limitation was that not all the nurse-educators who were selected returned the questionnaire. Only two percent (2%) of the questionnaires constituted nurse-educators with a western orientation.

- Only seven (7) nursing institutions were willing to provide their curricula.

4.8 THE VALUE OF THE STUDY

The value of the study lies in the fact that the results and the recommendations do not only benefit nurse-educators, but they also benefit all nursing practitioners and all other health care practitioners as the principles of Cultural Congruent Nursing Care are applicable to all types of care that has to be rendered to health care consumers of different culturally orientations. All health care consumers will thus receive the necessary quality health care as prescribed by the Health Care Act and the Professional Councils. Satisfaction will not only go to nurse-educators, but also to nursing students and health care consumers as cultural congruent nursing care leads to self-actualization of all role players-educators, practitioners and consumers.

4.9 SUMMARY

The research design and methodology were discussed in this chapter. A non-experimental approach of a reflective inquiry type was used as the research design. The techniques used to collect the necessary data were followed. All ethical principles were observed. The results will be discussed in the next chapter.

CHAPTER FIVE

ANALYSIS OF THE COLLECTED DATA

5.1 INTRODUCTION

The purpose of this chapter is to present the outcome of the study on culturally congruent nursing care as it relates to the research questions in Chapter One. As the study is of a non-experimental design of a descriptive, explorative, phenomenological and contextual nature, a qualitative approach was used in analyzing the data collected. According to Brink (1996:178) data analysis entails categorizing, ordering, manipulating and summarizing the data and describing it in meaningful terms. It involves activities such as reduction, categorizing and interpretation.

The description of the data analysis was done as follows: First a description of the data analysis process is given. This is followed by the exposition of the data analysis of the focus group interviews, the questionnaire and the checklist. The results are described on a nominal and ordinal level as well as on an inferential statistical level.

5.2 A DESCRIPTION OF THE DATA REDUCTION AND CATEGORIZATION PROCESS AS WELL AS THE DATA ANALYSIS PROCESS

5.2.1 The data reduction and categorization of all qualitative data

According to Lundgren (2000:19), data reduction is the process of selecting, focusing, simplifying and transforming the data in the transcriptions. Thus, because of its volume, the data acquired was reduced to facilitate examination. Reduction of all the qualitative data namely, focus group interviews and open-ended questions in the questionnaire were done according to the steps described by Tess (in Creswell, 1994:145-155).

- The researcher worked with two encoders from North-West University, who worked through all the data of all the instruments used;

- The researcher and the two co-encoders then (working separately) categorized the data by placing the inferences to the words, the statements and phrases which were used in the content, into categories based on content analysis as also described by Babbie and Mouton (2001:176);

- The coding system was accepted by all and the preliminary categorization of responses was done; and

- After confirmation, the final framework was drawn and all data was analyzed and categorized accordingly.

According to the analysis, similar themes that were categorized for the questionnaire were previously addressed in focus group interviews.

5.2.2 The analysis process used to determine the internal consistency of the data

It is important to check for data reliability in social research. If data is found to be unreliable, the research findings become questionable. The Alpha Chronbach (Carmines & Zeller, 1979) test of internal consistency of data was used in the analysis. While some authors argue that a minimum overall value of 0.65 coefficient alpha is an acceptable level of strong internal consistency, others contend a minimum value of 0.70 is necessary. It is therefore argued that minimum overall coefficient alpha lying within the range 0.65 and 0.70 is indicative of strong internal consistency.

5.3 THE EXPOSITION OF THE DATA OF THE FOCUS GROUP INTERVIEWS

The analysis of the focus group interviews (see Addendum) is tabled in Table 5.1

Table 5.1: Analysis of focus group interviews

MAIN THEME	SUB THEME	EXPLANATION
Multiculturality	• Cultural sensitivity	• Educators must be sensitive to other people's cultures

MAIN THEME	SUB THEME	EXPLANATION
	• Cultural values and beliefs	• Nurse-educators must teach novice nurses the knowledge and understanding of values and beliefs of health care consumers
Transcultural	• Western versus African culture	• High time to distinguish between western and African cultures. Avoid domination.
	• Culture and education	• Nursing education must include knowledge of cultures.
	• Cultural congruence	• Congruence related to genuineness in doing things.
	• Ethnocentrism	• Nurse-educators must guide and teach novice nurses to respect people of other ethnic groups and cultures.
	• Cultural imposition	• Learners must be guided not to exercise cultural imposition. Must be taught to learn

MAIN THEME	SUB THEME	EXPLANATION
		other languages and not to despise them as this will help them render culturally congruent nursing care.

Based on the above the themes for the questionnaire were set.

5.4 THE EXPOSITION OF THE DATA ANALYSIS OF THE QUESTIONNAIRE

The data analysis of the questionnaire will be presented as follows: The response rate will be exposed first, followed by the socio-biographical characteristics, with the exposition of the open-ended questions given last. To prevent misunderstanding of the representation, only percentage (%) will be used.

5.4.1 The response rate of the questionnaire and the internal consistency of the data

The total number of questionnaires distributed to the respondents was two hundred and fifty (250); two hundred (200) questionnaires were completed and returned. Table 5.2A shows the response rate.

Table 5.2A Response rate of the questionnaire

Questionnaire	Distributed	Returned	Response rate %
Total	250	200	80

Table 5.2B indicates the overall coefficient alpha of the data.

Table 5.2B Cronbach Coefficient Alpha

Variables	Alpha
Raw	0.624272

As can be seen in table 5.2B, the overall coefficient alpha is 0.624272, indicating a strong support for internal consistency.

5.4.2 Socio-biographical characteristics of the respondent

Table 5.3 reflects an exposition of socio-biographical characteristics of the respondents

Table 5.3: Socio-biographic characteristics of respondents

N = 200

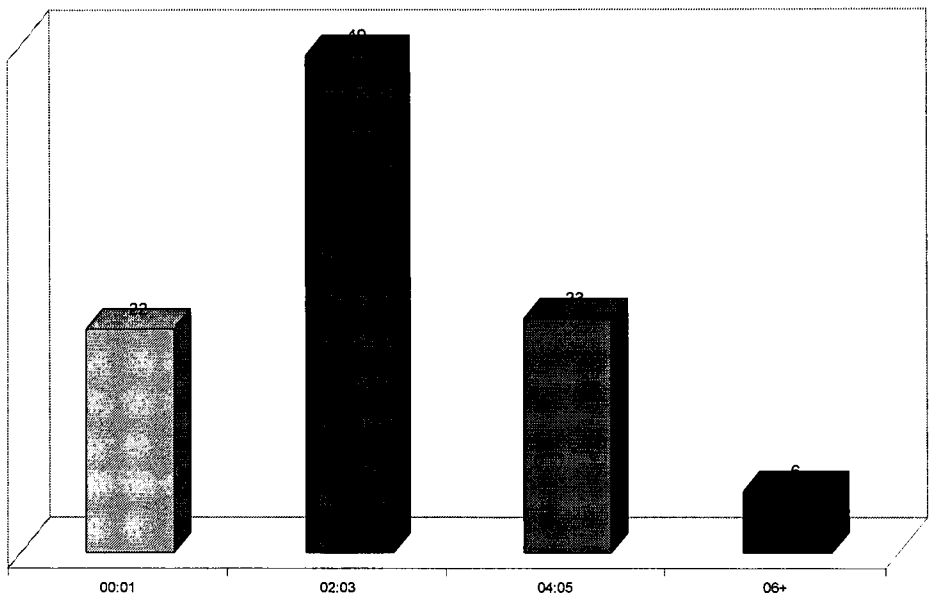
CHARACTERISTICS	PERCENTAGE
1. Gender	
Male	33
Female	67
2. Age in years	
30-34	8
35-39	9
40-44	16
45-49	20

CHARACTERISTICS	PERCENTAGE
50-54	18
55-59	19
60+	10
3. Cultural Orientation	
African	97
Western	2
African-Western	1
4. Generic Nursing Education	
Hospital/Schools	67
Nursing College (after 1981)	31
Universities	2
5. Years of experience as nurse practitioner	
5-10	70
11-15	23
16-20	3
20+	4

According to Table 5.3 the sample consisted of 67% females and 33% males. Most respondents were aged between 40 – 60+ years (80%) with the 45 – 49 year age category the highest at 20%. As far as the cultural orientation is concerned, there were more Africans (97%) than any other cultural group. Regarding the years of experience as nurse practitioners and as nurse-educators, the majority of the nurses (70%) have between 5 – 10 years working experience, followed by 23% of those who have between 11 and 15 years of experience as nurse practitioners. Only 7% worked for more than 15 years before they pursued the nursing education programme. Lastly, it can be said that 67% of the respondents indicated that they received generic nursing education at hospital nursing schools and 33% at nursing colleges and universities.

Figure 1 depicts nurse-educators' years of experience in nursing education.

Figure 1: Nurse-educators' years of experience in nursing education



Key: 00:01 = 0-1 year, 02:03=2-3 years, 04:05=4-5years and 06+ = 6+years.

According to Figure 1 the majority of nurse-educators (49%) have between 2 – 3 years of experience in nursing education, 23% have between 4 – 5 years, while 22% have experience of less than 9 years and 6% have more than 6 years experience

5.4.3 Exposition of the perceptions regarding culturally congruent nursing care

The exposition of the respondents' perceptions regarding culturally congruent nursing care follows now.

5.4.3.1 Perception of the health care consumer and health care provider as human beings

The respondents' perception of the health care consumer and health care provider as human beings is reflected in Table 5.4 and Table 5.5.

Table 5.4 Perception of the health care consumer as a person

(N = 200)

Response	Percentage
Requires Support And Guidance	42
Physically And Mentally Incapacitated	33
People In Need Of Medical Care	17
People Who Need To Improve Their Health Status	9

Table 5.5 Perception of the health care provider

(N = 200)

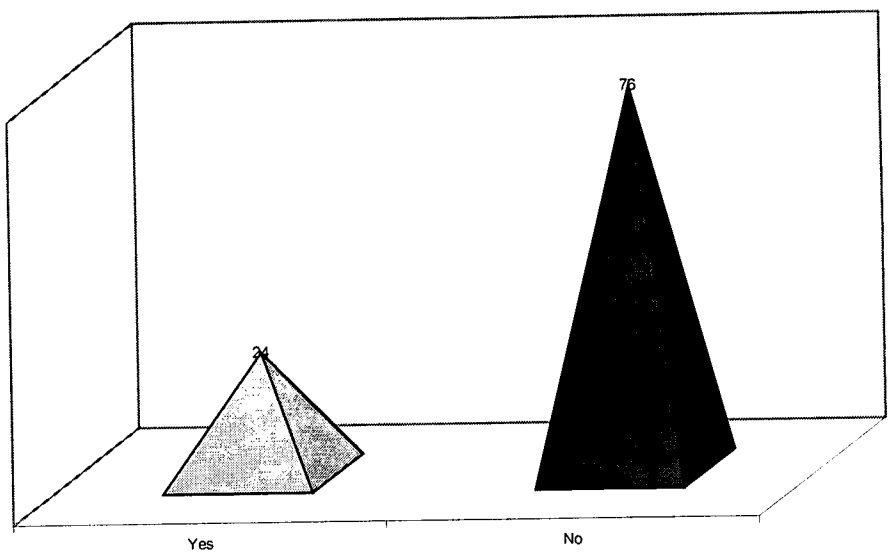
Response	Percentage
Professional Person Providing Health Care	45
Is An Advocate, Manager, Teacher And Caring Person	16
Person Giving Love And Support To Patients	11
Person With A Quest To Assist Those In Need	10
Person Who Renders Preventive, Promotive, Curative And Rehabilitative Care	18

All the respondents (100%) view the health care consumer and health care provider as human beings who needs care and who renders care to the consumer.

5.4.3.2 Education of nurse-educators on culturally congruent nursing care

Figure 2 reflects whether nurse-educators received education on culturally congruent nursing care or not.

Figure 2: Respondents who received education on cultural congruent nursing care



Seventy Six percent (76%) of respondents never received any form of education on cultural congruent nursing care.

5.4.3.3 Perception of health

The respondents' perception of health care reflects in Tables 5.6A, 5.6B and 5.6C.

Table 5.6A Perception of health

(N = 200)

Response	Percentage
When a person is free from physical, psychological and social problems/medical care	24
Integral part of ones living	19
Total functioning of a persons body	13
Being well physically, mentally and socially	16
When a person does not need medical attention	28

Table 5.6B An explanation of the perception of health by respondents

Main Theme	Sub-theme	Explanation
Freedom	• Free from physical infliction • Psychological harmony • Absence of social problems	• Physical infliction affects the body movement and function • Emotional disturbance interferes with the normal body function • Social problems disorganize the person's life and being
Well-being	• Physical fitness • Mental stability • Social balance	• The body become strong in the absence of physical disorder • Once the mind is at ease the whole body functions normal • Any social disorganization affects life ways of inter action
Total body function	• No need for intervention • No need for medication	• When the body is at rest there won't be any need to temper with it

According to Table 5.6A and B, all respondents perceived health as meaning that a person does not need medical attention.

In Table 5.6C a correlation is drawn between the perceptions of health by nurses who were educated in hospital schools and by nurses who were educated in nursing colleges.

Table 5.6C Perception of health according to place where generic nursing education was received

(N = 200)

Perception of Health	Nursing Colleges/ Universities	Hospital Schools	Total (%)
Person free from physical, psychological and social problems	9	15	24
Integral part of one's living	6	13	19
Total functioning of a person's body	6	7	13
Being well physically, mentally and socially	5	11	16
When a person does not need medical attention	7	21	28
Total	**33**	**67**	**100**

Alpha Chronbach

$X^2 = 3.5$ df = 1 ,0.6P<0.05

According to Table 5.6C no incongruencies where found.

5.4.3.4 The perception of illness

The perception of illness by the respondents will be reflected in Table 5.7A, 5.7B and 5.7C.

