

**NURSING STRATEGIES TO ENHANCE CULTURALLY SENSITIVE
PATIENT CARE IN A METROPOLITAN COMMUNITY: WESTERN CAPE,
SOUTH AFRICA**

by

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DECLARATION

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DEDICATION

I dedicate this thesis to the following people in my life:

My late father:

Senzangakhona Mfundisi (1942 – 2003)

My late mother:

Nofikile Mfundisi (1947 – 2025).

My siblings

(Kholeka, Sizeka, Thembisa, Zwelithini, Nomgqibelo, Zwelilungile, and Zikhona)

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Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

ABSTRACT

Background: Globally, more than 80% of people consult indigenous healers before seeking mainstream healthcare, indicating the influence of cultural beliefs on health-seeking behaviours. This presents challenges for fair, high-quality treatment in multicultural settings such as metropolitan Western Cape, South Africa. To address these challenges, one must consider culturally sensitive patient care, which respects and incorporates diverse cultural backgrounds.

Purpose: The study explored the perspectives of nurses, patients and community members on the integration of cultural beliefs and practices in healthcare. It strove to develop and validate nursing strategies that enhance culturally sensitive patient care in the Western Cape, South Africa, guided by Leininger's Sunrise Theory.

Methods: A qualitative, multiphase design was employed using semi-structured interviews, focus groups and observations. A total of thirty-seven participants took part, including eleven nurses, one focus group comprising seven nurses, twelve patients and seven community members, all representing a range of qualifications and experiences. Data saturation was achieved after 6 interviews from each group however, additional interviews were conducted to confirm saturation, consistency of emerging themes and to enhance the credibility. Focus group discussions were included to complement the data and were incorporated into the final analysis. Data was analysed using Braun and Clarke's (2006) six-step thematic analysis, supported by ATLAS.ti 25 software.

Results: The findings show that meaningful progress towards culturally sensitive integrative healthcare in South Africa requires moving beyond both biomedical dismissal of traditional healing practices and superficial multiculturalism that tolerates cultural

practices if they do not interfere with biomedical protocols. Seven strategic domains emerged: education and training, policy development, resource allocation, effective communication, integration of indigenous knowledge, professional support, and patient partnership. Validation results indicated strong agreement among experts regarding the relevance, clarity and feasibility of the proposed strategies.

Conclusion: The study concludes that implementing validated nursing strategies grounded in empirical findings can enhance culturally sensitive patient care by promoting collaboration between healthcare providers, patients and communities. True transformation requires reimagining healthcare as culturally plural, where biomedicine coexists with other healing systems on equal footing and advancing the WHO's vision for inclusive health systems and strengthening patient-centered care in South Africa's diverse metropolitan communities. The study recommends incorporation of culturally sensitive care into nursing education, development of institutional guidelines, and ongoing stakeholder engagement to support implementation.

Keywords: Culturally sensitive care, Nursing strategies, Patient care, South Africa, Multicultural healthcare, Qualitative research

TABLE OF CONTENTS

DECLARATION	ii
ACKNOWLEDGEMENTS	iii
DEDICATION	iv
ABSTRACT	v
TABLE OF CONTENTS	vii
LIST OF TABLES	xii
LIST OF FIGURES	xii
LIST OF APPENDIXES	xiii
LIST OF ABBREVIATIONS	xiv
CHAPTER 1	1
ORIENTATION TO THE STUDY	1
1.1 INTRODUCTION	1
1.2. BACKGROUND TO AND CONTEXT OF THE STUDY	3
1.2.1. The current healthcare system	3
1.2.2. Indigenous practice usage by the majority of people.....	6
1.2.3. The WHO stance on integration of the current system and Indigenous Knowledge Systems (IKS).....	7
1.3. Definition of key concepts	10
1.3.1 Strategies	10
1.3.2 Culture.....	10
1.3.3 Sensitivity	10
1.3.4 Cultural sensitivity	11
1.3.5 Patient	11
1.4 PROBLEM STATEMENT	11
1.5 RESEARCH PURPOSE	13
1.6 Research Objectives.....	14
1.7 RESEARCH QUESTION	15
1.8 RESEARCH PARADIGM	16
1.9 THEORETICAL BASIS OF THE STUDY.....	16

CHAPTER 2.....	20
RESEARCH DESIGN AND METHODOLOGY	20
2.1. INTRODUCTION	20
2.2. RESEARCH APPROACH	20
2.3. RESEARCH DESIGN	22
2.4. DATA ANALYSIS	23
2.5. TRUSTWORTHINESS AND RIGOUR	24
2.6. ETHICAL CONSIDERATIONS	26
2.7. CONCLUSION	29
CHAPTER 3.....	30
DATA COLLECTION AND ANALYSIS	30
3.1. INTRODUCTION	30
3.2. DATA COLLECTION PROCESS	30
3.2.1. Research setting	30
3.2.2. Research population	32
3.2.3. Research sampling.....	33
3.2.4. Purposive sampling	33
3.2.5. Inclusion criteria	34
3.2.6. Exclusion criteria	35
3.3. DATA COLLECTION APPROACH	36
3.3.1. Data collection tools	36
3.3.2. Participant recruitment	37
3.3.3. Data collection procedure.....	37
3.3.4. Interview process - Phase 1- 3.....	39
3.4. DATA ANALYSIS PROCESS (INCLUDING CODING, CATEGORIES, MERGING THEMES)	39
3.5. CONCLUSION	42
CHAPTER 4.....	44
PRESENTATION OF FINDINGS.....	44
4.1. INTRODUCTION	44

4.2.	DESCRIPTION OF PARTICIPANTS (PHASE 1: NURSES, PHASE 2: PATIENTS, PHASE 3: COMMUNITY)	45
4.3.	PRESENTATION OF FINDINGS PER THEME AND SUB-THEME	59
4.3.1	Introduction.....	59
4.4.	CONCLUSION	129
CHAPTER 5.....	131	
DISCUSSION OF FINDINGS AND LITERATURE CONTROL	131	
5.1	INTRODUCTION	131
5.2	DISCUSSION OF THEMES IN RELATION TO LITERATURE AND THEORY	131
5.3	INTERPRETATION OF FINDINGS AND IMPLICATIONS	156
5.4	CONCLUSION	211
CHAPTER 6.....	212	
STRATEGIES DEVELOPMENT	212	
6.1.	INTRODUCTION	212
6.2.	OVERVIEW OF DEVELOPED STRATEGIES	213
6.3.	THE BUILDING BLOCK APPROACH: FROM FINDINGS TO STRATEGIES.....	217
6.3.1	Phase One: Identifying core components from findings	217
6.4.	EXPERT VALIDATION FRAMEWORK: ENSURING RIGOUR AND CREDIBILITY	221
6.4.1	Purpose of expert validation	221
6.4.2.	Validation criteria detail.....	223
6.5	ALIGNMENT WITH FINDINGS AND LITERATURE.....	224
6.5.1	Grounding in participant voices	224
6.5.2	Alignment with scholarly literature	225
6.6.	IMPLEMENTATION PRIORITIES AND SEQUENCING	226
6.7	COMMENTS FROM THE VALIDATORS REGARDING THE EVALUATION TOOL.....	228
6.8	CONCLUSION	229
CHAPTER 7	230	
CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS.....	230	
7.1.	INTRODUCTION	230

7.2.	CONCLUSIONS DRAWN FROM THE STUDY.....	231
7.2.1.	Review of the research findings	231
7.2.2	Synthesis of key thematic conclusions	234
7.3	CONTRIBUTION OF THE STUDY TO PRACTICE, POLICY, NURSING EDUCATION, AND FURTHER RESEARCH	237
7.3.1	Nursing practice	237
7.3.1.1	Embed cultural safety as a core nursing value:.....	237
7.3.1.2	Enhance communication skills for culturally diverse contexts:	237
7.3.1.3	Promote reflective practice and peer dialogue:	238
7.3.2.	Develop patient disclosure protocols:	238
7.3.2.1	Strengthening interprofessional collaboration:	238
7.3.3	Recommendations for policy	238
7.3.3.1	Institutionalise cultural competence standards:.....	238
7.3.3.2	Formal recognition of traditional healing systems:	238
7.3.3.3	Cultural safety accountability mechanisms:.....	238
7.3.3.4	Equitable resource allocation:	238
7.3.4	Recommendations for nursing education	238
7.3.4.1	Integrate Southern and cultural epistemologies in curricula:	238
7.3.4.2	Experiential and community-based learning:.....	239
7.3.4.3	Gender and culture sensitisation training:	239
7.3.4.4	Promote reflective pedagogies:	239
7.3.4.5	Continuous professional development:	239
7.3.5	Recommendations for further research	239
7.3.5.1	Comparative studies across provinces in South Africa:.....	239
7.3.5.2	Evaluation of integration models:	239
7.3.5.3	Longitudinal studies on cultural competence development:	240
7.3.5.4	Patient perspectives on cultural safety:	240
7.3.5.5	Policy impact research studies:.....	240
7.4	LIMITATIONS OF THE STUDY	240
7.4.1	Sample and context:.....	240
7.4.2	Self-reporting bias:	240

7.4.3 Language and translation:	241
7.4.4 Researcher positionality:	241
7.5. FINAL REFLECTIONS.....	241
REFERENCES.....	243
APPENDIXES	255

LIST OF TABLES

Table 4.1:	Nurse Participants' Profile and Background Characteristics	45
Table 4.2:	Focus Group Participants' Profile and Background Characteristics	48
Table 4.3:	Patient Participants' Profile and Background Characteristics	54
Table 4.4:	Community Members Participants Profile and Background	57
Table 4.5:	Theme 1	60
Table 4.6:	Theme 2	70
Table 4.7:	Theme 3	83
Table 4.8:	Theme 4	94
Table 4.9:	Theme 5	106
Table 4.10:	Theme 6	118
Table 5.1:	Individual – Level Patterns	158
Table 5.2:	Group - Level Similarities and Differences Across	175
Table 6.1:	Summary of Developed Strategies for Enhancing Culturally	218
Table 7.1:	Cultural Dimensions of Research Findings	232

LIST OF FIGURES

Figure 2.1:	Sunrise theory (Leiniger, 2004)	16
Figure 3.1:	Mitchells Plain's geographical configuration (Source: ResearchGate, 2018).....	31

LIST OF APPENDIXES

APPENDIX A:	University of South Africa Ethics Approval Letter	256
APPENDIX B:	City of Cape Town – City Health Ethics Approval Letter.....	257
APPENDIX C:	Western Cape Department of Health Ethics Approval	259
APPENDIX D:	Western Cape Department of Health Ethics Approval	260
APPENDIX E:	Western Cape Department of Health Combined Ethics Approval	262
APPENDIX F:	Acknowledgement Letter from the Community Leader	264
APPENDIX G:	Information Sheet for Nurses	265
APPENDIX H:	Information Sheet for Patients	270
APPENDIX I:	Information Sheet for Community Members	275
APPENDIX J:	Permission Letter to Western Cape Department of Health	280
APPENDIX K:	Permission Letter to Conduct Research at Mitchells Plain Hospital.	283
APPENDIX L:	Permission Letter to Conduct Research at Eastridge Clinic.....	286
APPENDIX M:	Permission Letter to Conduct Research at Mitchells Plain.....	289
APPENDIX N:	Consent Form	292
APPENDIX O:	Interview Guide for Nurses	294
APPENDIX P:	Interview Guide for Patients.....	296
APPENDIX Q:	Interview Guide for Community Members.....	298
APPENDIX R:	Observation Schedule.....	300
APPENDIX S:	Observation Guide	302
APPENDIX T:	Facility Managers/Senior Nurse Clinician Strategy Evaluation Form	304
APPENDIX U:	Sample Transcript – Nurses.....	306
APPENDIX V:	Sample Transcript – Patients.....	316
APPENDIX W:	Sample Transcript – Community Members.....	324
APPENDIX X:	Sample Transcript – Focus Group Nurses.....	334
APPENDIX Y:	Language Editing Certificate.....	343
APPENDIX Z:	Technical Editing Confirmation Letter.....	344

LIST OF ABBREVIATIONS

CHC:	Community Health Centre
CP:	Community Participant
FGPN:	Focus Group Participant Nurse
IKS:	Indigenous Knowledge Systems
PN:	Participant Nurse
PP:	Participant Patient
SANC:	South African Nursing Council
THC:	Traditional Health Practitioner
WHO:	World Health Organisation

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Globally, over 80% people uses the indigenous healing before consulting with the mainstream healthcare (WHO, 2022; Mphuthi & Husaini, 2022:2). Providing quality patient care is essential for society's well-being, aiming to keep people healthy, prevent illnesses and offer treatments. However, making sure everyone has fair access to good healthcare is hard, mainly in diverse communities where traditional beliefs, values and practices can affect how people seek healthcare and how well they respond to treatment (Sibeudu, 2022:2). According to Varkey (2021:17), patient care practices have evolved from ancient times, where indigenous healing were closely tied to cultural and spiritual beliefs. As medical science and technology advanced, modern patient care systems were developed to offer proven care to different groups of people. However, recognising cultural sensitivity and its impact on patient care outcomes is a relatively recent development. This has led to a growing focus on nursing strategies to enhance culturally sensitive patient care in a diverse metropolitan community in the Western Cape, South Africa, with a strong focus on respecting different cultures.

Culturally sensitive patient care involves methods that understand and respect the various cultural backgrounds of individuals and communities, recognising how culture affects health beliefs, actions and results (Handtke, Schilgen & Mösko, 2019:24). These practices can build trust and teamwork between healthcare providers and patients, making patient care more effective (Handtke, et al., 2019:24). Despite recognising the importance of culturally sensitive patient care, there are still significant gaps in understanding how to apply these practices for different groups. Consistence in training healthcare providers to be culturally competent is still lacking and healthcare systems often lack policies ensuring cultural inclusivity. Consequently, many people from diverse backgrounds encounter barriers to accessing quality healthcare, resulting in disparities in patient care outcomes.

Healthcare access and patient care outcomes vary internationally because of cultural differences. In addition, despite universal health rights being supported by the European Union (EU) and the World Health Organisation (WHO), there are still inequalities and discrimination based on cultural beliefs (Handtke et al., 2019:24) furthermore, these disparities persist because of factors like people's legal and financial status and the laws and policies of each country. Cultural beliefs, language barriers and discriminatory practices affect healthcare access and outcomes worldwide.

The research on patient care on the African continent highlights the critical elements that require consideration. To deal with these elements, Bantham, Taverno Ross, Sebastião and Hall (2021:64) suggest combining healthcare with the economy, integrating sociocultural training into healthcare practitioner's training and education to establish a uniform framework for evaluating values and implementing policies. An Africa-based study by Cerf (2021:789), has also identified issues such as inadequate infrastructure, limited access to healthcare in rural areas and unbalanced resource distribution. This emphasises the importance of holistic initiatives to improve healthcare outcomes, considering the different cultural, social and economic landscapes throughout the continent.

Despite efforts to enhance cultural sensitivity in healthcare services in South Africa, significant challenges persist (Joo & Liu, 2020:2). Therefore, further research is necessary to identify and implement effective nursing strategies to address these challenges. Studies have emphasised the crucial significance of culturally tailored interventions in the South African context, and Drigo, Makhado, Lebesse and Chueng (2021:130) conducted a study examining cultural practices influence on pregnancy management and the utilisation of indigenous medical knowledge across various healthcare domains, encompassing remedial, preventive and protective measures. This research underscores the importance of patient care strategies that align with local cultural norms and values. Similarly, Lekgothoane and Ross (2020:18) explored the views of black South African mothers regarding the use of indigenous and/or Western medical approaches for managing childhood or infancy ailments. This study revealed that

traditional healing and Western medicine can work together, mothers appreciated both methods. Makhakhe's (2023:109) recent research focuses on nursing interventions for chronic illness patients in the Western Cape. The study found that culturally sensitive care, which involves embracing traditional methods of healing and respecting patient beliefs, has improved treatment adherence and chronic condition management in the Western Cape, Cape Town's low-income communities. Similarly, Lehmann, Zulu and Matos (2023:11) demonstrate how Cape Town's public health system addresses the needs of its diverse residents. The research investigates healthcare delivery methods that emphasise cultural sensitivity, such as multilingual services and cultural competence staff training and finds that these activities have a positive effect on reducing healthcare disparities and increasing patient satisfaction.

Maboko, Armstrong and Casteleijn (2024:2), examine the cultural challenges that nurses experience in South Africa, particularly in metropolitan areas such as Cape Town. Their research demonstrates that misunderstandings and cultural disconnects between nurses and patients can lead to poor health outcomes and they advocate for ongoing cultural competence training and the participation of community health workers who understand local cultural dynamics. While some initiatives have been undertaken to address cultural sensitivity in patient care, there remains a need for systematic research to evaluate their effectiveness and identify best practices. The welfare services aimed at addressing the healthcare needs of diverse populations exist, but their effectiveness in promoting cultural sensitivity is variable (Lekgothoane & Ross, 2020:18).

1.2. BACKGROUND TO AND CONTEXT OF THE STUDY

1.2.1. The current healthcare system

The global healthcare system continues to change in response to the growing demand for culturally sensitive patient care (Daniels & Mtshali, 2023:203). Internationally, health services are under increasing pressure to provide care that respects diverse patient societies' cultural values, beliefs and practices (WHO, 2022:4). Cultural sensitivity refers to the ability of healthcare providers to recognise, respect and appropriately respond to

patients' cultural beliefs, values and practices in the delivery of care (Truong, Paradies & Priest, 2021:3). Despite global awareness of cultural diversity, many systems continue to use biological models that underrepresent or exclude indigenous knowledge systems (IKS) in clinical practice (Clark & Draper, 2023:57). Indigenous knowledge systems refer to locally developed knowledge, beliefs and practices related to health and illness that are embedded within specific cultural traditions and passed across generations (Makhene, 2023:5). Such deliberate exclusions cause inequities in healthcare delivery and limit the responsiveness of systems to the cultural realities of minority communities.

Efforts to enhance cultural sensitivity in healthcare have included the introduction of culturally competent care training, diversity-responsive curricula in nursing education, and policy frameworks promoting patient-centred care (Joo & Liu, 2020:2; Truong et al., 2021:4). However, implementation of these initiatives remains inconsistent, with limited evaluation of outcomes and inadequate integration into routine clinical practice.

Across the continent of Africa, colonial medical system's historical legacies continue to shape how healthcare is conceived and delivered (Mulaudzi & Lebesse, 2022:36). While traditional healing practices are becoming more widely accepted across the continent, IKS integration into professional healthcare systems remains minimal and frowned upon (Koenig, 2023:18). According to Moyo and Mkhize (2022:18), traditional medicine is regarded as unscientific and inferior, despite its widespread use and trust manifest in the communities. This perception undermines the importance and integrity of indigenous health practices and generates an adversarial relationship between IKS practitioners and professionally trained nurses, many of whom received training within Western scientific frameworks.

Healthcare provider training in cultural sensitivity remains inconsistent, particularly in low- and middle-income countries, where curricula often prioritise biomedical approaches with limited inclusion of cultural sensitivity (Makhene, 2023:6). Furthermore, healthcare systems frequently lack institutional policies that explicitly promote cultural inclusivity,

resulting in variable implementation of culturally sensitive care practices (Zulu & Mtshali, 2023:28).

According to Molefe and Ramlall (2021:145), the healthcare system in South Africa is divided into two parts: Western medical methods and traditional healing. Western medical practice refers to biomedical approaches grounded in scientific diagnosis and pharmacological treatment, whereas traditional healing encompasses culturally embedded therapeutic practices such as herbal remedies, spiritual healing, and ancestral consultation (Maphumulo & Bhengu, 2023:245). However, Molefe and Ramlall (2021:145) state that there is still insufficient policy-driven integration between these systems, resulting in disjointed service delivery and missed chances for collaborative health practices. The National Health Act (Act No. 61 of 2003) recognises traditional healers, but implementation of inclusive practices within public health institutions is inconsistent and often symbolic. This results in a yawning gap between IKS and formal healthcare services, consequently compromising the quality of care for culturally varied patients.

Locally, in the Western Cape, metropolitan healthcare institutions are under siege to satisfy the demands of diverse populations. The region is marked by huge cultural diversity, with African, Coloured, Indian and White residents all with their own health beliefs and practices. Daniels and Mtshali (2023:203) found that nurses in the Western Cape fail to integrate cultural traditions due to institutional constraints, a lack of culturally sensitive training and negative attitudes toward traditional medical practices. These challenges are compounded by communication barriers, differing health belief systems, and limited collaboration between healthcare professionals and community-based practitioners, which collectively influence culturally sensitive care delivery (Nuuyoma, Muvumwaeni & Chihururu, 2024:3). These obstacles impede the creation of a truly inclusive health care system that represents the cultural realities of its users.

The clash between IKS and the western medicine approaches is worsened by healthcare workers' attitudes toward indigenous practices, notably nurses. While nurses are ethically

required to give non-discriminatory care (South African Nursing Council, 2020:3), according to Berman, Ncube and Venter (2022:89) many nurses are skeptical about traditional healing. This skepticism frequently manifests in dismissive behavior and an unwillingness to engage with patients who admit to taking traditional treatments. Such misunderstandings and cultural disconnects between nurses and patients have been associated with reduced patient satisfaction, delayed treatment-seeking, and poorer adherence to care plans (Zulu & Mtshali, 2023:28). Furthermore, professional training, institutional cultures and social narratives apparently promote Western medicine as superior, and this complicates the reality of medical care practices in the Western Cape.

Efforts to bridge the gap between IKS and the western healthcare systems are gaining traction and momentum, although the process is still in its early stages. According to international best practices, culturally sensitive patient care should go beyond cosmetic acknowledgements of diversity and instead integrate culturally sensitive care into education, policy and service design (Shakwane, 2022:2). In South Africa, this requires a reorientation of nursing curriculum, the implementation of inclusive health policies and systematic coordination between the traditional and formal health sectors (Mtetwa & Khumalo, 2022:122).

1.2.2. Indigenous practice usage by the majority of people

Indigenous health practices continue to play an important role in healthcare systems around the world, especially in areas where access to formal medical services is limited. Globally, nearly 80% of the population in underdeveloped countries relies on traditional medicine for their primary healthcare (WHO, 2022:4). These practices are deeply rooted in cultural beliefs and are the initial point of contact for health-related problems, particularly in rural and underserved areas (Booth, 2023:1).

According to Kendi (2024:18), in the African continent traditional medicine is not only a cornerstone of healthcare, but it also reflects the continent's rich cultural past. Kendi further states that traditional medicine is used by over 80% of the African population for a

variety of health conditions. This extensive reliance is ascribed to accessibility, affordability and traditional healers' holistic approach, which addresses physical, spiritual and emotional dimensions of health. In South Africa, for example, traditional healers are generally more accessible than Western practitioners, with one traditional healer per five hundred people against one Western medicine doctor per 40,000 people (Mulaudzi & Lebese, 2022:30).

Approximately 60% of citizens seek traditional healers in South Africa, typically in conjunction with Western medicine (Booth, 2023:1). Traditional healers, sometimes known as sangomas or inyangas, play an important role in communities by offering culturally relevant care and addressing health conditions that are often outside the ontological scope of Western medicine. Despite their importance, traditional healers often encounter obstacles such as a lack of formal acknowledgment, restricted integration into the national health system and ostensible distrust from Western medicine specialists (Mulaudzi & Lebese, 2022:35).

Indigenous health methods are still widely used in many communities around Western Cape province of South Africa (Daniels & Mtshali, 2023:203). Traditional healers are commonly visited for a variety of health conditions, including common medical conditions and chronic diseases. The methods they use are deeply rooted in the cultural understanding of the communities they serve (Molefe & Ramlall, 2021:140). However, these methods are not fully integrated into the formal healthcare system, leaving a gap in culturally sensitive care furthermore, nurses and other healthcare professionals who often lack training in indigenous knowledge systems (IKS), leading to severe misconceptions and inadequate use of therapeutic traditional health resources (Daniels & Mtshali, 2023:203).

1.2.3. The WHO stance on integration of the current system and Indigenous Knowledge Systems (IKS)

The World Health Organisation (WHO) has long recognised the role of traditional medicine, especially IKS, in healthcare delivery around the world (WHO, 2023:15). Furthermore, The WHO's recent report states that Traditional, Complementary and Integrative Medicine (TCIM) is an important component of health and well-being for many communities, particularly in the Global South. The WHO Traditional Medicine Strategy 2023-2032 outlines WHO's strategic approach, which seeks to promote the safe and effective use of traditional medicine by integrating it into formal health systems through regulation, research and teaching. This represents an important paradigm shift in global health policy, as it aligns healthcare professional models with indigenous and traditional health practices in a patient-centred framework.

Globally, countries like China, India and South Korea have made substantial progress in integrating traditional medicine into formal healthcare systems. In China, Traditional Chinese Medicine (TCM) is performed alongside allopathic medicine in hospitals and is governed by national health policies (Li, Zhang & Wang, 2022:133). Similarly, in India, the Ministry of AYUSH oversees integrating Ayurveda, Yoga, Unani, Siddha and Homeopathy into mainstream healthcare practices (Rao & Iyer, 2022:89). These countries demonstrate successful models of healthcare systems that value traditional knowledge, ensure cultural preservation and patient trust while also addressing accessibility and resource restrictions.