Table 5.7A Perception of illness

Responses	Percentages
Deviation from the normal	34
Disruption of health, inability to perform functions	14
State of being unable to survive	19
Any disturbances that can happen in a person's body	19
Well being incapacitated	11
Depreciation of health	3

Table 5.7B An explanation of perception of illness

Main Theme	Sub-Themes	Explanation
Deviation from normal	• Inability to perform functions	• Any deviation from normality in the body affects normal body functions
	• State of being unable to survive	• A person may not survive deviation from normal depending on the extent of that deviation
Disruption of health	• Any disturbance in person's body	• A disruption or disturbance of health status is manifested by disturbance in a person's body status
	• Well being incapacitated	• Where there is incapacitation there will be

	• Depreciation of good health	disturbance the in well being of a person • A disruption and disturbance in a person's body status depreciates his/her good health

Table 5.7C A correlation of perception of illness according to place where generic nursing education was received

(N = 200)

Perception of illness	Nursing Colleges	Hospital Schools	Total (%)
Deviation from the normal	13	21	34
Disruption of health, inability to perform functions	6	8	14
The state of being unable to survive	7	12	19
Any disturbance that can happen in a person's body	4	15	19
Well being incapacitated	3	8	11
Depreciation of good health	0	3	3
Total	**33**	**67**	**100**

Alpha Chronbach

$X^2 = 3.5$; df = 1; 0.006>P<0.05; p-value=0.5

According to Table 5.7A, 5.7B and 5.7C the majority of respondents perceived illness as a deviation from the normal. There is also a strong significance between the respondent educated at hospital schools and nursing colleges/universities regarding the perception of illness as shown by the P value of 0.06 and the fact that $X^2 = 3.5$; df of 1.

Perception of cultural-congruent nursing care is reflected in Tables 5.8A, 5.8B,5.8Cand5.8D.

5.4.3.5 The perception of culturally congruent nursing care

The perception of culturally congruent nursing care is reflected in Tables 5.8A, 5.8B, 5.8C, 5.8D and 5.8E.

Table 5.8A Perception of culturally congruent nursing care

Responses	Percentage
Attaining knowledge of different cultures	33
Nursing across cultural borders	14
Relevance of cultures of nursing	8
Appropriate nursing	5
Consumer centered	38
Something that must be introduced in nursing programme	3

According to Table 5.8A the majority of respondents (38%) perceived culturally congruent nursing care as being consumer centered.

Table 5.8B An explanation of the perception of culturally congruent nursing care by respondents

Main Theme	Sub-Theme	Explanation
Attaining knowledge of different cultures	• Knowledge of care of different cultures • Nursing across cultural borders	• There is a need for knowledge and under-standing of different cultures • Health care providers must know and be familiar with caring for people across cultural borders

Consumer centered	• Appropriate nursing • Relevant nursing	• Health care providers have a duty to provide care that is congruent with the needs of health care consumers • It must be a relevant health care
Something that must be introduced in nursing programme	The importance of inclusion of culturally congruent nursing care in the curriculum	It is only with inclusion into the curriculum for programmes of nursing education that culturally congruent nursing care can be taught, known and applied in health care

Table 5.8C A correlation of perceptions of culturally congruent nursing care according to experiences as a nurse practitioner

(N = 200)

Perception of culturally congruent nursing	**Duration as a Nurse Practitioner in years**				**Total (%)**
	5-10 (%)	**11-15 (%)**	**16-20 (%)**	**20+ (%)**	
Attaining knowledge of different cultures	24	6	1	1	32
Nursing across cultural borders	8	3	1	2	14
Relevance of culture or nursing	6	2	0	0	8
Appropriate nursing	4	1	0	1	6

Consumer centered	26	5	3	1	35
Something that must be introduced in nursing programmes	4	1	0	0	5
Total	**70**	**23**	**2**	**5**	**100**

In general 70% of respondents are newly employed with a service of 0-1 year followed by 23% with duration of 11-15 years. The lowest are those with 16-20 years at 2% and 20 years at 5%.

Table 5.8D A correlation of perceptions of culturally congruent nursing care according to years of experience as nurse-educators

(N = 200)

Perception of culturally congruent nursing	**Years of experience**				**Total (%)**
	0-1 year	**2-3 years**	**4-5 years**	**6+ years**	
Attaining knowledge of different cultures	7	13	9	4	33
Nursing across cultural borders	5	4	3	2	14
Relevance of culture or nursing	0	7	0	1	8
Appropriate nursing	1	3	0	1	5
Consumer centered	8	20	9	1	38
Something that must be introduced in nursing programmes	0	1	1	0	2
Total	**21**	**48**	**22**	**9**	**100**

According to the above table, the majority of respondents (48%) who have 2 – 3 years of experience as nurse-educators perceived culturally congruent nursing care as consumer centered. That means there is generally consistency in the way the respondents perceive culturally congruent nursing care.

Table 5.8E A correlation of perceptions of culturally congruent nursing care according to where generic nursing education was received

(N = 200)

Perception of cultural congruent nursing	Nursing Colleges	Hospital Schools	Total (%)
Attaining knowledge of different cultures	12	21	33
Nursing across cultural borders	5	9	14
Relevance of culture or nursing	3	5	8
Appropriate nursing	2	3	5
Consumer centered	9	29	38
Something that must be introduced in nursing programmes	2	1	3
Total	**33**	**67**	**100**

Alpha Chronbach

$X^2 = 9.2$;df = 15; $0.005 > P < 0.05$

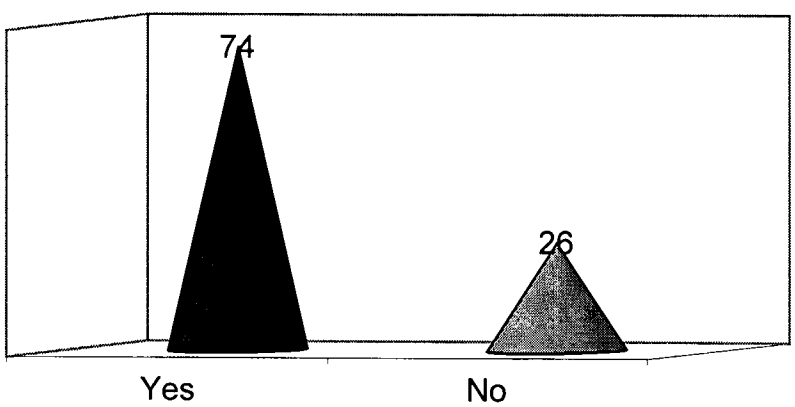
According to the correlation, more respondents who were hospital trained perceived culturally congruent nursing care as consumer centered as compared to the number of those who studied generic nursing at colleges. But, according to the analysis, the Chi-square, there is a significant

relationship between the perception of culturally congruent nursing care and the generic training of all respondents by looking at the $X^2 = 9.2$; significant P value of 0.05 and df = 5.

5.4.3.6 The inclusion of culturally congruent nursing care in the curriculum

The inclusion of culturally congruent nursing care is reflected in Figure 3 and in Table 5.9.

Figure 3: Inclusion of culturally congruent nursing care in the curriculum



According to figure 3 above 74 % of respondents agreed and 26% disagreed that cultural congruent nursing should be included in the curriculum.

Reasons respondents gave on inclusion of cultural congruent nursing care in the curriculum are reflected in Tables 5.9.

Table 5.9 Reasons respondents gave on the inclusion of culturally congruent nursing care in the curriculum

(N = 200)

Response	Percentage
Relevant nursing must be provided	23
So that health care provider be aware of different cultures in S.A.	58
There is multi-cultural society in S.A	5
To know different cultures	14

The majority of the respondents (58%) indicated that inclusion of culturally congruent care in nursing in the curriculum will make health care providers aware of the different cultures found in South Africa. This will enable them to know how to handle people of different cultures.

5.4.3.7 Content to be included

The content of culturally congruent nursing care is reflected in Tables 5.10A and 5.10B.

Table 5.10A Respondents' suggestion on curriculum content regarding culturally congruent nursing care

(N = 200)

Response	Percentage
Trans-cultural concepts and application	19
Trans-cultural nursing	14
Practices, activities, language and rituals	7
Folk care, tradition and culture	10
Cultural diversity	3

Response	Percentage
Cultural practices regarding health care	41
Cultural difference	6

Table 5.10B An explanation of the content to be included in the curriculum

Main Theme	Sub-theme	Explanation
Transcultural Nursing	Concepts Practices Activities	• Transcultural nursing concepts must be taught • Transcultural health and nursing activities and practices according to different cultures
Cultural diversity	Differences Application Language	• Practice should be according to different cultures. • Application of health care to strictly take culture into consideration • Language use depends on different cultures
Folk care	Tradition Culture Rituals	• Tradition should be respected in people who uphold it • Accommodation of different cultures • Observation of rituals where they are practices

According to Table 5.10A and 5.10B the respondents concentrated mostly on transcultural nursing care concepts, cultural diversity concepts and folk care as the main content to be included in the curricula.

5.4.3.8 Inclusion of the content of culturally congruent nursing care in the curriculum according to study years

The inclusion of the content of culturally congruent nursing care in the curriculum according to study years is reflected in Table 5.11A, Figure 4 and Table 5.11B.

Table 5.11A Inclusion of cultural congruent nursing care in the curriculum according to study years

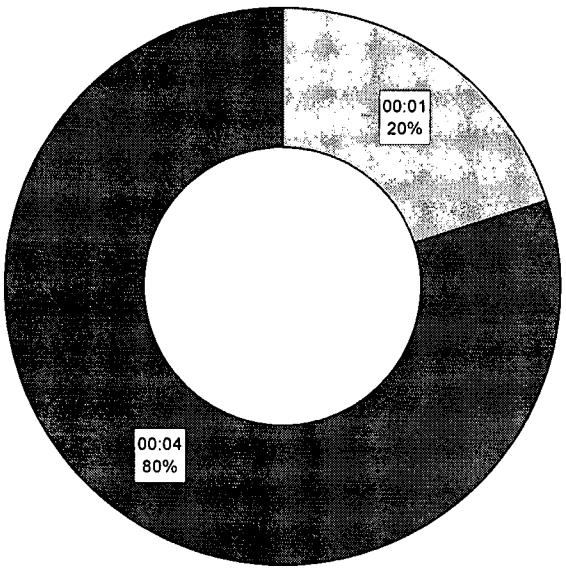
(N = 200)

Levels of inclusion	Inclusion of cultural congruent nursing care in the curriculum
	Yes
1st year only (%)	20%
1st-4th year (%)	80%
Total	**100%**

Alpha Chronbach

$X^2 = 0.05$; df = 1; 0.8 < P > 0.05

Figure 4: Introduction of culturally congruent nursing levels



Key: 00:01 = 1 year and 00:04=1-4 year

Table 5.11B The inclusion of the content of culturally congruent nursing care at different levels

(N = 200)

Content of cultural congruent nursing	Level of introduction of cultural congruent nursing		Total (%)
	1st year only (%)	1st-4th year (%)	
Trans-cultural concepts and application	3	16	19
Trans-cultural nursing	3	11	14

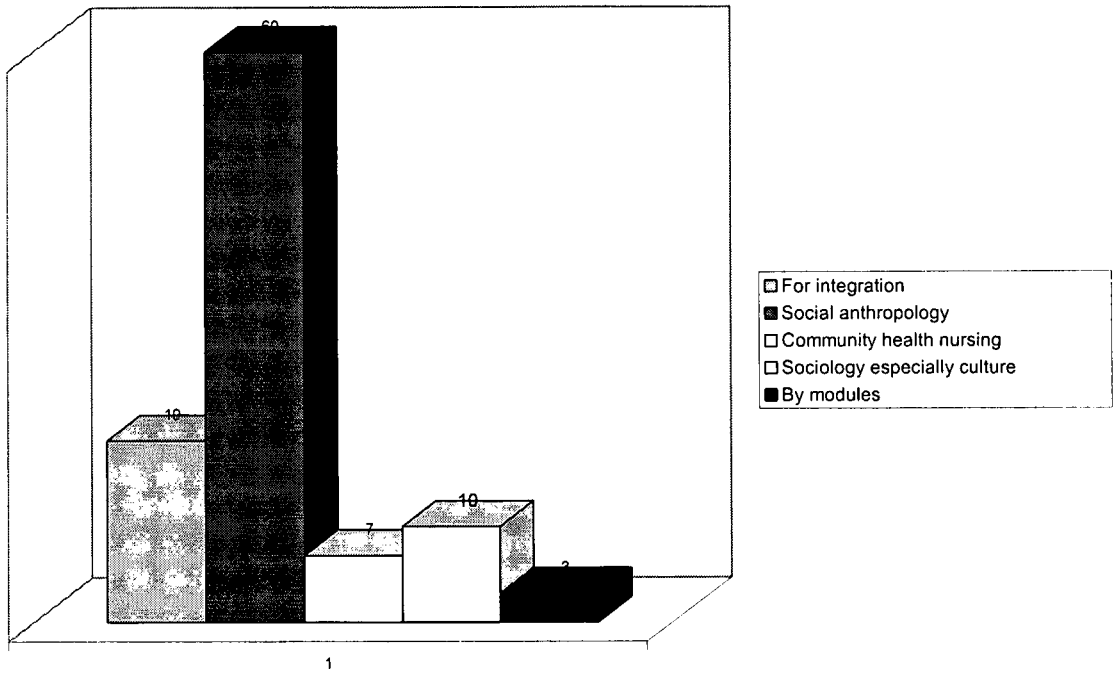
Practices, activities, language and rituals	1	6	7
Folklore, tradition, and culture	1	9	10
Cultural Diversity	1	2	3
Cultural practices regarding health care	10	31	41
Cultural difference	1	5	6
Total	**20**	**80**	**100**

According to table 5.11A above, all of the respondents indicated that cultural congruent nursing care should be included in the curriculum. The response from those who prefer the inclusion at 1 – 4th year level is the highest at 80%. The chi-square result confirms a strong relationship between both the inclusion of culturally congruent nursing care in the curriculum and levels of inclusion. The association between the inclusion of cultural congruent nursing care in the curriculum and levels of inclusion is strongly indicated by X^2 = 0.05; df = 1; 0.8 < P > 0.05

5.4.3.9 The placement of the content of the culturally congruent nursing care in the curriculum

The placement of the content of the culturally congruent nursing care in the curriculum is reflected in Figure 5.

Figure 5: Curriculum placement of culturally congruent nursing care

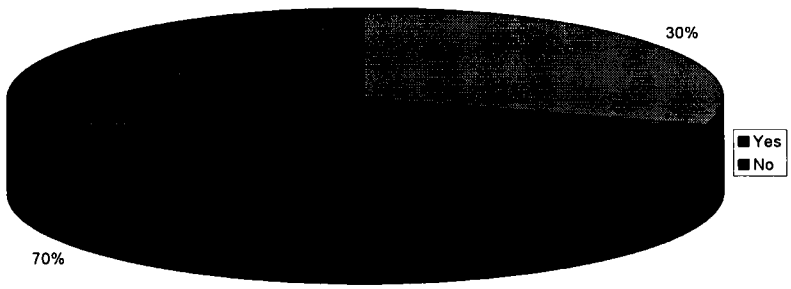


The majority of nurse educators (60%) feel that culturally congruent nursing should be included in the curriculum for social anthropology. This implies that these nurse educators are not used to a nursing curriculum that is inclusive of cultural aspects.