Despite WHO endorsement, IKS integration into formal healthcare has been inconsistent across the African continent. Countries such as Ghana and Nigeria have established national policies on traditional medicine and are pushing to integrate traditional healers into the broader health care system (Adebayo, Alabi & Ojo, 2021:60). However, practical challenges such as a lack of standardisation, limited training and skepticism among healthcare practitioners continue to impede full integration (Kendi, 2024:19). South Africa is at a crossroads where the potential for integrating indigenous practices with formal healthcare is underexplored. While the Traditional Health Practitioners Act (Act No. 22 of 2007) provides a legal framework, its actual implementation has been marred by inter-

professional tensions, policy ambiguity and resource constraints (Maphumulo & Bhengu, 2023:245).

South Africa has recognised the importance of IKS in its legislative framework (Traditional Health Practitioners Act; Act No. 22 of 2007). However, in practice, the healthcare system is primarily Western. The Traditional Health Practitioners Act (Act No. 22 of 2007) of South Africa is an important legislative foundation for recognising and regulating methods of indigenous healing. Traditional health practitioners (THPs) have been a component of African healthcare for generations and their role in providing culturally relevant healthcare is significant, especially in communities that value indigenous knowledge systems (IKS). When discussing "Developing strategies for culturally sensitive patient care," this Act becomes an important locus in understanding how healthcare institutions could incorporate western medicine with indigenous health practices to ensure culturally sensitive and holistic care for patients.

The THP Act highlights a gap in the present healthcare system, which has failed to recognise and integrate traditional healing practices despite WHO recommendations (WHO, 2023:3). The THP Act (Act No. 22 of 2007) seeks to protect patients, encourage collaboration between indigenous and mainstream healthcare systems and ensure that indigenous methods are carried out safely and ethically. It recognises the cultural significance of indigenous health practices, particularly in areas where these methods of treatment are deeply rooted in daily life.

Most nurses receive little training in traditional practices, leading to mistrust and disapproval for IKS (Mogale & Sibiya, 2022:78). This gap is most evident in metropolitan areas like Cape Town, where multicultural dynamics increase the demand for culturally sensitive patient care. According to Dlamini, Mkhize and Khanyile (2021:112), nurses often feel unprepared to engage with patients using traditional healing approaches, as they feel it could lead to lower patient satisfaction and trust.

In the Western Cape, indigenous medicine is becoming more common, particularly among older and rural populations. Only a few healthcare facilities have produced clear

protocols or training modules for integrating IKS into formal patient healthcare (Nuuyoma, Muvumwaeni & Chihururu, 2024:3). Without this integration of IKS into formal healthcare, the gap complicates communication, continuity of care and patient safety, particularly when patients combine herbal treatments with prescription drugs without alerting their nurses or doctors (Molefe & Ramlall, 2021:140) furthermore, the lack of cooperation frameworks between traditional healers and healthcare professionals exacerbates the situation, despite WHO's appeal for integrated, holistic approaches to health.

1.3. Definition of key concepts

1.3.1 Strategies

Strategies refer to planned, systematic approaches designed to achieve specified objectives or goals (Bryson, 2018:1). In this study, strategies refer to protocols and interventions designed in providing culturally sensitive patient care which could be communication, training programmes and or procedural changes aimed at improving healthcare delivery for patients from various cultural backgrounds.

1.3.2 Culture

Culture is defined as the shared beliefs, values, customs and traditions that influence how people think, behave, and interact in groups (Dimmock & Walker, 2021:1). In this study culture refers to the different backgrounds of patients and healthcare providers. Understanding and appreciating cultural differences is essential for providing patient-centred culturally sensitive care.

1.3.3 Sensitivity

Sensitivity is defined as being alert, empathic and responsive to the feelings and needs of others (Hodson, 2018). In the study, sensitivity refers to healthcare providers' ability to understand and accommodate patients' cultural diversity, ensuring they feel respected and supported throughout their care journey.

1.3.4 Cultural sensitivity

Truong, Paradies and Priest (2020:1) define cultural sensitivity as the ability to understand and respond properly to others' cultural ideas, behaviours and practices. In this study, cultural sensitivity refers to understanding and respecting cultural practices of patients aiming to promote patient-centered care that is sensitive.

1.3.5 Patient

According to WHO (2022), a patient is anybody who seeks medical attention, care, or therapy. This includes people who are ill or injured, as well as those receiving routine check-ups or preventive care. Patients in the study refers to healthcare recipients from different kinds of cultural backgrounds who have consulted indigenous healers prior to coming to the mainstream health system.

1.4 PROBLEM STATEMENT

The WHO recently advocated for the integration of indigenous healing systems into mainstream healthcare (Ambtman-Smith, Crawford, D'Hondt, Lindstone, Linklater, Longboat & Richmond, 2024:282). This was due to observations or research that revealed that more than 80% of the population seeks indigenous advice before attending the mainstream health system. In addition, Nguyen, Subhan, Williams and Chan (2020:112), found that healthcare providers often struggle to grasp and accommodate the cultural preferences and needs of their patients, resulting in less-than-optimal care and exacerbating health inequalities. Ideally, culturally sensitive nursing care should allow nurses to understand patients' cultural beliefs, work respectfully with diverse health cultural practices, and integrate these perspectives into holistic patient management (Berhanu, Golja, Gudeta, Feyisa, Rikitu & Bayane, 2024:182).

Considering the above, the researcher identified that nurses possess limited skills in addressing cultural aspects when dealing with patients who have interacted/consulted indigenous healers before visiting a clinic or hospital for healthcare. However, according to Moloney, Stuart, Chen and Lin (2023:272) this limitation does not apply uniformly to

all nurses indicating variability in knowledge, attitudes, and preparedness among healthcare providers when engaging with indigenous practices.

This highlights a critical need for effective nursing strategies to reduce gaps in patient care outcomes across ethnic groups. Evidence suggests that inadequate cultural sensitivity may contribute to communication barriers, reduced patient trust, delayed care-seeking behaviour, and poor adherence to treatment plans (Nuuyoma, Muvumwaeni & Chihururu, 2024:3). This gap leads to worse health, and less satisfaction for patients (Sibeudu, 2022:2). Hence, it is important to prioritise cultural sensitivity in patient care to promote fair health and better global outcomes. Through nursing strategies aimed at enhancing culturally sensitive patient care in a metropolitan community in the Western Cape, South Africa, healthcare organisations could improve the quality of care, reduce healthcare disparities and promote social inclusion.

Despite policy recommendations and training initiatives, there remains insufficient guidance on how nurses should practically engage with patients who use indigenous healing practices. (Asamoah, Khakpour, Carr & Groot, 2023:14). This creates uncertainty in clinical decision making and contributes to inconsistencies in culturally sensitive care delivery.

Rationale

This study fills a significant gap in both academic training and clinical healthcare provision on the delivery of culturally sensitive patient care. Despite an increasing amount of research highlighting the importance of indigenous healers in healthcare delivery, there remains a gap between theoretical understanding of cultural sensitivity and effective application (Chauhan, Walton, Manias, Walpola, Seale, Latanik, Leone, Mears & Harrison, 2020:118). Nursing curricula often provide limited practical guidance on integrating indigenous knowledge systems into patient care, and healthcare institutions may lack structured protocols to support culturally sensitive patient care (Molise, Botma & Van Jaarsveldt, 2023:1).

This study aims to add to the existing body of knowledge by developing and validating nursing strategies that could be used to sensitise healthcare practitioners on how to be culturally sensitive when dealing with healthcare users. These strategies are intended to inform curriculum development, guide continuing professional training, and support clinical policy formulation for culturally sensitive care. The study's findings help to influence policies that promote more inclusive and culturally sensitive in-patient care.

1.5 RESEARCH PURPOSE

Mayring (2022:240) argues that a research purpose is the fundamental intention that guides a researcher's actions throughout the study. It describes the desired outcomes and acts as a focus point for the research process.

The purpose of this study was to gain an understanding on the perspectives of nurses, regarding patients who have sought consultation with indigenous healers prior to hospital or clinic visit, with the aim of gaining insights into how these patients were perceived. The study also strives to gain deeper insight on patients' lived experiences after consulting indigenous healers prior to seeking care at healthcare facilities and lastly, to understand community member's views on consulting indigenous healers before visiting clinics or hospitals and their expectations for culturally sensitive treatment from nurses.

Additionally, this research develops and validates nursing strategies to enhance culturally sensitive patient care in a metropolitan community in the Western Cape, South Africa, to benefit patients when accessing healthcare services. Given the significant challenges culturally diverse populations face in accessing quality healthcare such as (language barriers, differing health beliefs, cultural differences, mistrust of the healthcare system) and the limited research on effective nursing strategies to promote cultural sensitivity in patient care, there is a need for further research in this area

1.6 RESEARCH OBJECTIVES

The research objectives are detailed, specific and measurable measures that were taken to address the research problem and accomplish the study's anticipated aim (Kirmayer & Jarvis, 2019:11). Objectives were divided into four phases for this research study, guiding data collection, analysis and interpretation to ensure that the study's goals were met effectively. To accomplish this goal, the following research objectives were developed:

Phase 1: Qualitative (nurses)

- Explore and describe nurse's perspectives on different cultural belief systems, including consultation of indigenous healers by healthcare users.

Phase 2: Qualitative (patients)

- Describe and explore the lived experiences of patients at healthcare facilities following the consultation with indigenous healers prior to coming to the healthcare.

Phase 3: Qualitative (community members)

- Explore and describe community views for consulting indigenous healers before visiting a clinic or hospital for healthcare.
- Explore and describe how the community would like to be treated by the nurses in healthcare facilities in a culturally sensitive manner after consulting with indigenous healers.
- Explore and describe the views of community members in a context where some may reject indigenous health practices while others may reject mainstream treatments.

Phase 4: Development and validation of culturally sensitive strategies

Based on the findings from phases 1-3 of this study, the researcher proceeded to develop culturally sensitive nursing strategies to enhance patient care. The strategies were developed in accordance with the WHO criteria (WHO, 2021:1) and were informed by themes derived from the qualitative data. The preliminary strategies were then compiled and presented to healthcare management and relevant stakeholders for validation. Validation focused on assessing the clarity, relevance, feasibility, appropriateness,

evidence-based, comprehensive, and potential impact of the proposed strategies within the metropolitan healthcare context. Feedback obtained from the stakeholders was incorporated to refine and finalise culturally sensitive nursing strategies, ensuring alignment with institutional goals and policies.

1.7 RESEARCH QUESTION

A research question is a clear and focused question that expresses the key problem or topic studied. It guides the study, establishing a clear framework for data collection, analysis and interpretation (Mayring, 2022:240). A well-crafted research question clarifies the study's aim and objectives. To accomplish this goal, the following research questions were developed:

Phase 1

- What are nurses' perspectives on different cultural belief systems including consultation of indigenous healers?

Phase 2

- What are the experiences of patients regarding culturally sensitive nursing care at the healthcare facilities following consultation with indigenous healers prior to coming to the healthcare facility?

Phase 3

- What are the views of the specific community regarding consulting indigenous healers before visiting a clinic or hospital for healthcare services?

Phase 4

- What strategies could be developed for the patients to be treated in a culturally sensitive manner.
- How could healthcare management ensure that the proposed nursing strategies enhancing culturally sensitive patient care be effectively implemented and integrated into daily nursing practices?

1.8 RESEARCH PARADIGM

According to Kuhn (1970), cited in Bogna, Raineri and Dell (2020), a paradigm is an orientation towards theory and research where shared ideas and concepts guide researchers of a field of study. Bonga et al., (2020) further states that constructivism paradigm relies on analysing social discourse recorded through activities such as observations and interviews aiming to identify worldviews, subjective meanings and perspectives within social contexts while depending on the beliefs and perspectives of research participants to identify patterns of complexity and themes, rather than narrowing meanings to a few categories.

This study was conducted within a constructivist paradigm, which believes that there is no single reality and that the reality needs must be interpreted (Daneshgar, 2023:52). To acquire these multiple realities, qualitative methods such as interviews were used. The constructivist paradigm is aligned with the study's goal of understanding the deeper meanings of human experiences as socially constructed. The researcher followed an inductive approach to gain a rich understanding of participants' perspectives, rather than a deductive approach that generalises information to larger groups (Daneshgar, 2023:52). This paradigm was suitable to understand the perspectives of nurses, patients and community members on different medical practices. The researcher spent substantial time with participants in all three phases of the study, observing and gathering data on various aspects of patient care to understand the cultural dynamics influencing healthcare-seeking behaviours and treatment preferences.

1.9 THEORETICAL BASIS OF THE STUDY

The researcher used Leininger's Sunrise Theory (2004) as the fundamental framework for developing nursing strategies to enhance culturally sensitive patient care in a metropolitan community in the Western Cape, South Africa. Leininger's theory, developed in 1995, emphasises the significance of understanding and integrating cultural beliefs, values and customs into nursing care.