5.4.3.10 Inclusion of culturally congruent nursing care according to the South African Nursing Council Directives

The response regarding whether the South African Nursing Council Directives include culturally congruent nursing care is reflected in Figure 6 and Table 5.13.

Figure 6: Inclusion of culturally congruent nursing care in SANC directives



The majority (70%) of the respondents indicated that the South Africa Nursing Council (SANC) does not emphasize the inclusion of culturally congruent nursing care. Only 30% stated that SANC does emphasize the inclusion of culturally congruent nursing care in the curricula.

Table 5.13 Reasons why directives on culturally congruent nursing care from the Nursing Council is not implemented in generic nursing education according to place of generic nursing education received

Reasons	Nursing Colleges	Hospital Schools	Total (%)
Still in the process of being included	3	4	7
Directive recopied without consideration to new developments	4	10	14

Reasons	Nursing Colleges	Hospital Schools	Total (%)
It is not reflected in the directives	23	50	73
Proposals not through	5	2	5
Do not address cultural congruent	0	1	1
Total	**33**	**67**	**100**

Alpha Chronbach

X^2 = 0.05; df = 1; 0.08<P>0.05

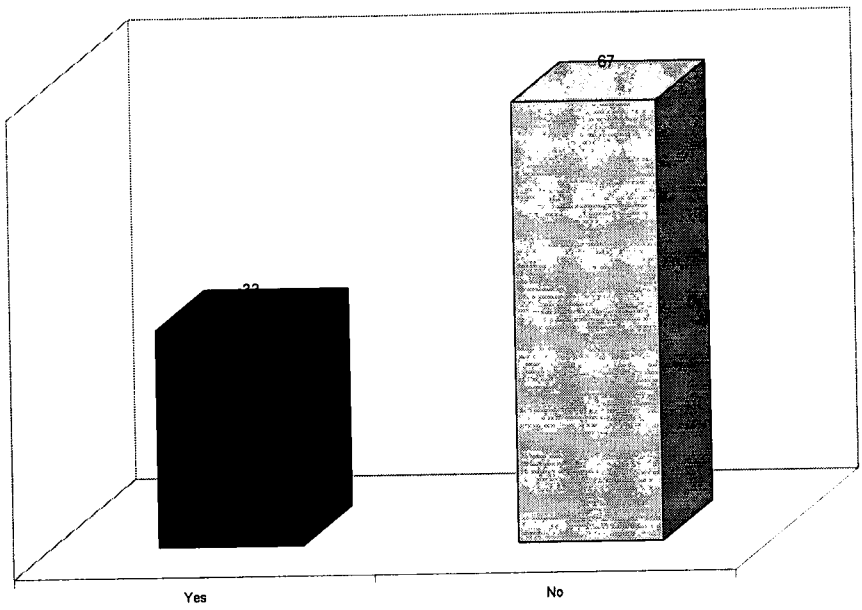
The reason given why culturally congruent nursing care is not taught is that the Nursing Council is still processing the inclusion of congruent nursing care in the curriculum.

The association between the reasons why directives from the South African Nursing Council are not implemented in generic nursing education is strongly indicted by X^2 = 0.05; df = 1; 0.08<P>0.05.

5.4.3.11 Preparation of nurse-educators to teach culturally congruent nursing care

The preparation of nurse-educators to teach culturally congruent nursing care is reflected in Figure 7.

Figure 7: Preparation of nurse educators' on culturally congruent nursing care



The above figure shows that 67% of the respondents displays that educators who teach culturally congruent nursing care in their institutions are not well prepared to teach culturally congruent nursing care.

5.4.3.12 Referral of students to a resource person

Regarding the referral of students to a resource person on culturally congruent nursing care all respondents indicated they would refer them to the person who teaches culturally congruent nursing care.

5.4.3.13 Teaching both traditional and professional health care systems

According to the respondents, the idea of promoting culturally congruent nursing care will be accomplished if novice nurses are taught the combination of both the traditional and professional health care systems.

5.4.3.14 *Teaching of novice nurses on involvement of health care consumers in their own health care plan*

90 % of respondents indicated they refer students to a resources person for help. The rest of respondents (10%) did not answer the question.

5.5 THE ANALYSIS OF THE CHECKLIST DATA FOR CURRICULUM/ COURSE OUTLINES

The data analysis was done on an ordinal level as only seven curricula and two course outlines were received. The table reflects the number of curricula that included cultural concepts forming culturally congruent nursing care and those that do not include them.

Culturally Congruent Health Care that has to be taught and assessed	**Included**	**Excluded**	**Explanation**
A.1 Dimensions addressed by culture: Kinship, Roles + Practices, Gender, Family, Community, Marriage, Parenting, Education, Health, Labour, Communication, Religion and Magic Accepted Behavioral Codes	2	5	Most of the curricula did not include any aspect of cultural dimensions and its importance in nursing. The curriculum for sociology was not included. Thus, it was not known whether the concepts where taught or not.
A.2 Theoretical grounding of culturally congruent nursing care	0	7	No relevant theories were indicated in the curricula/ course outlines provided.
A.3 Content of Cultural health care/Nursing care 3.1 Assessment	4	3	Of the seven, four curricula indicate that culture-assessment should be done, but this is not clearly

			spelled out.
3.2 Diagnosis	0	7	This aspect is not reflected anywhere in the curricula provided.
3.3 Intervention	2	5	Two out of seven curricula indicated the inclusion of cultural intervention. This is however, not clarified to address culturally congruent nursing care.
3.4 Evaluation	0	7	This aspect is not addressed in the curricula/ course outlines provided.
B. Culture and health care as interlocking dimensions			
B.1 Human Biology – genetics inheritance	0	7	No mentioned is made of the importance of human biology, environmental health, individual and family lifestyle regarding culturally congruent nursing care.
B.2 Culture and Environmental Health	0	7	
B.3 Culture and Health	0	7	
B.4 Individual and Family Lifestyle	0	7	Of the seven curricula, only two referred to life events, but even then just as part of culture, but not addressing its importance in nursing care.
B.5 Life events	2	5	
C. Society and Cultural Health as interlocking dimensions			
C.1 Health Care Systems	7	0	All the curricula/course outlines refer to biomedical health systems
Biomedical	0	7	
Traditional			

C.2 Social Factors Science & Technology Political, Judicial, Economic, Environ-mental, Ethnohistorical Religious Merging of biomedical and traditional health	2	5	Education and environment are included by two curricula but their importance in health care is not spelled out. The rest of the social factors are not included

5.6 SUMMARY

In this chapter a description was given of the analysis of the data obtained through the focus group interviews, the questionnaire and the auditing of the curriculum by a checklist.

The data were presented in tables and figures followed by a short discussion.

The findings will be addressed in the next chapter.

CHAPTER SIX

FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter addresses the findings and discussions of the conclusions reached and the recommendations made.

6.2 FINDINGS OF THE STUDY

6.2.1 Findings of the focus group interviews

The findings indicate that nurse-educators recognize and emphasize the importance of teaching novice nurses on cultural aspects that will address culturally congruent nursing care.

6.2.2 Findings obtained through analysis of responses through the questionnaire

- **Age, training schools, years of experience as practitioners and as nurse-educators**

  Generally, the findings revealed that the age of the majority of nurse-educators in the field and currently engaged in teaching generic nursing range between 40 – 59 years. These nurse-

educators studied at hospital nursing schools, consequently have more experience as nurse practitioners as revealed by the findings, and less experience as nurse-educators as they studied late in life to become nurse-educators.

- **Perception of health and illness**

Most nurse-educators define health according to the World Health Organization approach, a perception referred to by Tranabranski (1994:733) as the biomedical orientation regarding health. The findings also revealed that most respondents perceive illness as deviation from the normal bio-physiological status.

- **Perception of the health care consumer and the health care provider as a human being**

The findings revealed that the majority of respondents perceive the health care consumer as a human being, as an individual and as a person who requires support and guidance. On the other hand, the findings indicate that the health care provider is perceived by most respondents as someone who has superiority in power to guide and support.

- **Perception of culturally congruent nursing care**

The majority of respondents perceived culturally congruent nursing care as "attaining knowledge of different cultures". Very few of these respondents were inclined to see culturally congruent nursing care as referring to relevant cultures.

- **Inclusion of culturally congruent nursing care in curriculum**

According to the findings, the majority of respondents felt that cultural congruent nursing care should be included in the curriculum of the generic nursing education programme. This tally with the confession of the majority of respondents who said they never received any education on culturally congruent nursing care during their generic preparation or any other nursing education programme.

In addition, the findings revealed a variety of opinions regarding the content to be included in the curriculum to address culturally congruent nursing care. Only a few respondents suggested that the content to be included in the curriculum should address transcultural issues, while the majority of the respondents felt the contents should in include only cultural practice regarding health.

- **Educational preparation of nurse-educators**

Most nurse-educators confirmed that they are not well prepared to offer education on culturally congruent nursing care to novice students, or to any one for that matter. This tally with the expressions indicated during the focus group interviews that there is a need for nurse-educators to be equipped with the necessary knowledge that will enable them to teach novice students on culturally congruent nursing care.

- **Levels of inclusion of culturally congruent nursing care**

  Regarding the levels at which culturally congruent nursing care should be included in the curriculum, there was also a variety of opinions voiced. The majority of respondents indicated that they are of the opinion that the concept should be introduced at first year level, while others felt that it should be introduced throughout the programme of generic nursing education, that is, from first year to fourth year.

6.2.3 Findings obtained through the checklist for auditing the curriculum

The findings, as reflected, suggest that the curriculum for generic nursing education is lacking in the cultural aspects that address culturally congruent nursing care. Thus, it is not taught because it is not reflected in the curriculum or course-outlines.

6.3 DISCUSSIONS OF THE CONCLUSIONS

- **Age category, experience as practitioner and educators**

  The majority of the respondents are between 40 – 59 years and have had hospital based generic nursing education. Regarding the age category of the respondents it is attributed to the fact that in the past nurses were only educated at hospital nursing schools because nursing education only became predominantly college based after 1981. It is also largely attributed to this historical fact that the many nurse-educators gained more experience as nurse practitioners and not as nurse-educators. The fact that the education was at hospital nursing schools confirms that it was

predominantly biomedical structured, with emphasis on anatomy, physiology, pathology and medical treatment as well as first aid. As the biomedical approach does not take cultural concepts, and in particular, culturally congruent nursing care into consideration, it can not be expected that this age category should be knowledgeable of culturally congruent nursing care. Therefore culturally congruent nursing care is not taught to novice nurses. The very low percentage of nurse-educators (2%) who studied at universities is a confirmation that generic nursing education at universities only started in 1956 for whites and in 1979 for blacks (Mashaba, 1995:28). Thus, the high percentage of hospital based nurse training, as compared to colleges and universities, explains why nurse-educators are more experienced as nurse practitioners as cited by the respondents as compared to their years of experience as nurse-educators. The majority of nurse-educators who have experience of between 2 – 3 years in the field of nursing education is attributed to the fact that, with time, there was more demand for nurse-educators to cope with the number of novice nurses who wanted to pursue the programme, and to keep pace with the new development in the nursing education field. These findings also tally with the findings of Kotze and Rottkamp that the educational programme for nurse-educators is biomedical orientated and focuses largely on the nurse as practitioner and not on the nursing care to be rendered.

- **Gender and cultural orientation**

The majority of respondents are females – a fact that tallies nursing are predominantly a female dominated world and therefore not many men are interested in enrolling in this field. The cultural orientation indicates that respondents are mostly Africans – a fact

that can be partly attributed to the differences in population sector numbers but also largely to the fact, according to Mashaba (1995:28), that more black nurses had to be later recruited to the nursing field in order to cope with new challenges as it was said that black persons waver on the borders of western and indigenous traditional systems of health care, because most Africans still believe that illnesses are culturally induced.

- **The perception of health and illness**

Regarding the perceptions of health and illness, it was found that the majority of the respondents are biomedical orientated; a paradigm and orientation that excludes culture. Leininger (1978:23) would not agree with such a perception, because, according to this author, a holistic definition of health and illness includes culture as a base from which the health care provider can gauge the values and beliefs of health care consumers.

- **The perception of the health care consumer and the health care provider as human beings**

All the respondents perceived both provider and consumer as human beings, but the majority of the respondents indicated that they have a lack of knowledge of how culture can influence concepts and behaviour in health care. These perceptions may lead to the reduction of the health care consumer to a passive object that will be required to accept any health care decision suggested by the health care provider (who is perceived to be superior in health care) (Van den Berg, 1999). This altered perception of a health care consumer does not leave any room for self-reliance.

- **Knowledge of culturally congruent nursing care**

The findings indicated that culturally congruent nursing care is not known by the majority of the respondents, because it was never taught to the respondents at generic nursing education level or at any level of nursing education programmes. Leininger (1991:56) argues that culturally congruent nursing care refers not only to differences in culture, but also to the general relevance thereof. The limited knowledge of the concept of culturally congruent nursing care by the majority of respondents suggests that the concept must be included in the curriculum for generic nursing education so that it can be taught as early as from the first year onwards. This is alluded to by the majority of respondents who strongly felt that culturally congruent nursing care should be included in the curriculum of not only generic nursing but also in all other nursing education programmes (especially that the majority of the respondents confessed that it was never taught to them). The respondents also indicated that all the relevant aspects of the culturally congruent nursing care are to be identified and included in the curriculum of generic nursing education as well as the education programme for nurse-educators so that nurse-educators are well equipped with the correct and appropriate knowledge regarding culturally congruent nursing care. Most nurse-educators confessed, through their responses, that they are not well prepared to offer education on this concept to novice nursing students, or, for that matter, to anyone.

6.4 RECOMMENDATIONS

The following recommendations are made based on the findings and conclusions reached:

- Further research has to be undertaken on the perception of nurse-educators regarding culturally congruent nursing care and its implications for the education of novice nurses;

- When recurriculation of the generic nursing education programme has to be done, it must include culturally congruent nursing care (content and context);

- When recurriculation of the education programme for nurse-educators has to be embarked upon, it must include nursing as a major subject alongside education. The science and art of culturally congruent nursing care has to be subject matter in this nursing module as a major subject to enable nurse-educators to transfer this knowledge to novice nurses;

- The South African Nursing Council must be informed of the above recommendations so that the recurriculation of all nursing programmes can take place to bring about the inclusion of culturally congruent-holistic nursing care as an inherent subject of all nursing programmes;

- Regular workshops on culturally congruent nursing care should be held so that culturally congruent health care can become part of the in-service training programme of all care settings;

- Professional nursing organizations must encourage transcultural nursing symposiums, seminars and conferences where nurses of different cultural backgrounds can deliberate at length on culturally congruent nursing care; and

- To be a cultural broker, all novice nurses must be educated on how to provide cultural brokering including the acquisition of the necessary skills to function as broker. This means that the curricula for nursing and nurse education must include Culturally Congruent Nursing Care so that nurse-educators will model Culturally Congruent Nursing Care to novice nurses. Therefore, although nurse-educators do not necessarily have hands-on-contact with health care consumers on a daily basis, nurse-educators are nevertheless cultural health brokers indirectly. Thus, a model to empower nurse-educators to teach culturally congruent nursing care needs to be developed and explored.