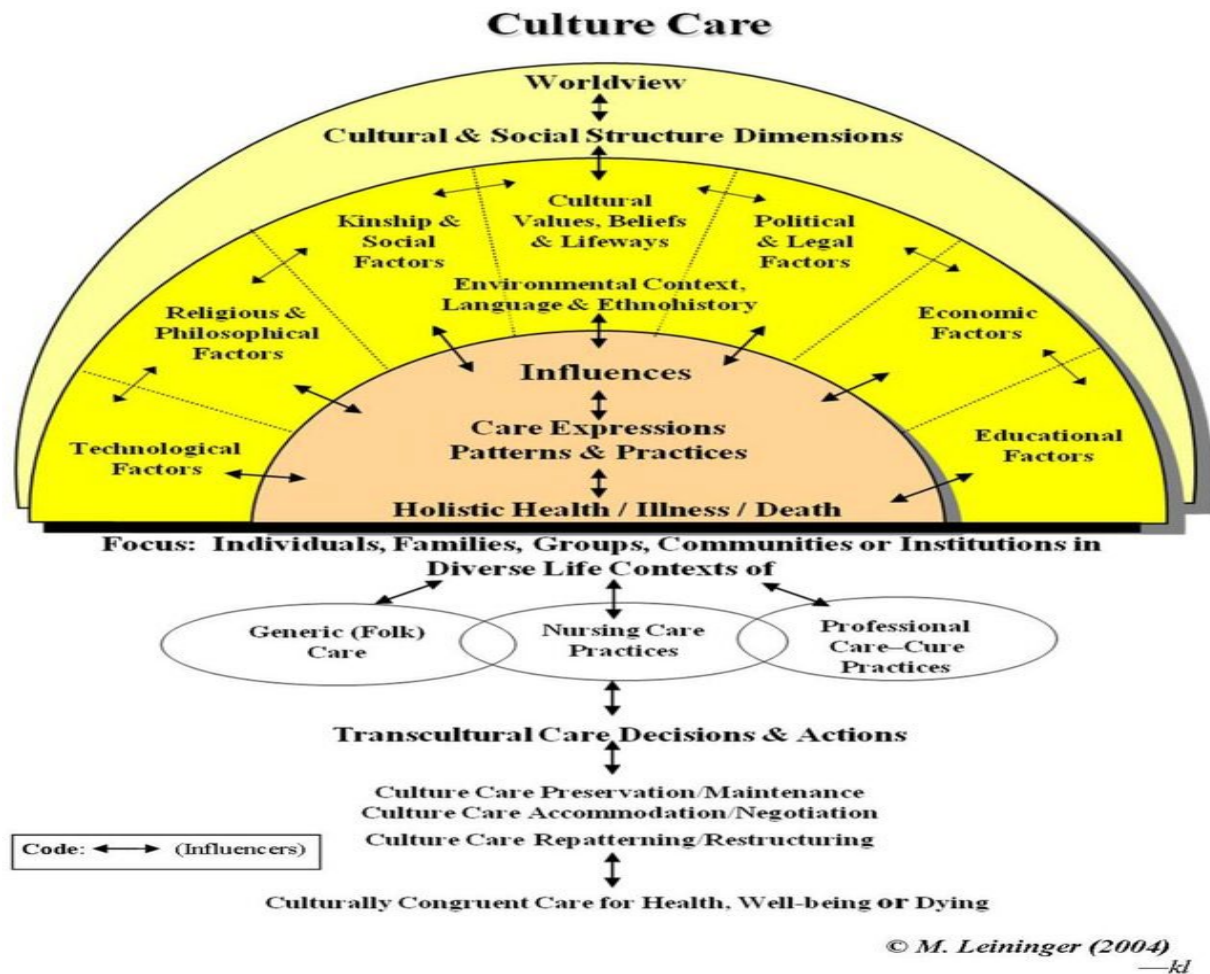


Figure 2.1: Sunrise theory (Leininger, 2004)

The Sunrise Theory has three major components which are described below:

- Generic (shared human care values) focuses on universal human care values that are common across different cultures and emphasise basic aspects of care that all humans need and share, such as compassion, empathy and support.
- The folk (culturally particular care values): This component focuses on specific practices and beliefs unique to cultural groups. It recognises the value of traditional and folk practices in healthcare that are passed down through generations and are important to the cultural nature of the community.
- Professional (theoretical and scientific nursing care): This component addresses the formal, professional components of nursing, which are founded on scientific research and theoretical frameworks. It includes evidence-based procedures,

professional standards and clinical skills to help nurses provide high-quality, effective care.

These components are like layers that help nurses provide culturally appropriate care to patients with different cultural backgrounds. In the context of diverse healthcare, the Sunrise Theory teaches nurses to acknowledge and respect each patient's cultural background and perspective. Understanding the folk and generic components of care in a cultural context allows nurses to customise their approach to patient care in a way that is respectful, sensitive and care effective.

When caring for a patient from a culture that values family engagement in decision-making, a nurse skilled in the Sunrise Theory would realise the importance of including the patient's family in conversations about treatment alternatives and care preferences. The Sunrise Theory promotes critical thinking when rendering nursing care by encouraging nurses to examine their own cultural prejudices and assumptions, as well as how they may influence their interactions with patients from other backgrounds. This theory offers a useful framework for designing culturally sensitive patient care techniques by highlighting the significance of recognising and incorporating cultural issues into nursing practice. By implementing Sunrise Theory ideas into their practice, nurses can improve the quality of care they deliver to various patient populations while also promoting better health outcomes based on the issues that influence their nursing practice.

Leininger's Sunrise Theory was appropriate for this study because it provides a complete framework for understanding and providing culturally sensitive care, which is important in the diverse metropolitan area of the Western Cape. The theory emphasises the centrality of cultural values, beliefs and practices in healthcare, which is consistent with the Western Cape multicultural context, where patients come from a diverse range of ethnic, linguistic and religious backgrounds (Maboko, Armstrong & Casteleijn, 2024:2). Leininger's theory is applicable for resolving gaps in healthcare in this metropolitan area since it focuses on holistic care and incorporates cultural understanding.

Furthermore, the theory's emphasis on cultural assessment and specific interventions allows nurses to incorporate the local culture, languages and health practices to improve health outcomes in areas where traditional beliefs and mainstream medicine often overlap. This makes it relevant in a Western Cape setting, where understanding cultural factors could improve patient trust and care delivery.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1. INTRODUCTION

The previous chapter introduced the study by describing the healthcare context in South Africa, including the role of indigenous cultural practices and the WHO's position on integrating Indigenous Knowledge Systems with the biomedical model. Major concepts were discussed such as problem statement, aim, objectives, and research questions. Building on this foundation, this chapter provides a detailed framework for carrying out the study, outlining the research methodology, design and methods used.

2.2. RESEARCH APPROACH

This study followed a qualitative research method, which involved gathering descriptive data from participants' spoken or written words and observed behaviours (Bryman, 2020; Creswell & Creswell, 2018; Hennink, Hutter, & Bailey, 2020:400). This approach aligns with the study's goal of gaining an in-depth understanding of participant's perspective and views. Qualitative research allows for in-depth exploration of the meanings that people assign to their lives, activities, events, and social relationships (Hennink et al., 2020:400).

According to Yin (2021:2), qualitative researchers usually collect data in natural settings. Unlike experimental research conducted in controlled environments or survey-based research that relies on distributed instruments, qualitative research involves direct engagement with individuals in their natural settings (Bryman, 2020; Yin, 2021; Flick, 2020:340). In this study, individual interviews and focus groups with open-ended questions were held in the communities where participants resided, ensuring that data gathering was grounded in real-world experiences.

Flick (2020:450), highlights that qualitative research seeks to understand the importance that people place on events in their lives. The researcher's goal in this study was to understand participant's thoughts and realities by empathising with them and discovering

their perspectives on culturally sensitive patient care. This methodology proved critical in capturing participants' diverse ideas and views (Hennink et al., 2020:400)

Rather than testing predetermined models or hypotheses, qualitative research draws insight into and understandings from developing patterns in data (Bryman 2020:360). This approach views settings and individuals holistically, considering participants' past and present circumstances (Hennink et al., 2020:400). The qualitative researcher explored participant's ideas and behaviours in their daily lives, and staying connected to the empirical reality (Flick, 2020:455).

All participant views were deemed valuable in this study, challenging the notion that stronger opinions hold more legitimacy than weaker ones (Bryman, 2020:360). Every participant was given an equal opportunity to share their perspectives in response to open-ended questions during interviews and focus groups, ensuring a comprehensive representation of views.

Qualitative research is by its very nature iterative, fluid and emergent. To facilitate the continuous interaction between data collection and analysis, the research design changes as data collection proceeds (Hennink et al., 2020). The researcher kept constant communication with the participants in this study, modifying the methodology in response to new information, honing the research questions, and exploring alternative avenues when needed (Flick, 2020:450).

This approach is especially well-suited for understanding complex cultural dynamics in healthcare since it focuses on the subjective assessment of attitudes, beliefs and behaviours. The study aimed to capture the diverse perceptions and beliefs of nurses and community members in the Western Cape, contributing to the development of strategies to enhance culturally sensitive patient care.

2.3. RESEARCH DESIGN

According to Saunders and Lewis (2021:45), a research design serves as a blueprint, directing the general structure and method for data collection and analysis to answer specific research questions. Saunders et al., (2021:45) emphasise that study design “defines the methodological approach, providing a clear path for the research process.” Bryman (2020:42), argues that research design covers the entire study process, from problem formulation to final narrative and goes beyond data collection and analysis.

Kumar (2021:90) defines research design as an organised framework for gathering and interpreting data that connects research procedures with study objectives. This study concurs with the Flick (2020:36) approach, which states that research design is “a systematic plan that directs the inquiry process to effectively answer research questions.”

For this study, a multiphase qualitative research approach was used. According to van Kraaij, Lalleman, Walravens and van Oostveen (2022:165), this method is helpful when dealing with complex research issues that necessitate an extensive assessment from multiple angles. The focus of this study was to investigate the cultural factors that influence patient care by gaining insight from nurses, patients and community members, particularly those who have consulted indigenous healers before seeking professional healthcare services.

Given the complex nature of the research subject, the multiphase qualitative approach allows for an in-depth exploration of multiple cultural factors. This method was suited to studying complex social phenomena, such as the cultural factors on patient care. It enables a more balanced knowledge of individual perspectives and experiences, which is important in developing culturally sensitive nursing strategies (van Kraaij et al., 2022:165).

This approach has numerous advantages. It allows detailed exploration and understanding of the phenomena under investigation, providing flexibility and adaptability in data collecting and analysis. It also offers important insights into people's experiences

and perspectives, which are important in reflecting the richness and complexity of cultural factors influencing patient care.

The study was conducted in three healthcare facilities (district hospital, clinic and community health centre) in Mitchells Plain, Western Cape. The study population included nurses, patients, and community members. Participants were selected using purposive sampling based on defined inclusion criteria. Data were collected through semi-structured interviews and focus group discussions conducted in English, with clarification provided in isiXhosa where necessary. Interviews lasted approximately 45 minutes, while focus group discussions ranged from 60 - 90 minutes. Detailed data collection procedures and analysis steps are presented in Chapter 3 to ensure logical sequencing of the research process.

2.4. BRIEF METHODOLOGICAL OVERVIEW OF DATA ANALYSIS

Polit and Beck (2021:725) characterise “data analysis as systematically arranging and interpreting the data to derive meaningful insights.” It includes “sorting, questioning, reasoning and theme development” (Hesse-Biber 2020:336). According to Roller (2020:12), qualitative analysis requires an “intentional effort to accept complexity and immerse fully in the data” to reveal its deeper meanings. This method allowed interpretation that kept the uniqueness of the participants’ experiences while exploring the phenomenon under investigation (Creswell 2021:183).

Data analysis was guided by the thematic analysis framework of Braun and Clarke (2006), which provides a clear and structured method for identifying, analysing, and reporting patterns (themes) within the data. This approach offers flexibility and yields rich, detailed data, making it useful for exploring culturally sensitive patient care in the Western Cape context. The software ATLAS.ti 25 was used to support the management, organisation, and coding of large volumes of qualitative data.

Daneshgar (2023:36) underlines the importance of exact planning in data analysis, which includes categorising, structuring, and summarising data to generate understandable descriptions. Following this, Braun and Clarke's six-phase framework was applied systematically across the three phases of data collection to ensure credibility, coherence, and depth of analysis. The detailed data analysis process, including coding, categorisation, and theme development, is presented in Chapter 3, Section 3.4.