6.5 SUMMARY

In this chapter the findings and discussions of the study were presented and certain conclusions were drawn. Recommendations regarding how culturally congruent nursing care should be addressed were also made. The next chapter will focus on the model that has been developed for the teaching of cultural congruent nursing care.

CHAPTER SEVEN

A MODEL AS FOUNDATION TO GROUND HEALTH CARE EDUCATIONAL PROGRAMMES ENABLING PRACTITIONERS TO RENDER HOLISTIC HEALTH CARE

7.1 INTRODUCTION

In order for health care educators to teach holistic health care to novice practitioners to enable the latter to render holistic health care, the former themselves, have to be educated thoroughly in holistic healthcare (including culturally congruent health care) – the science as well as the art. Based on the perceptions expressed by nurse-educators on culturally congruent nursing care, it is therefore imperative to formulate a model that enables nurse-educators to become educational brokers for novice nurses so that the latter can render holistic culturally congruent nursing to the differently cultured people of South Africa. The proposed model is based on the Culture Brokering Model by Chalanda.

Culturally congruent nursing care is not prioritized as a core learning module in any nursing educational programme because nursing curricula (as set by the South African Nursing Council) are grounded in the bio-medical model (Kin-Godwin, Clark & Barton, 2001 and Cortis, 2000), regardless of the fact that the South African nation is multi-cultural in orientation; furthermore, culturally congruent nursing care leads to higher/better health care outcomes as well as empowerment of the health care consumer. As such, Clark (1996:311) states unequivocally that

culturally congruent nursing care can only be rendered if professional health care providers are educated to provide culturally congruent nursing; only then can care givers be culturally sensitive because they have mastered cultural relativism, cultural accommodation and cultural brokering. Pattishel (1973), Bennett (1976), Wexler (1976) and Seager (1981), on the other hand, noted that all educational programmes for health care practitioners accentuates only the care practitioner's role as a delivery agent, while very little attention is given to the nature and essence of the care to be rendered. According to Quint (1967) the content of curricula, the teaching methods, and the assessment of care rendering behaviour of novice practitioners focus on cognitive learning outcomes. The type of health care offered in order to satisfy the health care consumer falls outside this ambit.

The proposed foundation model, attentive to the limitations identified above, aims to ground the training of nurse-educators and other health care educators, enabling them to become "educational brokers". It is structured in order to benefit educators regardless of their own cultural orientation and the generic health care educational programme followed. Furthermore, it is imperative that the proposed model should ground all educational programme(s) of health care-educators and practitioners (both the context and content of the curriculum) thereby enabling first, the educator to teach and model holistic health care, and, then the novice practitioner to internalize it as his/her own, in order to be able to render holistic health care.

7.2 THE EXPOSITION OF A FOUNDATION MODEL TO GROUND EDUCATIONAL HEALTH CARE PROGRAMMES WHICH ENABLE HEALTH CARE PRACTITIONERS TO RENDER HOLISTIC CULTURAL CONGRUENT HEALTH CARE

The development of "a foundational model to ground educational programmes enabling practitioners to render holistic cultural congruent nursing care" is based on the following points of departure:

- The self-actualization of health care provider (educator and practitioner) and health care consumer;
- Nurse-educators teach nursing similar to how they were taught (context) and what they were taught (content);
- The curriculum is a tool in doctrinal conversion and it is of critical importance;
- The unwritten values and norms modeled by educators to novice practitioners are of crucial importance;
- All nursing curricula must be grounded in the holistic health care model and its underlying paradigm;
- All the philosophical strands that have to be reflected throughout the curricula, must be fully described;
- All educational programmes should be seen as building blocks for one another;

- Culturally congruent nursing care forms an integrated facet of holistic nursing care; and

- The health care consumer is the only person who can declare that the care which was rendered has satisfied him/her.

"The foundational model to ground educational programmes enabling practitioners to render holistic care" is schematically depicted in Figure 7.1. The depiction of the model must be seen as a *Gestalt* in which the content and context of the educational curriculum for nurse-educators enables the educator to become an educational broker to the novice practitioner through the teaching and modeling of comprehensive holistic culturally congruent nursing care. The educational generic nursing programme, as a tool of doctrinal conversion, enables the novice practitioner to become a cultural health care broker to the health care consumer when rendering holistic nursing care that satisfies the consumer. The different processes that are employed must achieve the aim of the different facets of the model and must serve as tools for linking the different facets to one another; the linking cannot be changed around. Through both the content and context of the different facets and processes, the self-actualization of educators, practitioners and consumers, as persons (human beings), is achieved.

The content and context of the different facets of the model: the education of the educator, the education of the novice practitioner and the rendering of holistic nursing care that satisfy the health care consumer; as well as the different processes employed to achieve the aim of each facet, are tabled as a summary in Figure 7.2.

Figure 7.1 A model to ground all educational programmes in the health care sciences

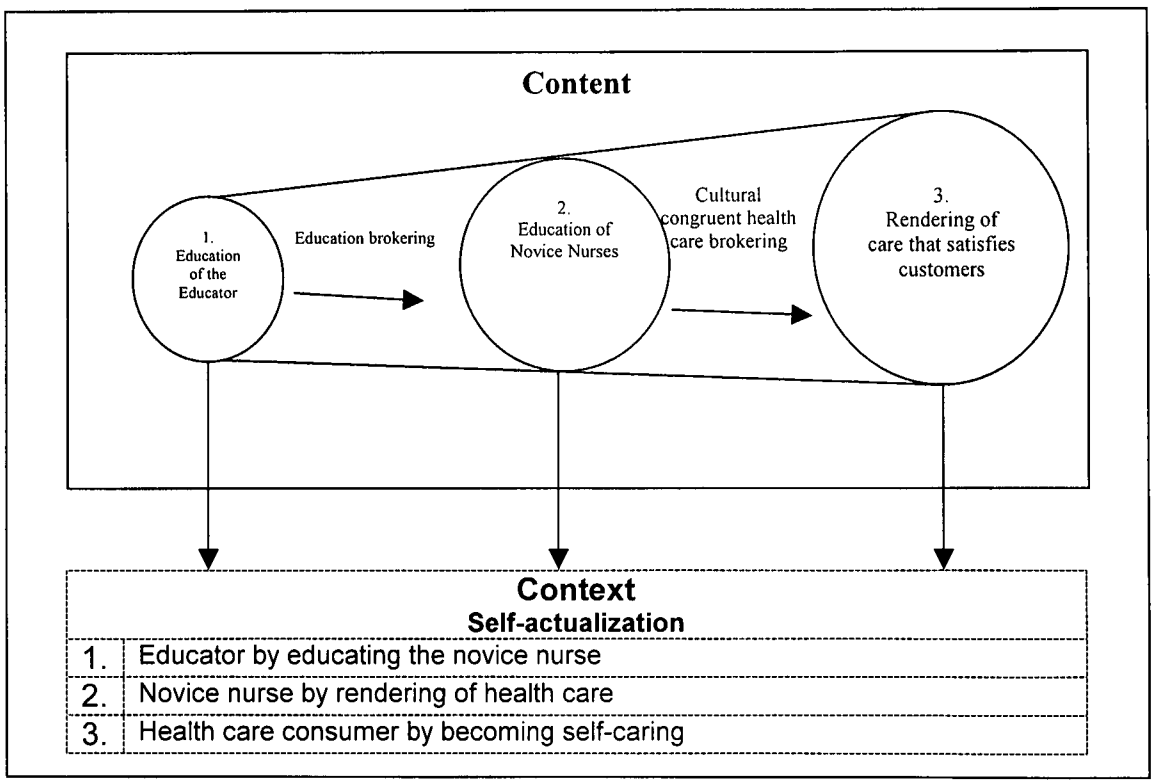
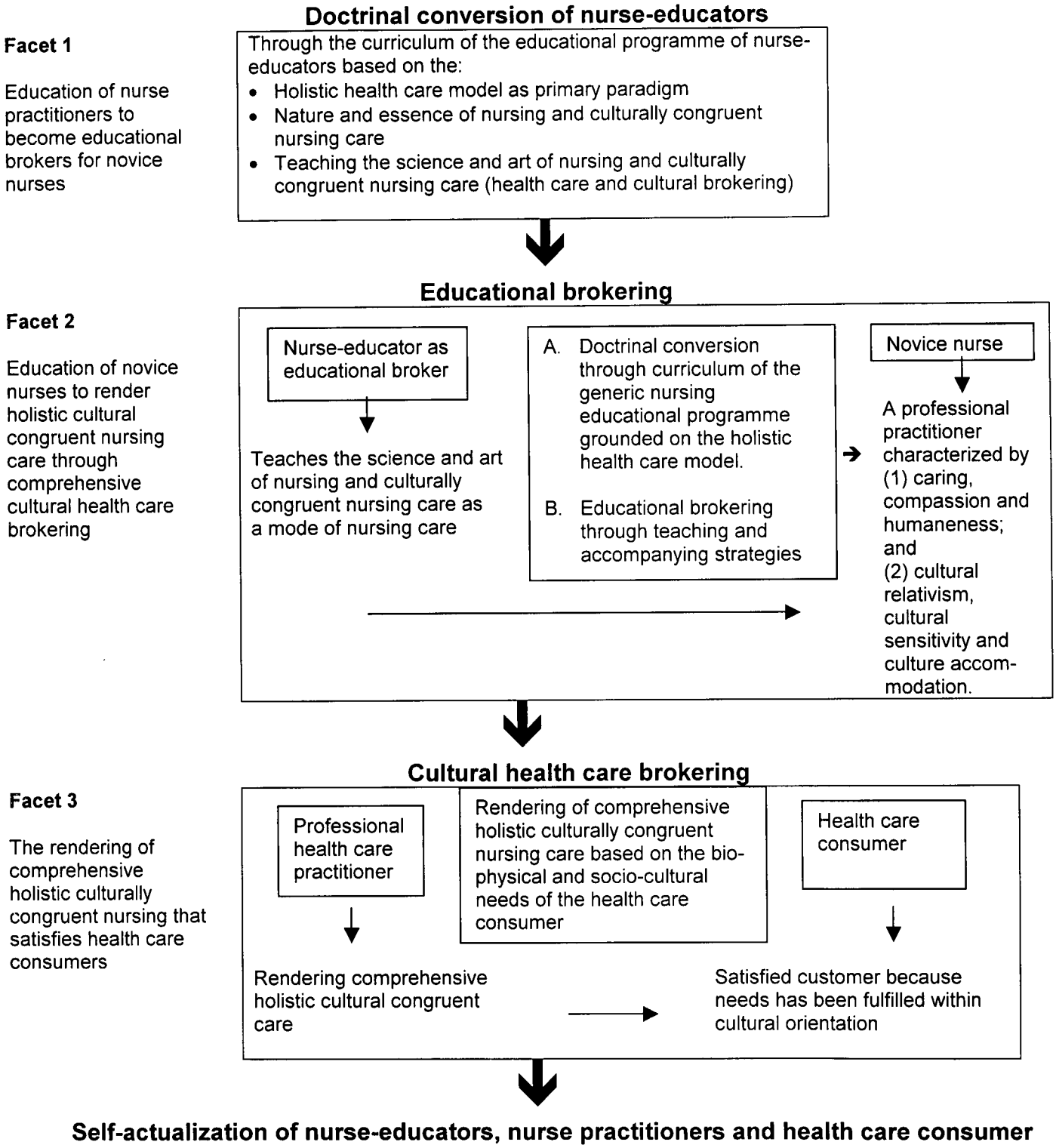


Figure 7.2: Clarification of the components of the different divisions of the educational model



The exposition of the content and context of the model is done as follows:

- First an exposition of the contextual nature of the model is given;
- The content of each facet of the model is then described; and
- Lastly, the processes employed in achieving the aims of the different facets is explored.

7.2.1 The contextual nature of the model

The contextual nature of the model refers to the core strands of the components defining the model while serving as the critical/crucial points of departure for the content of each facet. The philosophical and ethical foundations are necessary because they form the cornerstones of the curricula of the generic nursing educational programme and the educational programme of nurse-educators. As such, the philosophical strands/cornerstones must be continuously reflected in all educational programmes as the encases, and be clear in the theoretical framework. If the philosophical foundations/strands are wanting, the curricula cannot be used as positive doctrinal conversion tools for the rendering of holistic health care (including cultural congruent nursing care); further, the unwritten values and norms which educators have to model to novice practitioners cannot be identified or internalized by both the educator and the practitioner (Aldridge, 1992). The following philosophical strands have been identified as cornerstones (as described in Chapters 2 and 3):

- The health care consumer and health care provider as human beings in the health care consumer-health care provider-relationship;

- Health and illness (including disability and death;

- The ethos, nature and essence of health care (as holistic nursing care which includes culturally congruent nursing care); and

- Nursing education as a mode of health care education.

7.2.1.1 The encamps identified

The encamps are the basic concepts/ideas that have to be reflected throughout the different educational programmes and have their origin in the core philosophical strands (Torres, 1974:42-43). As the programmes progress the depth of the encamps increases. The vertical encamps refer to the concepts/ideas that increase in depth, e.g., care rendering to individuals, care rendering to individuals and their families, and care rendering to groups and the community. The horizontal encamps refer to those basic ideas/concepts that have to be reflected in every module and be repeated throughout the duration of the programme, e.g., health care consumer-health care provider relationships, the nature and essence of nursing; the personhood of humanity (consumer and practitioner). The encapses have also to be reflected in all learning experiences to strengthen the inherent nature and essence of holistic nursing, to be taught by educators, and to be practiced by practitioners when rendering care.

The following encapses have been identified out of the philosophical grounding (as described in Chapter 2):

Horizontal

- Humankind

  - The personhood of humankind in general and the personhood of the healthy/ill/disabled/dying person – as individual, as family member and as community member. The multi-dimensional life lived by human beings.