2.5. TRUSTWORTHINESS AND RIGOUR

Rigour was maintained to ensure the study's trustworthiness throughout all phases, including preparation, organisation and reporting of findings. The process demonstrated the study's reliability and validity (Fong, DeWitt, & Leng, 2021:66). The researcher constantly clarified qualitative research principles, emphasising the importance of nature and use of qualitative findings while also addressing the study's quality and accuracy (Leung, 2020:324). Rigour in qualitative research ensures that participant's experiences and perspectives are accurately represented, which was the primary goal of this study (Leung, 2020:324).

According to Holloway and Galvin (2020:314) rigour refers to the meticulous steps taken by the researcher to conduct the study in an acceptable, credible and reliable manner. Johnson, Adkins and Chauvin (2021:145) argued that rigour includes the trustworthiness of the findings, indicating the extent to which they can be trusted by other researchers and applied in similar contexts. Trustworthiness is considered the cornerstone of qualitative research, as it evaluates the strength of the study by examining all aspects of the research process (Grove, Gray & Burns, 2020:845). As Daniel (2022:102) and Willig & Rogers (2021:510) suggest, trustworthiness reflects the confidence that other researchers place in the quality of the research and the validity of the findings. In this study, trustworthiness was established using four key criteria: credibility, dependability, transferability and confirmability (Boswell & Cannon, 2021:189):

Credibility: Credibility, as described by Johnson, Adkins and Chauvin (2020:7120), pertains to the reliability and acceptability of a study's findings. In this study, credibility was enhanced by demonstrating the researcher's ability to document and express their knowledge of the research process (Dahal, 2023:2). Purposeful sampling methods and data triangulation were used to strengthen the credibility of the findings.

The researcher prioritised prolonged engagement in the field and consistent observation to establish credibility. Adequate time was spent within the study setting to build rapport with participants and collaboratively generate meaning. A detailed and comprehensive account of the phenomenon under investigation was provided to ensure the findings accurately reflected participant's realities (Dahal, 2023:2). This was achieved through self-reflection and taking notes on the perspectives of participants on the problem at hand.

Transferability: Transferability refers to the extent to which the findings of a study can be applied to other contexts or populations (Johnson, Adkins & Chauvin, 2020:7120). In this study, transferability was ensured by providing detailed descriptions of the research procedures, participants and study environment. By offering comprehensive explanations, the researcher enabled readers to assess the relevance and applicability of the findings to their own settings or populations of interest. Extensive demographic information about the participants was presented, along with a thorough description of the study setting and the cultural context of Cape Town. Purposeful sampling was employed to ensure participant diversity, allowing for a richer and more complex understanding of cultural sensitivity in patient care across varied segments of the target population.

Dependability: Dependability is defined as the stability and consistency of study findings over time and among different researchers (Dahal, 2023:3). To enhance the dependability of this study, the researcher used rigorous and transparent research techniques, documented decision-making processes and established explicit protocols for data collection and analysis. An interview guide with standardised questions was developed to ensure uniformity across all interviews.

Additionally, member checking was implemented, allowing participants to review and provide feedback on the researcher's interpretations. This process helped to validate the findings and improve the reliability of the study.

Confirmability: Confirmability, described as the objectivity of study findings, ensures they were free from the researcher's personal bias and assumptions (Dahal, 2023:3). In this study, confirmability was strengthened by relying on the data provided by participants and ensuring corroboration on themes and categories between the researcher and an independent coder. Written field notes and audio recordings from semi-structured interviews served as references to support the study's conclusions.

The researcher engaged in reflexivity by critically assessing the personal assumptions and prejudices that could have influenced the research process. Peer debriefing was also used to mitigate bias by allowing the researcher to share findings and interpretations with colleagues, enhancing the impartiality of the study. Confirmability ensured that the results and conclusions were derived from the participant's input and research context rather than the researcher's own perspectives (Moser & Korstjens, 2021:6).

2.6. ETHICAL CONSIDERATIONS

Ethical considerations are essential guidelines that ensure quality, safety and respect for participants in a research study (Hennink et al., 2020:90). This study adhered to fundamental ethical principles to uphold the integrity, respect and well-being of all participants during the exploration of culturally sensitive patient care. These principles included informed voluntary consent, respect for autonomy, non-maleficence, justice and respect for individuals. Ethical approval was obtained from the University of South Africa Research Ethics Committee (REC-240816-052), Western Cape Department of Health (WC_202503_005), and the City of Cape Town (Ref: 12205).

Informed voluntary consent

Informed voluntary consent is a critical ethical requirement, providing participants with sufficient, comprehensible information about the research (Hennink et al., 2020:90). In this study, all participants were informed about the research's nature, including its purpose, the type of information being collected and how their information would be used. Participants were assured that their involvement was entirely voluntary, with no coercion, and that they could withdraw at any time without any repercussions. Written informed consent (Appendix N) was obtained from all participants before data collection commenced.

Authority to conduct the study

The study was conducted with prior approval from relevant authorities to ensure compliance with ethical standards. Ethical clearance was obtained from the University of South Africa (UNISA) Research Ethics Committee (Appendix A), and the research proposal was reviewed by the Institutional Review Board (IRB) of the healthcare facility where the data was collected. Additionally, permissions were obtained from the participating healthcare facilities to ensure the study adhered to institutional and academic standards.

Respect for autonomy

Respect for autonomy recognises individual's right to make informed decisions and exercise self-determination (Varkey, 2021:17). Participants were provided with clear information about the research purpose, procedures, potential risks and benefits. Informed consent was obtained before data collection to ensure participants fully understood their rights and the study's scope.

Non-maleficence

The principle of non-maleficence emphasises the researcher's obligation to avoid causing harm to participants (Ferreira & Serpa, 2018:2324). This study adhered to this principle by ensuring that no harm or injury was inflicted upon participants throughout the research process. Data collection was conducted in a private, secure environment to minimise

psychological or emotional distress. Sensitive questions were posed carefully and the researcher, trained as a mental health practitioner, was prepared to address emotional discomfort by offering support or referring to counselling services if needed.

To comply with the Protection of Personal Information Act (POPIA), data was anonymised by removing personal identifiers and stored securely in password-protected digital files accessible only to the research team. Physical documents, including consent forms, were securely stored in a locked cupboard at the University of South Africa.

Justice

The principle of justice entails fair, equitable and respectful treatment of all participants (Varkey, 2021:17). This study ensured justice by recruiting a diverse sample that represented various demographics and perspectives relevant to the research. Recruitment strategies aimed to eliminate discrimination or prejudice, and participants were treated with respect and impartiality throughout the data collection process. Semi-structured interview questions were used consistently to avoid bias and Tesch's method was applied during data analysis to ensure impartiality in identifying themes.

Respect

Special consideration was given to vulnerable participants, including individuals who might have been cognitively impaired or experiencing illness, as outlined by Ferreira and Serpa (2018:2324). Additional safeguards were implemented to protect their rights, welfare and dignity, ensuring that all participants were treated with the utmost respect throughout the study.

Minimizing harm

The study prioritised minimising harm by creating a safe and comfortable environment for participants. Interview questions were designed to be sensitive and non-invasive, and measures were taken to ensure participants did not face discrimination or stigma because of their involvement.

2.7. CONCLUSION

The theoretical framework, research design, and methodological procedures that directed the study were described in this chapter. The study is grounded in a paradigm that highlights the significance of cultural values, beliefs, and practices in nursing care within the diverse Western Cape environment by using Leininger's Sunrise Theory. A flexible yet rigorous method for assessing the lived experiences of nurses, patients, and community members was made possible using a qualitative, multiphase design. Rich and relevant data were collected using focus groups, semi-structured interviews, ethical recruitment, and purposive sampling. Tesch's data analysis approach made sure that the information was interpreted methodically, which resulted in the discovery of significant themes.

CHAPTER 3

DATA COLLECTION AND ANALYSIS

3.1. INTRODUCTION

This chapter discusses the data generation and analysis methods used to address the study's research objectives. It begins by explaining the data gathering procedures, including the inclusion and exclusion criteria used to select participants. The approach to data collecting is then discussed, including the tools used, the rationale for using both interviews and focus groups, and the procedures for recruiting participants. The chapter details the step-by-step interview procedure, which was divided into three phases to ensure data depth and richness. Finally, the data analysis procedure is described, including the methodical approach to coding, categorising, and finding emerging themes.

3.2. DATA COLLECTION PROCESS

Research methods are required for organising a study, as well as methodically collecting and analysing data. According to Polit and Beck (2021:743), research methods are the systematic procedures for organising, collecting and analysing data in a structured manner. Similarly, Creswell & Creswell (2021:45) underline that research procedures refer to the tools and processes used to collect and interpret data, ensuring that the research is carried out efficiently and effectively.

Kumar (2022:98) defines research methods as the systematic activities or actions done to acquire and analyse data in accordance with the study's objectives. These approaches comprise the behaviours and instruments used to identify and develop the study framework.

3.2.1. Research setting

A research setting is the physical environment in which researchers engage with participants to build meaningful relationships and collect data that is directly related to the

study's aims (Bryman, 2020:32). This study was conducted in Mitchells Plain, located within the City of Cape Town, South Africa, with data collected in one district hospital, one Clinic and a Community Health Centre (CHC).

This researcher collected data from participants in their natural settings, assuring authenticity and contextually rich insights (Polit & Beck, 2021:464; Saunders et al., 2022:46). Mitchell's Plain was chosen as the study setting due to its diverse, multicultural population and high utilisation of both biomedical and indigenous healthcare systems, which provides a rich context for exploring culturally sensitive nursing practices. As a metropolitan area within the City of Cape Town, Mitchell's Plain is home to various ethnic and cultural groups, each with unique healthcare needs and practices. This diversity presents both challenges and opportunities for healthcare providers in culturally sensitive patient care. By focusing on Mitchell's Plain, the study uncovers specific cultural factors influencing patient care, enabling the development of nursing strategies that address the various needs of this community. Mitchell's Plain's well-established healthcare infrastructure, including district hospitals, local clinic and community health centres, further supports the feasibility of conducting in-depth qualitative research within natural healthcare settings.

The map below (Fig. 3.1) shows Mitchells Plain's geographical configuration (Source: ResearchGate, 2018).



Fig 3.1: Mitchells Plain's geographical configuration (Source: ResearchGate, 2018)

3.2.2. Research population

The research population is all individuals or elements with defined characteristics from which a study sample is drawn (Leavy, 2021:76). This population serves as the foundation for developing study-relevant insights and generalisations. Williamson and Johanson (2020:269) define a population as all individuals or elements that meet the study's objectives and share at least one common attribute. Williman (2021:143) emphasises that the population consists of all individuals that match the criteria given in the study questions. In this study, the population consists of all nurses, patients and community members from Mitchell's Plain, Western Cape, South Africa, all of whom interact with or are influenced by culturally sensitive patient care. This diverse population gives rich data about cultural aspects affecting healthcare delivery in a metropolitan environment.

3.2.3. Research sampling

Sampling means selecting a small number of individuals from an overall population to represent the entire group (Williman, 2021:143). It involves strategically choosing participants to ensure that the sample appropriately represents the larger population studied (Kothari, 2020:55). This study used a non-probability, purposive sampling method to gain in-depth understanding into elements of culturally sensitive patient care (Boswell & Cannon, 2020:186; Silverman, 2020:355; Creswell & Clark, 2019:269).

Participants were chosen based on their relevance to the study's objectives, particularly their experiences and insights into culturally sensitive nursing practices. Purposive sampling ensured that participants met the inclusion criteria set out in section 2.5.5. The final sample size was determined by the point of data saturation, where no new information or themes emerged from the data.

3.2.4. Purposive sampling

Purposive sampling, a non-probability sampling technique, was used to deliberately choose participants with specific characteristics relevant to the study's objectives. Silverman (2020:355) defines three major approaches to purposive sampling: maximal variation sampling, extreme case sampling and homogeneous sampling. Maximal variation sampling selects people with different perspectives to capture a wide range of viewpoints. Extreme case sampling selects individuals with unusually unique or insightful experiences, whereas homogenous sample selects participants who share specified characteristics, resulting in a more uniform subset (Silverman, 2020:355).

In this study, maximal variation sampling was used to recruit nurses, patients and community members from diverse cultural backgrounds, all of whom had prior experience or understanding of culturally sensitive patient care. As Daneshgar (2023:35) points out, this strategy assured the selection of individuals who could provide rich, complex insights

into the topic. By focusing on participants with relevant cultural and healthcare experiences, this strategy ensured that the data collected was complete and relevant, contributing strongly to the research objectives.

The intentional inclusion of a broad participant pool enhanced the depth and richness of the data, allowing for an in-depth exploration of culturally sensitive patient care. This technique ensured that the sample accurately reflected the target demographic while also allowing for the identification of common themes and specific challenges within the context of the Western Cape metropolitan community. Finally, the findings informed the development of nurses' strategies (Appendix Q) designed to meet patient's cultural needs, while enhancing the quality of care provided.