- Nursing care

  - The nature of health care as holistic nursing care (family-centered)

    1. Nursing as an interpersonal and cultural phenomenon;

    2. The nurse-patient relationship (health care consumer-health care provider relationship) as the feeding ground for all nursing care activities through which the nurse practitioner actualizes himself/herself as person and practitioner; and

    3. The nurse as a health care and cultural broker to the health care consumer in rendering holistic care that satisfies the health care consumer enabling the consumer to actualize himself/herself as a person.

- Holistic culturally congruent nursing care (the science and the art of nursing)

- Ethos of nursing

  - Legal and ethical values grounding the care to be rendered (written norms); and

  - The identified non-written values and norms nurse-educators and nurse practitioners have to internalize as their own as grounded by the holistic health care model and philosophies.

- Health care education

  - The integration of the science and art of nursing care enabling the rendering of holistic nursing care.

Vertical

- Ethos of nursing

  - Health care consumers as human beings living a multi-dimensional life;

  - The nature and essence of health care as holistic nursing care and holistic culturally congruent nursing care; and

  - The integration of the art and science of holistic nursing.

7.2.1.2 The theoretical framework

The theoretical framework refers to the theories, models and approaches/concepts underlying the model. The theoretical framework ensures that all learning experiences are well structured and that the content of the science as well as the art of health care (as nursing care) are scientifically grounded. Thus, the learning experiences become meaningful and lead to doctrinal conversion through the content of the curriculum. Because of the extensiveness of the model, a dialectical approach is followed indicating only the theories/approaches/ models/concepts and the importance thereof.

- The caring models (including cultural brokering, cultural bridging and culturally congruent nursing care) as described by Chalanda, Watson, West and Leininger;

- The theories regarding nursing as an interpersonal phenomenon as described by Watson, Peplau and Henderson;

- The model on self caring as described by Orem;

- The theories regarding the needs of mankind as described by Maslow, Nightingale and Henderson;

- The holistic health care model (including the paradigm grounding it);

- The concepts regarding the nursing process, the use of self in the health care consumer-health care provider-relationship and the assessment of a health care consumer with the aim of providing

care as described by Wilson (1971), Van den Berg (1985:255-561) and Clark (2000:365);

- The concepts of health/illness/disability/death as defined from an existential-phenomenological-philosophical view;

- The existential and phenomenological philosophies regarding humankind and the world;

- The socio-interpersonal relationship model described by Bruins; and

- The concepts of "care and cure" health care activities in fulfilling the instrumental and expressional dimensions of care giving (Colliére, 1980).

7.2.2 The content of the model

The content of the model refers to the scientific knowledge and health care skills the nurse-educator and nurse-practitioner must possess to become competent humane and compassionate health care providers. As such, the content of the curricula of the different educational programmes is moulded to the overall (final) outcome of the specific programme as well as to the critical and specific outcomes set by the National Department of Education and the South African Nursing Council. Grounded in the point of departure underlying the model, namely that educational programmes are building blocks to another and that the content and context of the model are united, intertwined and interwoven and (differentiated but not compartmentalized/divided) the content of the model is elucidated as follows:

- A description of the overall aim and critical outcomes of the model;
- An exposition of the situational analysis done to determine the content;
- A condensed outline of the content of the curricula for nurse-educators and novice nurses based on the specific outcomes that have been set; and
- The learning experience required to achieve the outcome(s) of the programmes.

7.2.2.1 The overall aim and the critical outcomes of the model

The overall aim/vision of the model refers to the continuous endeavour to be achieved by the model itself, the different educational programmes, as well as to the cornerstones and essence the model and programmes are grounded in. As such the overall aim can be stated as follows:

The overall aim/outcome of the model is to mould the personhood of nurse practitioners to actualize them as human beings and practitioners. This will be done by enabling nurse-educators to inculcate holistic culturally congruent nursing care to novice nurses to enable novice nurses, as nurse practitioners, to render holistic nursing care to all health care consumers, basing their care on the cultural orientation and needs of the consumer. The above mentioned outcome uncovers the scientific knowledge and culturally health care skills the nurse practitioners needs to internalize as his/her own in order to render holistic nursing care. It also grounds this as the scientific knowledge and skills (including cultural

brokering skills) nurse-educators have to teach novice nurses in guiding them (the novice nurses) to become competent, humane and compassionate care providers.

The critical outcomes of the model refer to the outcomes that the National Department of Education set for all learning programmes. These outcomes can be ensured if all learning programmes, through doctrinal conversion, shape the personhood of the learner so that the learner/practitioner directs his/her life and practices through these guidelines. Although the outcomes have been adapted to include nursing as a profession, the essence of the guidelines has not been chanced as nurse-practitioners, as members of the nation of South Africa, have to model the essence to their fellow citizens. As such the critical outcomes of the model are as follows:

- The rendering of holistic culturally congruent nursing care (as health care) to all health care consumers based on the holistic health care model and paradigm with the aim of fulfilling the needs of the consumer and his/her family within their community;

- Leading others by being a value-led leader, role model and expert in the multi-professional health care team as well as in the educational setting of nursing and in all life settings;

- Acting as advocate for all health care consumers and fellow citizens within life itself and the multi-holistic professional health care teams in advocating culturally congruent health care through negotiating and formation of partnerships;

- Becoming a life long learner by actualizing oneself through education (in both its broadest and specific meaning);

- Respecting the dignity and uniqueness of all people within their socio-cultural and religious contexts and incorporating this respect in life dimensions and care rendering; and

- Ascribing to an own socio-cultural and holistic world view and philosophies living an own multi-dimensional life and modeling it to all fellow citizens.

By educating all nurse practitioners (novice practitioners, expert nurse practitioners and nurse-educators) to achieve the above outcomes, nursing as a profession fulfills the overall vision set by the National Department of Health, namely rendering comprehensive holistic and quality health care to the inhabitants of South Africa.

7.2.2.2 The exposition of the situational analysis conducted/undertaken to determine the specific content of the model

The situational analysis refers to all those factors, internal as well as external, which were taken into consideration in determining the specific content (knowledge and skills) of the different facets of the model. The following factors were described by Van den Berg (1985:627) as being of extreme importance:

External factors:

- The South African nation consisting of many people with different cultural orientation;

- Different acts regulating the practice of health care providers;

- The vision and mission of the National Department of Health regarding the care to be rendered to all inhabitants of South Africa;

- Regulations regarding the Scope of Practice of different health care practitioners;

- Educational philosophies, policies, standards and curricula for health care as set by statutory bodies of health care;

- The national health care system of South Africa as grounded on the Reconstruction and Development Plan; and

- The Constitution of South Africa and the Patients' Right Charter grounded in the Constitution.

Internal factors:

- The anthropological, axiological and agogic principles grounding the rendering of health care and the education of health care practitioners grounded on the holistic health care model and its underlying paradigm;

- The nature, extent and quality of health care to be rendered by health care practitioners and to be taught to novice health care practitioners;

- The unity of the essential/core elements of health care enabling the rendering of holistic cultural congruent nursing care;

- The embodiment of the science and art of health care to be rendered as holistic culturally congruent care after cultural health care brokering has taken place;

- The structures of health care curricula based on both the biomedical model and holistic model;

- The knowledge by health care educators (including nurse-educators) and health care practitioners of the philosophy of the personhood of health care consumers and nurse practitioners as human beings, when taking different socio-cultural relations of people/persons as a point of departure in providing health care that is satisfying to both the consumer and the provider;

- The role models who model holistic culturally congruent care to novice health care practitioners in the educational and the clinical setting;

- The clinical accompaniment of novice health care practitioners by all health care providers (educators and practitioners) in the different health care professions (including traditional African practitioners); and

- The unity of the different facets, the processes, the context and content in the model.

7.2.2.3 The content of the curriculum for health care educators and novice health care practitioners

As health care embraces both a science and an art, it is necessary to describe both the specific curriculum outcomes as well as the content of the curricula for module(s) as part of a curriculum to achieve the main aim, namely, to enable nurse-educators to teach holistic nursing care to nurse practitioners enabling practitioners to provide satisfactory care to the consumer. Because of the comprehensiveness of curricula, only the content applicable to the inculcation of holistic culturally congruent nursing care will be outlined. The content of the generic educational nursing programme will be outlined first, followed by the content of the educational programme for nurse-educators.

7.2.2.3.1 The generic educational nursing programme

The content of the generic nursing educational programme is compiled according to the standards/guidelines set by the South African Nursing Council. Based on the contextual nature and processes of the model, the following outcomes have been set:

- The overall/final outcome of the educational programme.

  "The educational programme must enable nurse practitioners to render comprehensive, holistic and culturally congruent nursing care to all health care consumers. The care to be rendered must support health care consumers to become self-caring for themselves, their families and their communities and must be based on the needs of the health care consumer as it helps the consumers to actualize themselves as persons."

- The specific outcomes of the educational programme will encompass the following:

  The nurse practitioners must:

  - Render comprehensive and holistic health care (based on cultural health care brokering) to the health care consumer through the integration of the science and art of nursing care;

  - Enter into the health care consumer-health care provider-relationship, and, by using himself/herself therapeutically, support the health care consumer to become self-caring for himself/herself, his/her family and his/her community; and

  - Fulfill the needs (bio-physical as well as socio-cultural) of all health care consumers based on the integration of socio-cultural practices, health care activities (care and cure), technological engineering and physical and chemical commodities.

Based on the above, the curriculum for the generic education of nurse practitioners must include a specific module on the values, nature and essence of nursing and nursing care. This module will act as the building block for the modules in general nursing care, psychiatric nursing care, midwifery, unit management, ethos and professional practice of nursing and research. The content of such a module must include knowledge on:

- The holistic and biomedical health care models and how integration is achieved;

- The nature and essence of the nurse-patient-relationship and therapeutic use of self;

- The needs of the health care consumer (bio-physical and socio-cultural) to reach self-actualization;

- The nature, essence and values of health care as nursing care and culturally congruent nursing care;

- The ethos, nature and essence of health care brokering (including cultural brokering);

- The instrumental and expressional dimensions of health care activities (care and cure) and the use of self;

- The vision set by the National Department of Health for the rendering of value-led, comprehensive and holistic culturally congruent health care as nursing care and the achievement thereof by fulfilling the dependent, interdependent and independent nursing functions based on value-led nursing care;

- The health care consumer as a human being and the influence of health/illness/disability/dying on the personhood of the consumer; and

- Health/illness/disability/dying as existential-phenomenological-philosophical, as well as bio-physical concepts.

Through educational brokering (doctrinal conversion through the compilation of curricula, teaching and assessment strategies, general and specific learning experiences and modeling of comprehensive holistic cultural congruent nursing care based on the needs of the health care consumer), all nurse-educators educating novice nurses must integrate the above into all educational activities (theoretical and clinical) throughout the duration of the programme.

7.2.2.3.2 The educational programme for nurse-educators

Based on the content and context of the generic nursing educational programme, the educational programme for nurse-educators must be seen as the building block for the rendering of comprehensive and holistic cultural congruent nursing care that satisfies the health care consumer as prescribed by the National Department of Health. Therefore, the curriculum for the education of nurse-educators should consist of nursing as a first or second major subject/discipline over and above education as a major discipline/subject. The overall outcome of the major subject "Nursing" can be defined as follows:

"The educational programme for nurse-educators should educate nurse-educators to enable novice nurse practitioners, (through educational brokering) to render comprehensive and holistic cultural congruent health care (as nursing care) to all inhabitants of South Africa."

The specific outcomes of the educational programme should embrace two types of outcomes, based on the two major subjects, namely:

- Nurse-educators must be knowledgeable on the science and art of education in order to impart the necessary knowledge and skills of health care to novice health care practitioners enabling the practitioners to render comprehensive and holistic cultural congruent health care to all health care consumers through the process of educational brokering.

- Nurse-educators must be knowledgeable on the science and art of health care as nursing to enable novice nurse practitioners to render the value-led nursing care prescribed by the vision set by the National Department of Health through the processes of educational brokering as well as health care and cultural brokering.

Based on the above, the compilation of the curriculum for the education of nurse-educators should be done in such a way that nurse-educators become experts in the integration of context, content and processes of health care rendering as an intertwined unity. Nurse-educators must also be aware that the curriculating process is informed by the vision set by the National Department of Health and that all educational brokering activities (theoretical and clinical) must lead to the achievement of the overall outcome of the generic nursing educational programme, namely, the rendering of comprehensive and holistic cultural congruent nursing care that satisfies the health care consumer by supporting the consumer to actualize himself/herself as a person. The importance of doctrinal conversion of novice nurses through the curriculum must be explored. Nursing as a major subject must include arguments/themes/topics on the following:

- The health care consumer and health care practitioner as human beings/persons living a multi-dimensional life in his/her family and community;

- Health and illness/disability/death as existential-phenomenological and philosophical, as well as bio-physical concepts;

- The influence of health/illness/disability/death on the personhood and family and community of the health care consumer;

- The holistic and biomedical health care models, the paradigm underlying each model, its integration in rendering care and the health care systems it underlies;

- The axiological, agogic and anthropological values underlying nursing and the nature and essence of nursing (including culturally congruent nursing care) and the care to be rendered (including concepts such as nursing as an interpersonal and cultural phenomenon, the essence of nursing care activities (care and cure, its instrumental and expressional dimensions and all independent, interdependent and dependent functions to perform as well as health care and cultural brokering to be done to render holistic care);

- The nurse-consumer-relationship as umbrella to the use of self and the rendering of holistic health care; and

- The science and art of nursing care.

The education of health care educators takes place mainly via doctrinal conversion through the curriculum. Thus, the curriculating of the context and content of educational programmes for nurse-educators is of utmost importance as it determines the quality, depth and mindset for health care rendering that educators teach and model to novice nurses. Thus, the recurriculating of the educational programme for nurse-educators must be implemented on a regular basis to prevent the weakening of the educational programme as foundation to the generic nursing educational programme.

- The context of nursing educational programmes (aim, philosophies, horizontal and vertical encapses, processes, theories, vision set by the National Department of Health, critical and specific outcomes to be reached).

- The content of nursing educational programmes (generic and post-basic) including such aspects as standards and guidelines set by the South African Nursing Council, the National Department of Health and National Department of Education.

7.2.3 The processes involved in the achievement of the overall and specific aims/outcomes of the model

The processes buttressing the different facets of the model to achieve the overall and specific outcomes are of utmost importance as they strengthen the contextual nature of the model while also acting as instruments to secure the entanglement of the context and content. They also determine (to a certain extent) the specific context of the different facets of the model. To understand the power that these processes radiate, the

processes will be described as follows (**see Figure 7.2** for the graphic depiction thereof):

- Firstly, the process of self-actualization will be described (a);
- Secondly, the vision of the National Department of Health will be exposed (b);
- Thirdly, the process of cultural health care brokering will be explored (c);
- Fourthly, the process of educational brokering will be examined (d);
- Fifthly, doctrinal conversion as process will be described (e); and
- Lastly, the main strand of entanglement between the context and content and processes will be defined.