3.2.5. Inclusion criteria

The inclusion criteria for this study were participants who could contribute valuable insights into culturally sensitive patient care in a metropolitan community. According to Creswell and Creswell (2021:115), developing defined inclusion criteria is important for defining the study population and ensuring the relevance and quality of the data collected.

Phase 1: These were nurses who had at least one year's work experience in the selected healthcare facility and registered with the South African Nursing Council as a nurse. Nurses aged 18 years and older involved in direct patient care within the selected healthcare facilities were included. This criterion was essential to gather perspectives from frontline healthcare providers who play a critical role in delivering culturally sensitive care (Smith & Taylor, 2022:45).

Phase 2: Patients from diverse cultural, ethnic and religious backgrounds who sought healthcare services at the selected facilities were considered for inclusion. This diversity was crucial to understand the complex cultural needs and experiences of patients, as highlighted by Johnson and Brown (2020:78), who emphasise the importance of patient diversity in healthcare research.

Phase 3: Community members aged 18 years and older, residing in the vicinity of the research setting for at least one year were included. This phase aimed to capture the community's broader perspective, incorporating a wide range of cultural, ethnic, linguistic and religious backgrounds. The one-year residency requirement ensured participants had sufficient exposure to the local healthcare context, enhancing the reliability of their insights (Williams & Clark, 2023:112).

3.2.6. Exclusion criteria

Developing clear exclusion criteria is important for maintaining a study's integrity and focus, ensuring that only participants with relevant data are included (Bryman, 2021:134). Specific exclusion criteria were used throughout the three phases of this study.

Phase 1: Nurses in administrative or managerial positions who are not involved with direct patient care were excluded. This decision essentially focused on the perspectives of frontline healthcare workers who have direct interactions with patients and actively participate in implementing culturally sensitive patient care strategies (Green & Thorogood, 2020:88).

Phase 2: Patients who either refused or were unable to participate due to medical conditions, cognitive impairments or language barriers were excluded unless an interpreter was available. This criterion meant that participants could fully engage in the study and provide meaningful input, as emphasised by Taylor and Francis (2022:67).

Phase 3: Community members under the age of 18 or those who declined to participate were excluded from the study. The age restriction ensured that participants had the maturity and life experience necessary to contribute valuable perspectives on culturally sensitive patient care, aligning with the recommendations of Johnson and White (2023:54) regarding participant selection in community-based research.

3.3. DATA COLLECTION APPROACH

This section discusses the data collection process, and the instruments used in the study. Data collection, defined as information or facts gained throughout the research process, were methodical, measured and analysed to answer research questions and estimate trends (Creswell & Poth, 2021:148). The qualitative data collection provided verbal and visual material for exploring phenomena, social contexts, subjective and collective experiences and the associated meaning-making processes (Flick, 2020:7).

Participants were recruited by the researcher, a trained mental health practitioner with extensive experience in data collection. The researcher completed multiple courses on data collection and analysis, including those offered by the Insimbi Training Institute and participated in several virtual seminars on qualitative research methods. Recruitment commenced following ethical approval from the relevant ethics committee, with permissions sought from Western Cape Department of Health (Appendix C and D), City of Cape Town known as City Health (Appendix B) and Mitchells Plain Community Leader (Appendix F). Informed consent (Appendix N) was obtained from all participants, ensuring they were fully informed about the study's purpose, procedures and potential risks.

3.3.1. Data collection tools

Data collection involved semi-structured individual interviews and focus group discussions: Phase 1 (nurses), Phase 2 (patients) and Phase 3 (community members). Semi-structured interviews allowed participants to share their experiences in-depth while maintaining flexibility in questioning to ensure coverage of critical topics related to culturally sensitive patient care. Focus group discussion, conducted with nurses, facilitated collective dialogue, providing a broader range of perspectives.

The interview guide was aligned to the study's objectives, allowing the exploration of cultural beliefs, patient experiences and expectations of culturally sensitive patient care.

As the study adopted a qualitative approach, no pilot was conducted, allowing for flexibility and in-depth exploration of participant's experiences.

3.3.2. Participant recruitment

Participants were recruited purposively based on inclusion criteria. Facility managers assisted in identifying eligible participants. Interviews were chosen for all phases due to their effectiveness in capturing personal accounts of experiences with culturally sensitive care. Focus group discussions supplemented individual interviews by promoting collective reflection on shared experiences and cultural challenges that might not emerge in one-on-one interviews. This combined approach enriched the data, balancing individual depth with group dynamics (Polit & Beck, 2022:337).

3.3.3. Data collection procedure

Data was collected through semi-structured individual interviews and focus group discussions. Data collection took place face-to-face in locations convenient for participants. Interviews and focus groups were held in private rooms to ensure confidentiality. Participants were asked for permission to use an audio recorder, which ensured accurate transcription and analysis. Nonverbal cues, such as body language and facial expressions, were also observed and interpreted contextually. Each interview lasted approximately 45 minutes, providing ample time to explore participant's perspectives fully, while focus group session lasted at least 60 - 90 minutes and took place in a neutral, private location that was easily accessible to participants. The researcher, skilled in mental health practice and qualitative research methods, conducted the interviews and facilitated the focus group discussion.

3.3.4. Interview process - Phase 1- 3

The interview process involved semi-structured and purposeful discussions aimed at gathering specific insights, as described by Sekaran and Bougie (2020:114). Interviews and observations are widely recognised as methods for data collection in qualitative research (Boswell & Cannon, 2021:187).

In this study, participant recruitment was facilitated with the assistance of a local councillor who served as indigenous leader and gatekeeper for two villages in the Mitchells' Plain area. The councillor met with the researcher to gain an understanding of the study (Appendix F). At each interview venue, ethical considerations were emphasised, and information sheet (Appendix I) was provided to participants.

At the healthcare facilities, two of my colleagues provided important support in the recruitment and coordination of both nurse and patient participants for individual interviews. Their primary role involved guiding participants into a designated private room to ensure confidentiality and a safe space for individual interviews. They distributed the participant information sheets (Appendix H and I) and assisted in explaining the study objectives, ethical considerations, and the voluntary nature of participation in a clear and respectful manner. Additionally, they managed the interview schedule to minimise disruption to community health centre and clinic operations, and helped maintain a calm and welcoming environment. Their assistance also included checking that the recording equipment was functional. Their contributions were invaluable in promoting the smooth and ethical execution of the data collection process.

The researcher maintained a semi-structured discussion format, allowing participants to express their experiences and opinions freely. To create a conducive atmosphere, the researcher dressed casually and engaged informally with participants before, during and after the interviews. Participants were reassured that their responses would remain confidential and that participation was entirely voluntary, with the option to withdraw at any stage. Those who preferred not to participate in a focus group were given the opportunity to take part in individual interviews, ensuring inclusivity and respect for personal preferences.

Interviews continued until data saturation was reached. Although data saturation was reached within each participant group, additional interviews were conducted to ensure representation across diverse cultural backgrounds and strengthen data richness. The

focus group discussion lasted between one hour and fifteen minutes, while individual interviews ranged from forty-five minutes to one hour. The entire data collection process was completed over 122 days (four months), ensuring a thorough and comprehensive gathering of perspectives. Data collection took place in a natural setting within the community where participants live to ensure familiarity and comfort. At the start of each interview, the researcher greeted the participants, introduced himself and explained the purpose of the study. The interview began with questions to gather biographical data, including age, level of education, number of times visited the healthcare facility and working experience.

The interview questions were written in simple English and for participants who had difficulty understanding English, the researcher provided translations. The researcher speaks English and understands some Afrikaans and isiXhosa as well. English was a shared language understood by almost all participants, allowing consistent communication and accurate transcription. Probing questions, as outlined in the interview guide, were used to encourage deeper discussion and gather comprehensive information on the subject matter. Once the researcher confirmed that no new information was forthcoming, he thanked the participants for their time and contributions. Participants were assured that they would be informed of the study's findings upon completion. Both individual and focus group interviews were audio-recorded with participant's permission to ensure accuracy in data collection.

3.4. DATA ANALYSIS PROCESS (INCLUDING CODING, CATEGORIES, MERGING THEMES)

The research journey into culturally sensitive patient care in the Western Cape revealed a complex landscape of interconnected experiences, challenges, and transformative strategies. By employing Braun and Clarke's (2006) six-step thematic analysis, supported by ATLAS.ti 25 software, the study systematically identified, organised, and interpreted patterns within the data. This rigorous inductive approach was applied across nurses, patients, community members, and focus group participants, ensuring that the analysis reflected multiple perspectives and lived experiences. Data source triangulation was

achieved by comparing findings across nurses, patients, and community members. Convergences and divergences across datasets were examined during theme development to strengthen interpretation and enhance analytical rigour.

Familiarisation with the data

Data from nurses' interviews, focus groups, and field notes were transcribed verbatim and read repeatedly to immerse the researcher in the content. During this stage, initial ideas were noted, and reflective memos written in ATLAS.ti 25 to capture early impressions.

Generating initial codes

Each transcript from nurses, patients, and community members was systematically coded in ATLAS.ti 25. Segments of text were labelled with codes that captured meaningful features relevant to the research objectives. Codes were both semantic (explicit content) and latent (underlying assumptions).

Searching for themes

Codes were reviewed and collated into broader potential themes. For example, codes relating to communication barriers, respect for culture, and patient trust were clustered into higher-order categories. ATLAS.ti 25's network view function was used to visualise relationships between codes.

Reviewing themes

The themes were refined by checking them against the coded extracts and the entire data set to ensure they accurately represented participant perspectives. This involved a recursive process of collapsing, splitting, or discarding themes where necessary.

Defining and naming themes

Themes were clearly defined and named to capture their essence. Each theme was described in relation to the overall research questions, with subthemes identified to provide greater specificity.

Producing the report

The final phase involved weaving together the analytic narrative with illustrative participant vignettes and quotes to present a coherent story of the data. The findings were

compiled into a comprehensive report, supported by relevant literature (Nowell et al. 2021:1).

➤ **Emergence of themes: A methodological reflection**

The thematic development was not a linear process but a dynamic, iterative exploration. Open coding initially generated hundreds of discrete codes, which were subsequently clustered and refined through constant comparative analysis. This approach allowed for the emergence of themes that were deeply rooted in participants lived experiences rather than pre-existing theoretical frameworks.

The inductive approach was particularly powerful in verifying the multidimensional nature of cultural sensitivity. What began as a straightforward exploration of healthcare interactions transformed into a profound examination of power dynamics, epistemological conflicts, ontological differences and systemic inequities.

➤ **Coding and thematic development process**

Initial open coding generated over 669 codes across participant groups. These codes were examined for patterns, interconnections, and underlying conceptual similarities. The coding process was deliberately iterative, involving:

- Line-by-line coding of transcripts
- Identifying initial patterns and recurring concepts
- Clustering related codes into preliminary categories
- Developing overarching themes through constant comparison
- Validating themes against original data sources

➤ **Theoretical sensitivity and researcher reflexivity**

The researcher maintained a critical stance, recognising that the thematic development was itself a culturally mediated process. Coding continuously reflected on own positionality, acknowledging how personal and professional backgrounds might influence interpretative processes.

Key thematic insights

The six emergent themes represent more than mere descriptive categories; they constitute a context for understanding cultural sensitivity:

1. **Pathways to cultural competence established** the non-linear, complex ways healthcare professionals develop cultural understanding, challenging assumptions about training and expertise.
2. **Systemic barriers and institutional challenges** exposed structural mechanisms of discrimination and exclusion within healthcare systems.
3. **Knowledge system conflicts** highlighted fundamental epistemological differences between traditional and biomedical healing paradigms.
4. **Patient navigation and agency** demonstrated patients' sophisticated strategies for managing complex healthcare landscapes.
5. **Dignity, respect, and human rights**: Positioned cultural sensitivity as a fundamental human rights issue.
6. **Professional identity and ethical navigation**: Explored the intricate personal-professional negotiations healthcare workers undertake.

➤ **Methodological significance**

The inductive approach was particularly useful in revealing unexpected insights. For instance, the economic dimensions of healthcare choices and the cultural dual-system navigation strategies were not anticipated in the initial research design.

The emergence of these themes shows the value of Braun and Clarke's (2006) structured, flexible, and recursive framework in capturing the complexity of culturally sensitive patient care. The findings also highlight the methodological strength of combining thematic analysis with software-assisted coding through ATLAS.ti 25, which enhanced transparency, rigour, and traceability in the analysis process.