7.2.3.1 The process of self-actualization

Self-actualization is the process by which a person is moulded into what/who s/he wanted to become, has to become and should become. Although the process (the how, the where, the when, the why and the what) of transcending the Self of a person differs from person to person, it can be stated that health care consumers actualize themselves by transcending their health problems/illness/disability/death by constituting an own life and living world through becoming self-caring (totally or partially) for themselves, their families and communities. The health care practitioner actualizes himself/herself through the therapeutic use of self in the health care consumer-health care provider relationship by providing satisfactory holistic health care to the health care consumer enabling the latter to become what s/he wants to be, must be and should be.

Simultaneously, self-actualization of the nurse practitioner as person takes place through the actualization of his/her Self as provider and through fulfilling his/her own life as person – becoming the person and practitioner that s/he wants to become, has to become and should become. The nurse-educator actualizes himself/herself as practitioner by becoming a value-led educator through gaining the knowledge and skills (science and art) that have to be imparted to the novice nurse by teaching and modeling the provision of holistic health care to the novice health care practitioner. Thus, on the grounds of the health care practitioner becoming a competent, compassionate, humane and value-led person and practitioner, as well as through the educator's own fulfillment of his/her life, the educator actualizes himself/herself as person and as practitioner – becoming more and more what s/he wants to become, has to become and should become.

7.2.3.2 The influence of the vision set by the National Department of Health

The vision set by the National Department of Health namely, "the rendering of quality, comprehensive and holistic health care (by all care practitioners) to the inhabitants of South Africa", determines the values and norms as well as philosophies, theories and the contextual nature underlying health care, alongside the outcomes and content of all health care educational programmes. Grounded in the set vision, the care to be rendered becomes the main focus of all educational programmes. The scientific knowledge and skills the practitioner must possesses to render the described care can be deduced from the set vision. Based on the above, the learning outcomes of educational programmes must be written in such a way that they enable the novice health care practitioner to become a value-led, compassionate, humane and competent practitioner rendering the pre-described care defined by the highest authority.

7.2.3.3 The health care and cultural brokering to be conducted for the health care consumer

Based on the science and art of culturally congruent nursing care that was already been described in 3.5 (p68-88) grounded in the vision set by the Department of Health namely "that the care to be rendered to the inhabitant of South Africa must be comprehensive, holistic and of the highest quality", the following values shaping the health care to rendered, have been identified:

- Comprehensive care
  - All health care activities must be preventative, promotive, curative and rehabilitative in nature and fulfill the expressive as well as the instrumentive dimensions of all dependent, interdependent and independent functions.
- Holistic care
  - Based on the bio-physical and socio-cultural needs of the health care consumer, the care to be rendered must lead to self-care for self, family and community.
- Highest quality
  - The care must be satisfying to the health care consumer by helping/ supporting him/her to become what he/she wants, must and should become. To achieve self-actualization the consumer must be an active participant in his/her own care plan.

Thus, health care and cultural brokering refers to all modalities of care (technological, engineering and treatment interventions [whether physical, psychological or cultural]) undertaken by the health care provider to support the health care consumer to become self-caring (to die a dignified and humane death) for himself/herself, his/her family and his/her community. To be able to render the pre-described health care, the health care practitioner must be deeply influenced by the values informing holistic culturally congruent health care so as to render care from a holistic mindset based on relativism, sensitivity and compassion.

7.2.3.4 The educational brokering to be undertaken

Educational brokering embraces all educational activities such as the compilation of a curriculum (context and content) as well as all teaching strategies to impart knowledge and all learning experiences to integrate the science of nursing into the art of nursing and all assessments of outcomes (overall an specific [theoretical and clinical] as well as the programme as a whole). These activities, according to Colliére (1980) and Rottkamp (1980) are grounded in the process of doctrinal conversion, to inculcate the type and quality of the health care (comprehensive and holistic cultural congruent) health care practitioners must render. Therefore, because the umbrella aim of the curriculae for the generic nursing education of nurse practitioners and nurse-educators is directed by the vision set by the National Department of Health, all educational brokering activities such as the compilation of the curriculum (holistic health care model, philosophies, encapses, theoretical and skills content); learning experiences; teaching strategies; assessment strategies (formal and summative, overall and specific, theoretical and clinical) and content (theoretical and clinical) must reflect the context prescribed by the set vision. Furthermore, nurse-educators and clinical instructors must model

the set vision on the health care to be provided to the practitioner, thereby integrating the science of nursing into the art of nursing. Thus, since nurse-educators play the most important role in the socialization of novice nurses, they must be thoroughly knowledgeable on the process of education brokering because the quality and type of health care nurse practitioners render to health care consumers depend on the quality of the educational brokering conducted by the nurse-educators.

7.2.3.5 A description of the process of doctrinal conversion

Doctrinal conversion is the 'internalization of the 'institutionally approved' version of nursing practice which the school sought to inculcate (Davis, 1997:35). Kotze (1982 and 1984) states that doctrinal conversion occurs through the educational brokering process in which the curriculum (the context and content [theoretical and clinical], the outcomes [overall and specific], the philosophical foundations and encapses) plays the most important role shaping novice nurses to become competent, compassionate, humane and value-led health care practitioners in fulfilling the different roles constituting the nursing role (such as leader, health educator, therapist or professional practitioner, surrogate) while becoming the person and practitioner they want to become, should become and must become. According to Rottkamp (1980) positive doctrinal conversion takes place if the curriculum is used correctly – leading to humane and compassionate practitioners who render holistic care; negative doctrinal conversion occurs if the practitioner becomes a cold, scientifically-orientated, insecure practitioner performing technical procedures for, and on, the health care consumer.

Since nurse-educators play the most important role in the process of the doctrinal conversion of novice nurses, educators must be educated/converted through the curriculum for the education of nurse-educators, to become value-led educators by modeling the correct values and norms (unwritten) to novice nurses because they are grounded in the context and content of the curriculum for the generic nursing education for health care practitioners (Kramers, 1974:224). Thus, nurse-educators must be thoroughly/soundly educated and knowledgeable on the context of nursing and nursing care as well as educational brokering based on the values and norms underlying holistic cultural congruent health care (as nursing care). Ancillary subjects like Anatomy and Physiology must never become major subjects – Nursing and Nursing Care must be the major subjects alongside Education in the curriculum for nurse-educators. If the opposite exists, negative doctrinal conversion of novice practitioners will take place to the detriment of the personhood of the health care consumer (Rottkamp, 1980 and Colliére, 1980). Rottkamp (1980) further states that if nurse-educators are not educated to be value-led educational brokers for novice nurses, technical-orientated and biomedical minded educators will choose the wrong teaching strategies and learning experiences for the novice practitioners leading to the shaping of cold and scientifically minded nurse practitioners instead of humane and compassionate nurse practitioners. Therefore, the influence of the process of doctrinal conversion through the curriculum (and especially in the case of the education of nurse-educators) must never be negated or minimized as "…. many of the confusions in nursing are in the minds of nurse-educators who are communicating them to the young and spawning a new generation of insecure professionals" (Rottkamp, 1980).

7.2.3.6 The main strands of interwovenness

The golden interwoven strands between the contextual nature of the model, the different content of each facet in the model, and the different processes involved in unifying context and content are based on the following conceptualizations:

- Nurse-educators must be prepared/educated through doctrinal conversion to do the necessary educational brokering for novice nurses so that they can become value-led, compassionate and humane health care practitioners who render comprehensive, holistic and quality health care to health care consumers. The nurse practitioner uses health care and cultural brokering to render comprehensive and holistic nursing care that satisfies the health care consumer because his/her needs (bio-physiological and socio-cultural) have been fulfilled; and

- By being value-orientated educators, and educating novice nurses to become competent, value-led, humane and compassionate nurse practitioners, nurse-educators actualize themselves as persons and practitioners. By being value-led educated to rendering holistic health care (including culturally congruent nursing care) nurse practitioners actualize themselves as persons and practitioners. Through receiving holistic health care grounded in the values of the holism, health care consumers actualize themselves as persons by becoming self-caring for themselves, their families and their communities.

7.3 SUMMARY

Based on the results and findings of the study, a model was designed for the education of novice health care practitioners and health care educators. The model is based on the intertwined unity of the education of the health care educator, the education of the novice health care practitioner and the quality and depth of the health care that is rendered to health care consumers. Thus, the context and content of, and processes involved in, achieving the aims of the different facets of the model were outlined and described as fully as possible. The model should be used in the curriculating activities of all health care educational programmes. Only then can it be ensured that nurse-educators and all health care educators possess the right mindset and a comprehensive view of the science and art of health care and education to enable novice nurse and other health care practitioners to render value-led, comprehensive and culturally congruent holistic health care to all health care consumers in health/ illness/disability/dying supporting the consumers to actualize themselves as persons while simultaneously actualizing themselves as practitioners and educators.

Chapter 8 concludes the study.

CHAPTER EIGHT

8.1 CONCLUSION OF THE STUDY

To provide holistic health care to all health care consumers of different cultural orientations, all care providers must be well prepared in holistic culturally congruent nursing care, based on the values and health beliefs of the health care consumers, so that the care rendered can be meaningful. Thus, nurse-educators are faced with the task of educating all nurse practitioners to render holistic cultural congruent nursing care to all health care consumers. However, nurse-educators must be thoroughly empowered about the care to be rendered before they can impart any knowledge on it.

To prepare novice nurses to render holistic culturally congruent nursing care, nurse-educators must be able to transfer and instill holistic culturally congruent nursing care knowledge and skills by modeling the said nursing care to novice nurses. Based on this assumption, the research methodology was grounded in a non-experimental design of an explorative, descriptive, contextual and phenomenological nature. The research instruments used to gather the necessary data, were focus group interviews to define the content of the questionnaire, a structured questionnaire to ascertain the knowledge of the nurse-educators regarding cultural congruent nursing care, and an audit checklist to check the content of the curricula and course outlines regarding cultural congruent nursing care in the different Schools of Nursing which educate novice nurses. The population consisted of all nurse-educators in higher education institutions of learning in South Africa who are currently teaching nursing. The sample of nursing schools consisted of one

department/nursing school at a university and one at a college, in each of the nine provinces. The nurse-educators, who teach novice nurses, took part in the study on a voluntary basis.

The results of the study revealed that nurse-educators are knowledgeable about culture, but not on holistic culturally congruent nursing care in order to model it to novice nurses. The main reason for this situation is that, although nurse-educators profess to be knowledgeable on holistic culturally congruent nursing care, the inculcation of the context of nursing and holistic culturally congruent nursing through doctrinal conversion by the curricula for the education of nurse-educators never takes place. The curricula for educators are plastered together with ancillary subject as focal points, leading to the modeling of technical health care carried out on the health care consumer.

Based on these findings, a model was designed to serve as a guideline for nurse-educators to be educated in holistic culturally congruent nursing care, enabling them to act as educational brokers for the novice nurses and to render holistic cultural congruent nursing care leading to the self-actualization of nurse-educators, nurse practitioners and health care consumers.

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SUMMARY

The population of South Africa is multicultural and because of this multiculturalism, health care practitioners render care to health care consumers of different cultural backgrounds. For practitioners to render holistic care that satisfies the consumers, nurses must have been comprehensively educated to render culturally congruent nursing care to all health care consumers. For nurse-educators to be able to impart the science and art of culturally congruent, holistic nursing care to novice nurses, the nurse-educators must themselves have been educated on culturally congruent and holistic nursing care.

The purpose of the study was to ascertain how nurse-educators at universities and nursing colleges perceive culturally congruent nursing care, as well as the implications this has on the education of novice nurse practitioners. A non-experimental research design of a descriptive, explorative, phenomenological and contextual nature was used to achieve the goal of the study.

The point of departure for collecting the data was the "Reflective inquiry methodology" using focus group interviews, a questionnaire and a checklist to collect the necessary data. The focus group interviews were used to ground the formulation of questions included in the questionnaire while the checklist was used to audit the generic nursing education programmes on the educational grounding of culturally congruent, holistic nursing care.

Based on the results obtained, it became clear that nurse-educators are not well prepared to teach holistic, culturally congruent nursing care. Furthermore, the majority of respondents recommend that culturally congruent nursing care be included in the curriculum of generic nursing education programmes.

Based on the recommendations that were made, a model for the education of both the educators and the novice nurse practitioners was developed and adopted, taking the Brokering Model as described by Chalanda as a point of departure. The model ensured that both nurse-educators and practitioners possess the right mindset and have a comprehensive view of the science and art of nursing care, enabling them to teach and to render value-led, comprehensive and culturally congruent, holistic health care to all health care consumers.

OPSOMMING

Die bevolking van Suid-Afrika is multi-kultureel en op grond van hierdie multi-kulturaliteit, verleen gesondheidsorgpraktisyns gesondheidsorg aan gesondheidsorgverbruikers wie aan verskillende kulturele oriëntasies behoort. Om holistiese gesondheidsorg aan die verbruiker wat die verbruiker bevredig, te verleen, moet alle gesondheidsorgpraktisyns deeglik in die noodsaaklikheid om kultuur-kongruente verpleegsorg aan alle gesondheidsorgverbruikers te verleen, opgevoed word. Om nuweling-verpleegkundige praktisyns in die kunde en kuns van kultuur-kongruente, holistiese verpleegsorg op te voed, moet alle verpleegkundige opvoeders self insake kultuur-kongruente, holistiese verpleegsorg opgevoed wees.

Die doel van die studie was om die siening aangaande kultuur-kongruente verpleegsorg wat deur verpleegkundige opvoeders aan universiteite en verpleegkolleges gehuldig word, vas te stel asook die effek wat dit op die opvoeding van nuweling-verpleegkundige praktisyns uitoefen. 'n Nie-eksperimentele navorsingsontwerp van 'n beskrywende, verkennende, fenomenologiese en kontekstuele aard is gevolg om die doel van die studie te bereik. As uitgangspunt is die "Reflective inquiry Methodology' gebruik om die data deur middel van fokus groep onderhoude, 'n vraelys en 'n oudit-aftiklys in te samel. Die fokus groep onderhoude is gebruik om die vrae in die vraelys te begrond terwyl die aftiklys gebruik is om die opvoedkundige hoekstene van kultuur-kongruente, holistiese verpleegsorg soos vasgelê in die generiese kurrikulum na te gaan.