3.5. CONCLUSION

This chapter described the systematic data collection and analysis processes that supported the study. Purposive sampling, semi-structured interviews, and focus group discussions were used to collect rich and diverse perspectives from nurses, patients, and

community members. The application of Braun and Clarke's (2006) thematic analysis, supported by ATLAS.ti 25, allowed for rigorous data arrangement, coding, and interpretation, resulting in the formation of six interconnected themes. These findings yielded subtle insights into the challenges of culturally sensitive patient care, revealing both individual and institutional challenges. The chapter therefore provided a foundation for the presentation of findings in the following chapter.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1. INTRODUCTION

This chapter discusses the study's findings, based on thematic analysis of interviews and focus group discussions with nurses, patients, and community members. Based on the data collection and analysis methods discussed in Chapter 3, the findings are presented to reflect participants lived experiences, challenges, and perspectives on culturally sensitive patient care. The chapter begins with a description of the participants from all three phases of data collection, followed by a detailed description of the themes and sub-themes that emerged during analysis. These findings lay the foundation for the development of strategies to enhance culturally sensitive patient care, which are further discussed in subsequent chapters.

4.2. DESCRIPTION OF PARTICIPANTS (PHASE 1: NURSES, PHASE 2: PATIENTS, PHASE 3: COMMUNITY)

Table 4.1: Nurses Participant Profiles and Background Characteristics

Participant	Age	Gender	Education	Experience	Key Background Characteristics	Primary Cultural Approach	Traditional Healing Stance
PN1	34	Female	Postgraduate	8 years	Professional focus, safety-oriented, training gaps awareness	Evidence-based accommodation	Reluctant referral, advocates employment integration
PN2	31-40	Female	Diploma	11-15 years	Balanced practitioner, educational advocate	Systematic cultural accommodation	Professional neutrality, curriculum development
PN3	41-50	Female	Diploma	11-15 years	Ethics-grounded, experienced, framework-oriented	Professional pledge foundation	Legal boundaries, spiritual care distinction

PN4	31-40	Female	Higher cert/diploma	6-10 years	System critic, safety-focused, evidence-based	Operational gap identification	Safety skepticism, standardisation advocacy
PN5	31	Female	Postgraduate	10 years	Harmonious practitioner, equal treatment advocate	Mature cultural integration	Balanced ambivalence, clinical preference
PN6	45	Female	Grade 11	1-5 years	Values-driven, intuitive competence, respect-centered	Golden rule cultural philosophy	Patient autonomy, choice acceptance
PN7	31-40	Male	Diploma	6-10 years	Gender-aware, systematic, methodical	Cultural equality framework	Knowledge limitation, formal education advocacy
PN8	31-40	Male	Master's	6-10 years	Strategic thinker, professional development focused	Evidence-based systematic approach	Professional development, CPD integration
PN9	32	Female	Unspecified	10 years	Honest about limitations, peer-dependent learner	Colleague-based experiential learning	Complete ignorance, respectful silence

PN10	28	Female	Degree	4 years	Personal traditional medicine background, evidence-based	Personal-professional bridge	Evidence-based integration advocacy
PN11	31-40	Female	Diploma	6-10 years	Integration paradox, institutional awareness	Professional-personal separation	Personal belief, professional restriction

- **Participant Profiles**

- **Educational diversity and competence relationship**

The participant profiles depict a fascinating non-linear relationship between formal education and cultural competence. PN6, with only Grade 11 education, demonstrates sophisticated intuitive cultural sensitivity, while PN9, with 10 years of experience, openly acknowledges cultural insensitivity. This suggests that cultural sensitivity emerges from multiple pathways beyond formal education, including personal values, experiential learning, and peer mentorship.

- **Gender dimension impact**

The two male participants (PN7 and PN8) both highlight unique gender-specific challenges in culturally diverse healthcare settings, particularly regarding Muslim patients and touch restrictions. However, they show different response sophistication - PN7 develops systematic accommodation processes while PN8 focuses on strategic professional development solutions.

➤ **Experience-competence paradox**

Interestingly, years of experience do not predict cultural sensitivity levels. PN6 with 1-5 years shows remarkable sensitivity, while PN9 with 10 years acknowledges significant gaps. This suggests that quality of cultural encounters and reflection matter more than duration of practice.

➤ **Background influence on practice**

PN10's personal traditional medicine background creates unique tensions between personal experience and professional practice, representing nurses who bridge both worlds. This contrasts with other participants who approach cultural sensitivity primarily from professional or academic perspectives.

Table 4.2: Focus Group Participant Profiles and Background Characteristics

Participant	Age Range	Gender	Education	Experience	Key Characteristics
FGPN1	31-40	Female	Master's	1-10 years	Progressive thinker, advocates for traditional healing integration, holistic care supporter
FGPN2	41-50	Female	Diploma	5-10 years	Training advocate, regional cultural awareness, systematic approach to cultural competence
FGPN3	31-40	Male	Diploma	1-5 years	Practical accommodator, protocol-oriented, balanced cultural respect

FGPN4	40-50	Female	Master's	11-15 years	Experienced skeptic, questions cultural authenticity, training advocate
FGPN5	41-50	Female	Master's	11-15 years	System-change advocate, continuing education supporter, policy-focused
FGPN6	30-40	Male	Diploma	11-15 years	Gender-aware practitioner, resource realist, compromise advocate
FGPN7	30-40	Female	Diploma	15+ years	Holistic nursing advocate, most experienced, systems thinking

- **Focus group discussion analysis**

- **Group dynamics and interaction patterns**

The focus group revealed several interesting group dynamics that did not emerge from individual interviews:

- **Consensus building:**

Participants frequently build upon each other's ideas, particularly around training needs and system limitations. This collaborative discourse suggests shared experiences and common challenges across different healthcare settings.

- **Gender perspective amplification:**

The two male participants (FGPN3, FGPN6) brought unique gender-specific challenges that female participants had not initially considered, leading to richer discussion about cultural accommodation complexities.

➤ **Experience-based hierarchy:**

More experienced participants (FGPN4, FGPN7) often provided contextual depth to scenarios raised by less experienced colleagues, creating a natural mentoring dynamic within the discussion.

➤ **Challenge and counter-challenge:**

Unlike individual interviews, participants challenged each other's assumptions - particularly FGPN4's skepticism about authentic cultural practices, which prompted deeper exploration of cultural authenticity.

- **Power relations and professional hierarchy**

➤ **Educational hierarchy influence:**

The three master's degree holders (FGPN1, FGPN4, FGPN5) often initiated theoretical discussions and policy-level conversations, whilst diploma holders provided practical, experience-based examples. However, experience trumped education - FGPN7, despite holding only a diploma, commanded respect with her 15+ years of experience, and her closing statements went unchallenged.

➤ **Participation patterns:**

FGPN3 and FGPN6 (both male, diploma-level) spoke primarily when gender-specific issues arose, suggesting either cultural constraints around speaking in mixed-gender professional groups or recognition of their unique perspective value. FGPN5 and FGPN7 entered discussions later but provided synthesis and closure, indicating senior professional authority.

- **Consensus and dissent analysis**

➤ **Strong professional consensus:**

The group showed unanimous agreement on training inadequacy, cultural sensitivity importance, and traditional healing integration desires. This suggests these are not individual preferences but professional community standards.

➤ **Contested territories:**

FGPN4's skepticism about cultural authenticity (*"Sometimes people use culture as a reason, but it's not always genuine"*) created the most significant dissent, challenging the group's otherwise accommodating stance. This debate revealed underlying professional tensions about balancing cultural respect with clinical judgment.

➤ **Negotiated positions:**

The group collectively worked through resource constraint challenges, ultimately reaching consensus that cultural accommodation limitations *represent "everyone's responsibility, not just the nurse or the system"* - a sophisticated collective position unlikely to emerge from individual thinking.

➤ **Knowledge co-construction and collective problem-solving:**

Innovative solutions through interaction: The regional cultural orientation concept evolved from FGPN2's initial suggestion through group refinement, creating a more sophisticated training proposal than individual thinking could have generated. Similarly, the understanding of cultural accommodation as systemic challenge emerged collectively rather than from individual perspective.

➤ **Building professional experience:**

Participants combined individual experiences to create shared understanding - FGPN6's gender-based refusal experience, when discussed collectively, helped the group develop nuanced understanding of cultural authenticity versus convenience.

➤ **Professional identity protection and social positioning:**

Careful professional boundary navigation: Participants consistently protected nursing profession's reputation whilst acknowledging limitations. Notice the careful language around traditional healing: *"I wouldn't formally refer to them. it's not in our scope"* (FGPN2) and *"I might, even though I know it is not allowed"* (FGPN1). This suggests professional identity protection whilst expressing genuine support for patient needs.

➤ **Collective professional voice:**

Unlike individual interviews where personal opinions dominated, participants spoke as representatives of the nursing profession, using collective pronouns ("we," "our") and referencing shared professional standards and constraints.

- **Silence and participation analysis**

➤ **Meaningful hesitations:**

When discussing traditional healing referrals, participants showed notable hesitation before FGPN1's admission about working outside scope of practice. This silence suggests sensitive professional territory where personal beliefs conflict with professional requirements.

➤ **Strategic participation:**

FGPN6's contributions focused primarily on gender-related challenges, suggesting strategic expertise sharing rather than general participation reluctance. His detailed account of gender-based refusal provided expertise unavailable to female colleagues.

- **Context and facilitator influence**

➤ **Professional context shaping:**

The healthcare setting context consistently framed discussions around scope of practice, resource constraints, and professional obligations. Participants' responses were shaped by speaking as professional community members rather than individuals.

➤ **Research topic influence:**

The cultural sensitivity focusses likely promoted socially desirable responses emphasising respect and accommodation. However, FGPN4's skepticism about cultural authenticity suggests that participants felt comfortable expressing controversial professional opinions within peer groups.

➤ **Question impact:**

Direct challenge questions ("Do you think that patient was being unreasonable?") pushed participants beyond comfortable responses, revealing deeper professional tensions about cultural accommodation versus clinical efficiency.

The role of the moderator:

The researcher served as moderator, facilitating discussion, ensuring equal participation, managing group dynamics, and maintaining focus on culturally sensitive patient care

Table 4.3: Patients Participant Profiles and Background Characteristics

Participant	Age Range	Gender	Education Level	Healthcare Visits	Cultural/Religious Background	Key Cultural Practices
PP1	31-40	Female	Standard 8 (incomplete)	11+	Traditional African	Traditional medicine use
PP2	29	Female	Secondary	15+	African	Traditional cleansing (impepho)
PP3	54	Female	Grade 10	10-20	African	Traditional medicine, HIV+
PP4	52	Female	Primary	15+	Muslim	Prayer, dietary restrictions
PP5	58	Male	Primary	10+	African	Traditional healers' consultation
PP6	34	Male	Secondary	~15	Xhosa	Ancestral beliefs, rituals
PP7	51-60	Male	Diploma	15+	Muslim	Prayer, halal requirements
PP8	30-40	Female	Secondary	15+	Christian (foreign national)	Prayer, rejection of traditional practices
PP9	30-40	Male	High school	20-40	Xhosa	Traditional healing, ceremonies
PP10	26	Male	Grade 12	1-5	Bhaca	Traditional consultations

PP11	41-50	Female	High school	6-10	Xhosa/Traditional	Spiritual calling, beads, ancestral beliefs
PP12	42	Male	Standard 9 (incomplete)	1-5	Traditional African	Sangoma (traditional healer)

- **Discussion of participant profiles**

The participant cohort represents a diverse cross-section of the Western Cape metropolitan community, spanning multiple generations, educational backgrounds, and cultural orientations. The demographic profile illustrates several notable patterns that contextualise the cultural sensitivity experiences reported.

- **Age and experience distribution:**

Participants ranged from 26 to 58 years, with healthcare utilisation varying significantly. Younger participants (PP6, PP10) demonstrated fewer healthcare encounters but showed sophisticated understanding of cultural dynamics. Middle-aged participants (PP1, PP2, PP3, PP11) reported the most negative experiences, whilst older participants (PP4, PP5) exhibited more pragmatic approaches to healthcare navigation.

- **Educational background and cultural expression:**

Educational attainment varied from primary to diploma level, yet this did not correlate directly with cultural practice intensity or healthcare experiences. Participants with incomplete secondary education (PP1, PP12) demonstrated deep cultural knowledge and practice, whilst those with higher qualifications (PP7, PP9) showed nuanced understanding of both traditional and biomedical systems.

➤ **Cultural and religious diversity:**

The cohort encompasses traditional African belief systems (PP1, PP2, PP3, PP5, PP9, PP11, PP12), Islamic practices (PP4, PP7), Christianity (PP8), and syncretic belief combinations. This diversity reflects the multicultural landscape of the Western Cape and provides rich insights into varying cultural sensitivity experiences.

➤ **Healthcare utilisation patterns:**

Participants with chronic conditions (PP3 - HIV, PP10 - ARVs) demonstrated different navigation strategies compared to those with episodic healthcare needs. Foreign nationals (PP8) presented unique perspectives on cultural accommodation within the healthcare system.