Gegrond op die resultate wat verkry is, blyk dit dat verpleegkundige opvoeders nie voldoende opgevoed is om holistiese, kultuur-kongruente verpleegsorg te doseer nie. Ook het die meerderheid van die respondente aanbeveel dat kultuur-kongruente verpleegsorg in die kurrikulum van die generiese verpleegkundige opvoedingsprogram ingesluit word.

In die lig van die aanbevelings wat gemaak is, is 'n model rakende die verpleegkundige opvoeding van beide die opvoeder en nuweling-verpleegkundige praktisyn daargestel. Hierdie model is op die "Cultural Brokering Model" soos beskryf deur Chalanda, gebaseer en aangepas. Met die model is verseker dat beide die verpleegkundige opvoeder en praktisyn oor die regte ingesteldheid sal beskik tesame met 'n omvattende oorsig oor die kunde en kuns van verpleegsorg op grond waarvan hulle in staat is om nie alleen genormeerde omvattende en kultuur-kongruente, holistiese verpleegsorg te doseer nie, maar dit ook aan alle gesondheidsorgverbruikers te verleen.

ADDENDUM A

QUESTIONNAIRE

APPENDIX A

QUESTIONNAIRE

NURSE EDUCATORS' PERCEPTION OF CULTURAL CONGRUENT NURSING CARE: A MODEL FOR EDUCATION OF NOVICE NURSES

FOR OFFICE USE ONLY

Questionnaire No 1 1 1 1 1-3

Card No 1 1

SECTION A

BIOGRAPHICAL DATA

Please mark the applicable answer with a cross

1. Gender

   Male
   Female

2. Your Age in years

20-30

31-40

41-50

51-60

61 and above

3. Cultural Orientation

African

Western

Asian

African -Western

African -Asian

4. Generic Nursing Education

Hospital

Nursing College (after 1981)

5 How long did you work as a nurse Practitioner before you became an Educator?

---

6. Years of experience in Nursing Education

7. Did you ever receive education on cultural congruent nursing care?

If yes:

7.1 was it at basic nursing education level?

7.2 was it at post basic nursing education level?

7.3 what where you taught

SECTION B

B.1 How do you perceive the health care consumer(patient/client)?

B.2 How do you perceive the health care provider (nurse)

B.3 How do you perceive nursing?

B.4 How do you perceive health?

B.5 How do you perceive illness/disability/death?

Please motivate----------

B.6. How do you perceive cultural congruent nursing care?

B.7 Does the directive from South African Nursing Council emphasize the inclusion of cultural congruent nursing care?

YES NO

Please explain ----------

B.8 In your opinion, must cultural congruent nursing care be included in the curriculum of generic nursing programme?

Please motivate your answer----------

B.9 What content do you think must be taught to students regarding cultural congruent nursing care?

B.10 At what level do you think the cultural congruent nursing care should be introduced in nursing curriculum both for theory and for practical?

Please motivate your answer----------

B.11 How do you think the nurse educators must include cultural congruent nursing care in their curriculum?

B.12 Do you think the nurse educators at your institution are well prepared in cultural congruent nursing care?

YES NO

Please motivate your answer----------

B.13 Is cultural congruent nursing care taught at your institution?

YES NO

Please motivate----------

B.14 How do you teach the novice nurse to involve Health Care Consumers in the plan of their health care delivery?

B.15 Whom would you recommend for student consultation as a resource person for the knowledge of cultural congruent nursing care?

Please motivate your answer----------

B.16 What is your feeling about teaching of novice nurses on the combination of both traditional western health care system?

Please motivate your answer ----------

THANK YOU

ADDENDUM B

CHECKLIST FOR THE CURRICULUM

CHECKLIST FOR THE CONTENT OF CURRICULUM REGARDING CULTURAL CONGRUENT NURSING KNOWLEDGE AS REFLECTED IN OUTCOMES

	OBJECTIVES		
	YES	NO	COMMENTS
A CULTURAL CONGRUENT HEALTH CARE THAT HAS TO BE TAUGHT AND ASSESSED			
A.1 Dimensions addressed by all cultures:			
• Kinships	✓		
• Roles + Practices	✓		
• Gender	✓		
• Family	✓		
• Community	✓		
• Marriage		✓	
• Parenting	✓		
• Education	✓		
• Health	✓		Informal, not clearly spelled out
• Labour		✓	Does not seem to be known
• Communication	✓		
• Life Events			Nothing said about
• Religion and Magic	✓		
• Accepted Behavioral codes	✓		
• Orientation goods	✓		
• Orientation to human nature	✓		
• Orientation to competition		✓	
• Orientation to time	✓		
A.2 Theoretical Grounding of Cultural Congruent Nursing Care			
2.1 Leininger's Cultural Diversity and universality	✓		Though scantily understood
2.2 Chalanda's Culture Brokerage		✓	Not known
2.3 West's Cultural Bridging		✓	Not known
2.4 Kinney's Transcultural Caring cased on Community Partnership		✓	Not known
2.5 De Santi's Cultural Congruent Care		✓	Not known

	OBJECTIVES		
	YES	NO	COMMENTS
A.3 Content of Cultural Health Care/ Nursing Care			
3.1 Assessment of individual/family	✓		
3.2 Diagnosis	✓		
Cultural Wellness			Not properly treated though
Cultural High Risk			
3.3 Intervention			
• Self	✓		
• Supportive	✓		
• Mediation		✓	
3.4 Evaluation			
• Cultural Congruent Care Specifics			
• Medical Disciplines			
• Nursing Care Cultural Care Appropriates			
B. CULTURE AND HEALTH CARE AS INTERLOCKING DIMENSIONS			
B.1 Human Biology-genetics inheritance		✓	
• Physiologic functioning as culturally defined		✓	
• Cultural attitudes to body parts and physiological functions		✓	
B.2 Culture and Environmental Health			
• Physical Environment	✓		
• Agricultural Practice		✓	
• Different Environmental Practices	✓		

	OBJECTIVES		
	YES	NO	COMMENTS
B.3 Culture and Health			
• Attitudes and beliefs regarding:			
▪ Conception and pregnancy	✓		
▪ Health	✓		
▪ Pain	✓		
▪ Illness	✓		
▪ Disability	✓		
• Individual vs Group goals/ mode, authority and decision making:			
▪ Chiefs	✓		
▪ Pariachalism	✓		
▪ Matriachalism	✓		
▪ Professionals e.g. Teachers and community members			Vaguely mentioned
• Relationship with friends and community	✓		Though with some reservations
B.4 Individual and Family Life Style regarding:			
4.1 Dietary Practices			
• Cultural food preferences	✓		
• Cultural food preparation	✓		
• Cultural regulatory of consumption and pattern			
• Cultural sharing of food	✓		
• Cultural symbolism of food		✓	
4.2 Cultural therapeutic and preventive practices			
• Use of medicine			
▪ Traditional/alternative	✓		
▪ Chemical (bio-medical treatment)		✓	
4.3 The use of the following:			
• Alcohol		✓	
• Smoking		✓	
• Drugs		✓	

	OBJECTIVES		
	YES	NO	COMMENTS
B.5 Life events 5.1 Cultural practices and taboos during life events: • Maternal Pregnancy • Child Practices • Roles and Practices • Death and Dying Practices • Safety Practices	 ✓ ✓	 ✓ ✓ ✓	 Not clearly spelled out
C SOCIETY AND CULTURAL HEALTH AS INTERLOCKING DIMENSIONS **C.1 Health Care Systems** • Biomedical System • Perception of Health Care Institutions • Perception of Health Care Providers • Folk/traditional Health Care System • Medical Health Care System	 ✓ ✓	 ✓ ✓ 	
C.2 Social Factors • Scientific and Technological Factors • Political Factors • Judicial Factors • Economic Factors • Educational Factors • Environmental Factors • Ethnohistorical Factors • Religious Factors • Merging of biomedical and traditional health	 ✓ ✓ ✓ 	 ✓ ✓ ✓ ✓ ✓	 Not clear set

ADDENDUM C

ETHICAL CLEARANCE

UNIVERSITY OF THE FREE STATE

Office of the Director: Administration
Faculty of Health Sciences

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☎ (051) 405-3013 / 401-2847
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Enquiries Mrs G Niemand
Tel 4053004

25th October 2001

MS LA MASIPA
C/O DR RH VAN DEN BERG
SCHOOL OF NURSING
UNIVERSITY OF THE FREE STATE

Dear Ms Masipa

ETOVS NR 209/01
RESEARCHER: MS LA MASIPA
PROJECT TITLE: THE NURSE-EDUCATORS' PERCEPTION OF CULTURAL CONGRUENT NURSING CARE: A MODEL FOR EDUCATION OF NOVICE NURSES.

You are hereby informed that the abovementioned pilot study was approved by the Ethics Committee during their meeting held on the 23rd October 2001. The final protocol, Informed Consents and questionnaire have to be submitted for approval.

Your attention is kindly drawn to the following:

a) A progress report be presented not later than one year after approval of the project
b) That all extentions, amendments, serious adverse events, termination of a study etc have to be reported to the Ethics Committee.

Will you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries.

Yours faithfully

For DIRECTOR: MEDICINE ADMINISTRATION

ETHICS COMMITTEE FOR MEDICAL RESEARCH

ATTENDANCE LIST OF THE MEETING HELD ON 23rd OCTOBER 2001

FACULTY MEMBERS (CLINICAL)

Prof PH Wessels	**Chairman** M.B.Ch.B.,M.Med. (O.et G.)(UOFS), F.C.O.G. (SA) Department: Obstetrics and Gynaecology	Present
Prof BB Hoek	M.B. Ch.B. (Pret), M.Med. (Paed.) (UOFS), D.G.G. (UOFS) Department: Paediatrics and Child Health	Present
Prof L Goedhals	M.B. Ch.B. (U.C.T.) M.Med (Rad.T.) UOFS Department: Oncotherapy	Absent
Prof MVJ v Vuuren	M.B. Ch.B. (Pret) M. Prax. Med. (Pret) MRCGP (London) Dip. Forensic Med. (SA) Department: Family Medicine	Present
Prof BJS Diedericks	M.B. Ch.B. (UOFS), M.Med (Anes) (UOFS) FCA (SA), B.A. (UNISA) Department Anaesthesiology	Present
Prof R Barry	M.B. Ch.B. (Stell.), M.Med. (Surgery)(UOFS) Department: Surgery	Present

SCHOOL OF NURSING REPRESENTATIVE:

Dr WJC van Rhyn (Lady)	M.Soc.Sc. (Nursing) (U.P.) B.A. et Sc. (Nursing) (PU for CHE) Cert. Psychiatric Nursing (PU for CHE) Doc.Soc.Sc. (Nursing) (UOFS) School of Nursing	Absent
Prof M Mulder (Lady) *(Secundus)*	Hons B.Soc.Sc Nursing (UFS) M.Soc.Sc Nursing (UFS) D.Soc.Sc Nursing (UFS) School of Nursing	Present

REPRESENTATIVE OF SCHOOL OF ALLIED HEALTH PROFESSIONS

Prof MW Krause (Lady)	National Diploma (Physiotherapy) (UP) Tertiary Education Diploma (Physiotherapy) (UOFS) M.Sc. (Physiotherapy) (UOFS) Department of Physiotherapy.	Absent

RELIGIOUS/LAY MEMBER:

Rev D Keta (Coloured)	B.Th. (University of the North) B.Th. (Hons.) (UNISA) Department Biblical Studies	Present

Mr E Khutsoane	Matric At present: Technical and Logistical assistant Division for the Development Of Student Learning, UOFS	Present

LEGAL MEMBER:

Prof H Oosthuizen	B.Iur., LL.B., LL.D. (UOFS) Department: Criminal Law	Absent

EX OFFICIO MEMBERS: ***(not entitled to vote)***

Dr L Fouché (Lady)	M.B. Ch.B., (Pret) Senior Executive Officer: Psychiatric Complex of the Free State	Present
Ms NC Sondiyazi (Lady)	B.A. (CUR) (Hons.) (UNISA) Snr Executive Officer National District Hospital Bloemfontein	Absent
Dr SF Otto (Lady)	M.B. Ch.B. (UOFS) M.B. (UOFS) B.Legum (UNISA) B.Iuris (UNISA) LL.B. (UNISA) Snr Executive Officer Universitas Hospital	Absent
Dr H Smalberger (Lady)	M.B. Ch.B. (UOFS) D.G.G (UOFS) D.G.B (UOFS) J.B.G (UOFS) Snr Executive Officer Pelonomi Hospital	Absent

DIRECTOR: MEDICINE ADMINISTRATION
/hs

ADDENDUM D

PERMISSION GRANTED TO CONDUCT STUDY

MEMO

Agriculture, Science and Technology

Tel: +27 18 3892236
Fax: +27 18 3892052
E-mail: masipaa@uniwest.ac.za
Internet: http://www.nwu.ac.za/

20 OCTOBER 2004

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.....
.....

Dear Sir/Madam

REQUEST TO CONDUCT A STUDY

I hereby request to conduct questionnaire for a research study entitled: "The Nurse Educators' Perception of Cultural Congruent Nursing Care".

The study is aimed at investigating how nurse educators in nursing education institutions of South Africa perceive cultural congruent nursing care when they teach novice students, and how they can implement it in their teaching.

The study will be conducted in accordance with the requirements of Doctorate in Philosophy (Nursing) at the University of Free State. I therefore promise to abide by ethical principles expected of me. Your co-operation will be highly appreciated.

Please find attached here to protocol for this study.

Yours sincerely

Masipa L.

L.A. MASIPA
DOCTORAL STUDENT

MAFIKENG CAMPUS
Private Bag X2046, Mmabatho, South Africa, 2735
Tel: (018)389-2111 • Fax: (018)392-5775
Internet: http://www.nwu.ac.za

University
of the Witwatersrand,
Johannesburg

Nursing Education

Medical School, 7 York Road, Parktown, Johannesburg 2193 · Telegrams 'Witsmed' · Telephone: +27 11 488-4272 · Fax: +27 11 488-4195
E-mail: apfelpc@therapy.wits.ac.za · Website: http/www.wits.ac.za/fac/med/nursing

25th November, 2004

Ms L Masipa
School of Nursing
North West University
Mafikeng Campus
Private Bag X 2046
MMABATHO
2735

Dear Ms Masipa,

Re: Application to administer a questionnaire to the nurse educators in the Department of Nursing Education, University of the Witwatersrand:

Thank you for your application to pursue data collection in the Department of Nursing Education at this university. Professor Cleaton-Jones has forwarded the request to me as a nurse and member of the ethics committee with the suggestion that I assist you in your endeavour. May I suggest that you approach Professor Judy Bruce (Head of Department, Nursing Education) directly for permission to collect data in her department?

Should Professor Bruce acquiesce to your request, an information letter should be compiled for all potential participants in which you introduce yourself, invite voluntary participation, explain the aim of the study, describe the manner in which you intend to collect the data and explain what will be required of the lecturers you hope to interview. Included must be measures you will take to ensure anonymity, confidentiality and ensure all other participant rights. You should also include the assurance that participation for each person is entirely voluntary and that they may refuse to participate or withdraw from the study at any time without explanation or any penalty or consequence. Please include your contact details so that interested parties are able to obtain further information should they so desire.

A separate consent form should be appended.

I hope that this assists you in finalizing your preliminary arrangements.

Yours sincerely,

Gayle Langley.

Gayle Langley.
Committee Member, Human Research Ethics Committee (Medical)

UNIVERSITY *of the* WESTERN CAPE

Private Bag X17 Bellville 7535 South Africa Telegraph: UNIBELL
Telephone: 27 021 959-2111/2102 Fax: 27 021 959-3126 Telex: 52 6661
E-mail:

Dir. line/lyn: .....

OFFICE OF THE REGISTRAR
26 November 2004

Ref./Verwys:.....

Ms L A Masipa
C/O Dr RH van den Berg
School of Nursing
University of the Free State
P O Box 339
Bloemfontein
9300

Dear Ms Masipa

PERMISSION TO CONDUCT A STUDY

I wish to acknowledge receipt of your request dated 20 October 2004.

It gives me great pleasure to grant you permission to proceed with your research project. Kindly liaise with the department concerned.

Yours sincerely

DR I MILLER
REGISTRAR

GAUTENG PROVINCIAL GOVERNMENT

DEPARTMENT OF HEALTH

ENQ. : Ms. P. C Nel
☎ : 011 355 3522
fax : 011 355 3005 / 3549

22 November 2004

MS. L. A. MASIPA
C/O DR R H VAN DEN BERG
SCHOOL OF NURSING
UNVERSITY OF THE FREE STATE

REQUEST FOR PERMISSION TO CONDUCT RESEARCH - THE NURSE EDUCATOR'S PERCEPTION OF CULTURAL CONGRUENT NURSING CARE: A MODEEL FOR NURSING EDUCATION OF NOVICE NURSES.

Your application to conduct the abovementioned research refers.

I have the pleasure in informing you that you are hereby granted permission to conduct the above research at the Gauteng Department of Health Nursing College provided that the following conditions are met:

⇒ **You contact the Principals of the Nursing Colleges**
⇒ **Obtain their permission to conduct the research**
⇒ **The Management is kept informed regarding progress of the research.**
⇒ **The research does not interfere with the working environment of th respondents.**
⇒ **The confidentiality and the anonymity of the respondents and the institutic is maintained at all times.**
⇒ **A copy of your completed study is donated to this Department.**

You are advised to contact the principals as soon as possible as the colleges clo as from the 10 December until the new year.

The contact details of the principals of the nursing colleges is as follows:

Chris Hani Bara – Mrs C Ndhlovu – 011 933 8013
Ann Latsky - Mrs E Haarms – 011 644 8915
S G Lourens - Mrs M Rambua – 012 319 56 19
Ga Rankuwa – Mrs N Maringa – 012 560 0877

Best wishes for your research. The Department looks forward in hearing about y progress in this study. Please do not hesitate to contact us if we can be of assistance.

Yours sincerely

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MS. P. C. NEL
ASSISTANT DIRECTOR : NURSING EDUCATION AND TRAINING

MEDICAL UNIVERSITY OF SOUTHERN AFRICA

NURSING SCIENCE DEPARTMENT
P.O. Box 142
TEL: (012) 521 4664/4305
FAX: (012) 521 4481

Mobile: 082 908 2737
E-mail: jmokoena@medunsa.ac.za

Our ref.
DEPARTMENT
Tel.

MEDICAL UNIVERSITY OF SOUTHERN AFRICA

MEDUNSA

Medunsa 0204
Rep of South Africa
Tel (012) 521-4111
Fax (012) 560-0086

ATTENTION : MS L. S. MASIPA
Dept of Nursing Science
North West University
MAFIKENG

FAX NO. 018 – 389 2052

Dear Ms Masipa

RE: REQUEST TO CONDUCT A STUDY

Permission is hereby granted to you to administer a questionnaire for your doctoral study entitled *'The Nurse Educator's Perception of Cultural Congruent Nursing Care.'*

Kindly forward the questionnaire.

We wish you success with your studies.

Yours sincerely

J.D. MOKOENA (MRS)
ACTING HEAD : NURSING SCIENCE DEPT
November 26, 2004

ADDENDUM E

FOCUS GROUP TRANSCRIBED

TRANSCRIPTION OF A FOCUS GROUP INTERVIEW HELD AT THE UNIVERSITY OF NORTH WEST AMONG ACADEMICS IN HEALTH AND SOCIAL SCIENCES ON WEDNESDAY, 30 OCTOBER 2002

RECORDED:

You are assigned to teach novice nursing learners in the current multicultural South Africa. Debate on how nurse-educators in South Africa Nursing Education Institutions perceive cultural congruent nursing care. Indicate what implications such perceptions can have in the education of these novice nursing practitioners.

RESPONSE:

Perception of teachers. For me congruence has to do with genuiness. As teachers we have to teach genuiness. We must be sensitive of the way other people live and behave.

It will be useless if we do not consider cultural beliefs of other people.

Taking into consideration the culture in our new South Africa is that things have changed. In the past we used to look at things as being ethnic based. It is different now because people work in different areas. They have to think of other people's cultures in their interaction. It is common for people of a particular culture or ethnic group to be looking at other ethnic groups as "other people". At times this happens because people have not been exposed to other cultures, to other ethnic groups other than theirs. For example, a Motswana would be talking about ethnic groups like Shangaans and Vendas as if they are people who belong to another planet, which means he has not been exposed to other

cultures. To him people who matter are _____ or those of Sotho groups. Another indication here is that such people tend to think they or their cultures are superior to those of others.

One other thing is respect.

It is important for our students to be guided into respecting other cultures and learning other people's languages. If you say you don't know these people's language, already it indicates you are not prepared to do so, to know it. Knowledge of other people's languages and the way you understand them leads to respecting them.

In addition, it is important not to use derogative names. In the whole of South Africa we have derogative names. Nurses should be taught not to use such names to the health care consumers. You often hear of words like "Silwan", "letebele", "lekwapa", and maybe Shangaans could be having a name they use to other people: "Mavesha". If such names are used then the patient care will be affected. If you get a patient from another place and you use such names, then the patient will feel rejected. That patient will not get good nursing care as that will have a negative impact on his care.

IMPOSITION:

As care provider you must not impose your actions on other people but rather educate them (for example: I had an encounter with a mother of a child who had TB. She was from another country, another culture. According to her they are not suppose to take any medication). As a nurse, if you come across such a person rather than imposing your own culture on him, educate this person about the importance of taking medication without making him/her feel your beliefs are superior to his/hers, but rather try to educate him/her about the importance of

taking good medication, in a way that this person will feel comfortable in going to look for help.

RESPECT AND TRUST:

As soon as the patient senses you make a person feel that you respect him, he will be able to trust you as a care giver. But as soon as he senses that you are someone who looks down upon him, it is difficult to form that connection with you receiver of care.

CULTURAL PRACTICES:

There was another important point: cultural practices, I mean African Traditional Medication. You know most Africans still go for cultural traditional medicines. In most African countries, including South Africa, majority of people still use African traditional healers and still go to these healers. There is a cultural element there. Those who do not practice these traditions must also learn to respect them. As teachers if you are in the classrooms you do talk about them and there is no one who will say yes I go to African traditional healers. Even if you say there is nothing wrong about them, there must be something good about them for people to continue going there, no student will be brave enough to say yes, I do go to these people.

Going to traditional healers may maybe because of psychosomatic disorders. As Africans and even Europeans we must respect other health orientations. In essence we must be able to respect those who are taking these medications.

It will help if people know that you are accommodative to t heir beliefs. They will be more free to talk about it. A person can even easily say to you, yes I went to an African traditional healer before I came to you for help.

ADDENDUM F

CURRICULUM

LEARNING CONTENT

The themes of modules and the scope of papers and the credits are outlined in Table 2.

NURSING

The theoretical basis of the generic and specific nursing skills that are related to the theoretical contents of modules are presented in the nursing modules, where applicable:

- Problem-solving
- The application of comprehensive health care
- Implementing primary health-care principles
- Handling ethical issues
- Engaging in professional practice
- Management
- Communication
- Patient referrals
- Applying legislation
- Effective use of technology

TABLE 2: Themes of modules and the scope of papers and credits

Modules and papers	Themes	Credits
Nursing Theory VRT116 One paper of 3 hours	- Comprehensive health care - Principles of primary health care - Epidemiological process - Community profile - Community development - Environmental health	24
Nursing Theory VRT128 Two papers of 2 hours each	**Paper 1** - Family care - Nutrition - Developmental phases - Identifying crises - Identifying substance abuse **Paper 2** Using the nursing process in identifying and dealing with basic and selected health needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase with regard to: - the skin - the ear, nose and throat - the pulmonary system - wound care	32
Nursing Theory VRT217 One paper of 3 hours	- Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase of immune suppression.	28
	- An IMCI (Integrated Management of Childhood Illnesses) module as compiled by the WHO, is presented. It involves the five main causes of child deaths (0-5 years), namely , diarrhea, fever, breathing problems, HIV/AIDS, anemia and nutritional deficiencies	
Nursing Theory VRT229 Two papers of 2 hours each	**Paper 1** Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase that has bearing on: - endocrinology - the urogenital system - the reproductive system **Paper 2** Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase that has bearing on: - the musco-skeletal system - the cardio-vascular system - the ophthalmological system - pulmonology - the gastro-intestinal system	36
Nursing Theory NUR316 Two papers of 2 hours each	**Paper 1** Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase that has bearing on: - the pulmonary system - burn wounds - peri-operative care - pain - shock - assessing a patient's psychological wellbeing. **Paper 2** Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase that has bearing on: - the cardiovascular system - the gastro-intestinal system	24
Nursing Theory NUR326 Two papers of 2 hours each	**Paper 1** Using the Nursing process in identifying and dealing with basic and selected health-care needs, as well as identifying and treating selected acute and general disease conditions of individuals and/or groups in any developmental phase that has bearing on: - the musco-skeletal system - the nephrological system - the ophthalmological system	24

	- Acids and bases (chemical characteristics of acids and bases, medical applications, strong and weak acids/bases, the pH principle, pH and health). - Salts (formation and medical application of salts, buffer solutions). - Organic chemistry (introduction to organic chemistry, alkanes, alcohols, ethers, organic acids, the medical importance and applications of organic compounds).	
Microbiology (Introduction I) MCB214 One paper of 3 hours	Historical overview and introduction to Microbiology. Classification, cell structure and characteristics of higher protista (algae, protozoa and fungi) and the lower protista (bacteria, cyanobacteria, rickettsias and viruses). Microbial symbiosis, lichens, mycorrhiza, nitrogen binding, the rumen. Characteristics and importance of selected bacterial groups, metabolic pathways. Basic virology, structure, characteristics and replication of bacteriophages, animal viruses and plant viruses. Bacteria: classification, distinguishing characteristics, importance, nutritional groups and physiology, nitrogen and sulphur cycle in nature. Food poisoning: poisoning through the intake of micro-organisms and microbe toxins associated with contaminated food. Microbe genetics: flow of DNA to protein and control mechanisms. Principles and definitions, recombination, gene transfer, plasmids and mobile genetic elements. Microbe Biotechnology: conventional and modern biotechnology, fields of application in industry. Immunology: important historical events, definitions and terminology, non-specific and specific resistance.	16
Microbiology (Practical growth and decay) MCB224 One paper of 3 hours	- Microbe counts: Total counts (direct and indirect methods), living counts. - Microbe growth: Growth comparisons: Exponential growth and the general growth equation, calculating specific growth rate, doubling time and yield coefficient. The Monod equation. Growth curves: phases, linear growth. Oxygen as substrate: effect on growth, the provision of oxygen and volumetric transfer coefficient. - Microbe death: Measurement of rate of decay, decimal reduction time, Z value. Heat resistance. Factors that influence decay. Practical application of eliminating microbes through heat. The influence of other anti-microbe agents: radiation, physical and chemical agents. - Microbe nutrition: Carbon, nitrogen and mineral sources, growth factors. Nutrition classes. Formulation of cultural media. Buffers and pH. - Total and living counting methods. Microscopy. Bacterial isolations on selected and differential media. Growth and decay curves: determining kinetic parameters; the effect of environmental conditions. Determining viability of yeast cells. Students will also complete a computer-supported self-study module in bacterial growth.	16

Anatomy and Physiology BMN124 One paper of 3 hours	- Introduction, terminology and basic embryology - Skeletal systems - Articulatory system - Muscular system - Digestive systems - Chemical composition of the body - Nutrition and metabolism - Physiology of the digestive system - Physiology of respiration - Skin and body temperature - Autonomous nervous system - Basic physiology of the nervous system - Physiology of blood - Body protection	16
Anatomy and Physiology BMN214 One paper of 3 hours	- Circulatory system - Respiratory system - Nervous system - Sense organs and the skin - Uro-genital system - Endocrine system - Cardiovascular physiology - Endocrine physiology - Sexual physiology and physiology of pregnancy - Kidney physiology - Acid-base balance - Somatic nervous system	16
Pharmacology FRM212 One paper of 3 hours	- Pharmacokinetics and pharmocodynamics - Routes of administering, formulations and legislation - Anti-microbe medicines - Anti-fungal, anti-viral and anti-helminthic medical substances - Anti-tuberculosis medicines - Protozoal infections (including malaria) and rickettsiae - Analgesics - Diuretics - Fluids and electrolytes - Vitamins - Anti-histamines - Medicines used in the treatment of hematological conditions	8
Pharmacology FRM222 One paper of 3 hours	- Endocrine pharmacology - Pharmacology and the autonomous nervous system - The cardio-vascular system - The respiratory system - Neuropsychopharmacology - Gastro-intestinal tract - Dermatology - Uro-genital pharmacology - Eye pharmacology - Emergency conditions and anaesthetic substances - Cancer chemotherapy - Pharmacogenetics - Medicines in extreme ages, pregnancy and lactation - Interactions between medicines - Poisonings	8