Table 4.4: Community Members Participant Profiles and Background Characteristics

Participant	Age	Gender	Education Level	Healthcare Visits	Cultural/Professional Identity	Primary Healthcare Approach
CP1	47	Female	High school	15+	Xhosa community member	Dual system user (traditional & biomedical)
CP2	30-40	Male	Advanced certificate	5 (childhood only)	Ugandan traditional medicine seller	Traditional medicine provider, complete hospital avoidance
CP3	49	Female	Standard 5 (primary)	15+	Xhosa, father is Sangoma	Traditional priority with forced hospital use
CP4	36	Male	High school	15+	Black South African community member	Selective dual system user
CP5	18-30	Female	High school	1-5	Qualified Sangoma	Professional traditional healer with selective biomedical use
CP6	50	Male	Grade 10	15+	Christian minister/former patient	Faith-based healing with biomedical acceptance
CP7	43	Female	Grade 6	15+	Christian with Muslim children	Crisis-only hospital uses with prayer preference

- **Discussion of participant profiles**

The participant profiles show a striking diversity within the Western Cape metropolitan community, challenging monolithic assumptions about healthcare users. The cohort spans three decades in age (18-50 years), with educational backgrounds ranging from primary school to high school completion, reflecting the socioeconomic realities of South African townships where historical educational access remains uneven.

Gender distribution shows slight female predominance (4:3), which aligns with documented patterns of women as primary healthcare seekers and cultural knowledge holders in African contexts. Notably, both traditional medicine providers (CP2 and CP5) represent different gendered approaches. CP2 is a male Ugandan herbalist emphasising practical medicine preparation, whilst CP5 is a female South African Sangoma focuses on spiritual dimensions and professional legitimacy.

- **Healthcare utilisation patterns reveal a stark dichotomy:**

Those deeply embedded in traditional systems often avoid hospitals entirely (CP2's 15-year avoidance), whilst others with chronic conditions become reluctant frequent users (CP1, CP3, CP6, CP7 all reporting 15+ visits). This suggests that current biomedical services fail to address the needs of traditional medicine adherents until crisis points to compel engagement. The cultural identities represented Xhosa traditionalists, Christian faith healers, Muslim-Christian interfaith families, and transnational African practitioners - mirror South Africa's complex cultural landscape. Each participant navigates healthcare through distinct cultural lenses, from CP3's fierce defence of Xhosa cultural items to CP6's ministry-based approach, demonstrating that 'cultural sensitivity' cannot be reduced to simple protocols.

4.3. PRESENTATION OF FINDINGS PER THEME AND SUB-THEME

4.3.1 Introduction

This section presents the findings from the thematic analysis of data collected from nurses, patient participants, community participants (including traditional healers), and focus group participants on a metropolitan healthcare setting in the Western Cape, South Africa. The analysis reflects six major themes that illuminate the complex intersections of cultural accommodation, indigenous healing practices, and biomedical healthcare delivery. Each theme is presented with its constituent sub-themes, supported by verbatim quotations from participants, and synthesised to reveal both convergent and divergent perspectives across participant groups. The findings reflect the lived experiences of those navigating the intricate landscape where traditional healing practices meet contemporary healthcare systems, suggesting areas of profound similarity alongside significant differences in how cultural competence is understood, experienced, and enacted.

Table 4.5: Theme 1

Theme 1: Pathways to cultural competence

Theme	Sub-theme/Category	Codes
Theme 1: Pathways to Cultural Competence	Personal Values and Intuition	• Golden rule principle • Values-driven professional practice • Respect as fundamental value • Personal commitment to universal respect
	Formal Education Approaches	• Cultural curriculum integration • Systematic cultural training • Professional development frameworks • Ongoing cultural education needs
	Experiential Learning	• Learning through practice challenges • Colleague-based cultural learning • Experience-based cultural wisdom • Reflection on cultural encounters
	Peer-Based Knowledge Transfer	• Shared professional experiences • Mentorship in cultural understanding • Workplace cultural education • Informal cultural knowledge sharing

	Professional Identity Navigation	• Professional-personal boundary management • Cultural identity markers • Professional pledge foundation • Balancing personal beliefs with professional standards

Theme 1: Navigating Cultural Competence in Healthcare: Indigenous Healing

Perspectives

This research explored the intricate landscape of cultural competence within healthcare settings, with a particular focus on nurse's perspectives towards indigenous healing practices. Set in a metropolitan community of the Western Cape, the study delves into the complex intersections of traditional and biomedical healthcare approaches, revealing the nuanced ways in which nursing professionals understand, negotiate, and respond to diverse cultural health beliefs.

- **Cultural competence and indigenous healing: A multifaceted exploration**

- **Personal values and intuition: The foundation of respect**

The nurses' narratives unveil a profound recognition of cultural diversity as a fundamental aspect of healthcare delivery. Beyond mere tolerance, their approach demonstrates a deep respect for patients' cultural beliefs and practices grounded in personal values and ethical commitments. This is particularly significant in the context of indigenous healing, where traditional and biomedical approaches often intersect and sometimes conflict.

One nurse eloquently captured this perspective, stating, *"If it's an African patient who believes in certain cultural practices... you must respect that. But still, you give the same care"* (PN5). This statement reflects a critical balance between professional medical practice and cultural sensitivity, acknowledging the importance of patients' cultural beliefs whilst maintaining high-quality healthcare standards. The emphasis on providing *"the same care"* regardless of cultural

difference underscores a commitment to equity that transcends cultural boundaries, positioning respect not as preferential treatment but as a baseline standard applicable to all patients.

The comparative analysis illustrates that this values-driven approach was nearly universal across participants, with all groups endorsing respect for cultural beliefs even within biomedical routines. As the focus group participants concurred, *"Ultimately you respect their beliefs"* (FGPN). However, whilst the principle was widely endorsed, the translation of this value into practice established significant variation. What emerged was not a simple binary of respectful versus disrespectful practitioners, but rather a complex landscape in which personal values collided with institutional constraints, resource limitations, and knowledge gaps.

The golden rule principle of treating others as one would wish to be treated emerged as a foundational ethical framework guiding many nurses' approaches to cultural diversity. This intuitive moral compass operated even in the absence of formal training or institutional protocols, suggesting that cultural competence, in its most basic form, springs from fundamental human values of dignity and respect. However, reliance on personal values alone, whilst commendable, also contributed to the discretionary nature of cultural accommodation, wherein patients received different quality of care depending on which practitioner they encountered rather than experiencing consistent, systematised cultural responsiveness.

➤ **Formal education approaches: Bridging the knowledge gap**

Participants consistently highlighted the need for structured educational approaches to understand indigenous healing practices, recognising significant knowledge gaps that formal education could address. *"At nursing school, there should be a module that teaches about different cultures,"* one nurse recommended, emphasising the importance of systematic cultural education (PN2). This call for curriculum recalibration and integration reflects the awareness that good intentions alone are insufficient, cultural competence requires substantive knowledge about diverse healing traditions, illness conceptualisations, and culturally appropriate care approaches.

Another participant further elaborated, *"We need formal training in traditional medical practices. The Department of Health could introduce programmes focused on indigenous medicine"* (PN10). The specificity of this recommendation calling not merely for general cultural sensitivity training but for education specifically about traditional medical practices demonstrates sophisticated understanding that cultural competence in healthcare contexts requires more than awareness of difference. It demands concrete knowledge about the healing modalities patients use, the cultural logic underlying these practices, and the ways traditional and biomedical approaches might be safely integrated or sequenced.

This call for education stems from recognition of the significant knowledge gaps surrounding indigenous healing practices. Nurses expressed a desire to comprehend the cultural and medical significance of traditional healing, viewing this understanding as crucial to providing holistic, patient-centred care. The comparative analysis revealed convergence across nurses, focus group participants, and community participants on the need for clear policy and systematic education to improve consistency and fairness in cultural accommodation. Community participant CP3 noted the current reality: *"There are no policies... nothing like that... It's up to the person... if there were policy... they would know,"* highlighting how policy absence leaves cultural accommodation to individual discretion rather than embedding it as a systematic standard.

The emphasis on formal education also reflects nurses' professional identity as evidence-based practitioners who value systematic knowledge. Informal learning through experience, whilst valuable, was perceived as insufficient for developing the depth of understanding required to navigate complex cultural scenarios. Nurses wanted not merely to accommodate cultural practices reactively but to understand them proactively to comprehend why particular practices matter to patients, what healing logics underpin traditional approaches, and how biomedical and traditional modalities might complement each other. This desire for formal education positions cultural competence not as a "soft skill" peripheral to clinical practice but as substantive professional knowledge deserving of systematic curriculum inclusion.

However, the focus on formal education also verified a tension: whilst nurses called for more training, educational institutions and healthcare systems had not prioritised cultural competence in curriculum development or continuing professional education. This gap between what practitioners recognised as necessary and what institutions provided created a situation in which nurses felt ill-equipped to navigate cultural complexity yet were nonetheless expected to do so with competence and sensitivity.

➤ **Experiential learning and cultural negotiation: Learning through practice**

Practical experiences emerged as a pivotal mechanism for developing cultural competence, particularly in understanding indigenous healing practices. Nurses shared complex scenarios that challenged their preconceptions and expanded their cultural understanding, revealing that formal education alone could not prepare them for the nuanced, context-specific negotiations required in actual practice. As one nurse reflected, *"If you don't understand other people's culture, and you're trying to explain things medically, it becomes difficult... If you do understand, it makes communication easier"* (PN2).

This observation captures a fundamental insight revealed throughout the comparative analysis: cultural understanding is not merely an ethical imperative but a practical necessity for effective communication and care delivery. When providers lack cultural knowledge, even well-intentioned explanations can fail to resonate with patients' conceptual frameworks, creating barriers to understanding and adherence. Conversely, cultural knowledge enables providers to translate biomedical concepts into culturally resonant terms, facilitating mutual understanding and therapeutic alliance.

The experiences nurses shared highlighted the importance of communication and mutual understanding when patients seek care after consulting indigenous healers. One nurse recounted a scenario in which a patient arrived with traditional marks or preparations, creating a moment of uncertainty about how to proceed. Rather than dismissing or ignoring these traditional interventions, culturally competent responses required acknowledging them, seeking to understand their significance to the patient, and negotiating care plans that respected both traditional and biomedical approaches. These negotiation processes could not be scripted in

advance; they required in-the-moment cultural sensitivity, communication skills, and willingness to engage patients as partners in care planning rather than passive recipients of biomedical directives.

The nurses recognised that effective healthcare delivery requires more than medical expertise and it demands cultural sensitivity and open dialogue. This recognition aligns with the comparative analysis finding that respectful communication improves cooperation across all participant groups. PN7 noted: *"As soon as they understand what I'm doing, they are willing to cooperate,"* highlighting how clear, culturally sensitive communication functions as an enabler of therapeutic alliance.

However, experiential learning also had limitations. Learning through trial and error could result in mistakes that negatively impacted patients. Cultural scenarios that nurses encountered were highly variable, meaning that experience with one cultural group or healing practice did not necessarily translate to competence with others. Additionally, without structured reflection and feedback, experience alone might reinforce biases or misconceptions rather than correcting them. Nurses who had negative experiences with traditional healing (such as encountering complications from herbal remedies) might generalise these experiences, developing skepticism towards all traditional practices rather than developing nuanced understanding of which practices posed risks, and which could be safely integrated with biomedical care.

➤ **Peer-based knowledge transfer: Learning from colleagues**

Informal knowledge transfer played a crucial role in understanding cultural and indigenous healing practices, revealing that colleagues became important sources of cultural insight, sharing experiences and understanding that formal education often overlooked. This peer-based learning created communities of practice within healthcare settings, wherein nurses learned from each other's cultural encounters and collectively developed strategies for navigating cultural complexity. One nurse noted the value of peer learning, sharing how a colleague explained cultural nuances: *"If it wasn't for my Xhosa colleagues, I wouldn't have known about circumcision... Thulani said it's not allowed in the culture because they must go through rituals"*

(PN9). This example illustrates how culturally embedded knowledge the kind possessed by healthcare workers who are themselves members of the cultural communities they serve becomes a valuable resource for colleagues from different backgrounds. The specific knowledge about cultural protocols surrounding circumcision could not easily be learned from textbooks; it required insider understanding of cultural practices and their significance.

The importance of community-embedded knowledge was particularly emphasised in participants' recommendations for improving cultural competence. *"Let's use community health workers who come from the same communities they can help us navigate these situations better because they know the norms,"* suggested one participant (PN8). This recommendation positions community health workers not merely as translators or intermediaries but as cultural consultants whose embedded knowledge could enhance the cultural responsiveness of entire healthcare teams.

Peer-based knowledge transfer also emerged as a strategy for addressing the policy vacuum identified in the comparative analysis. In the absence of formal institutional guidance, nurses developed informal protocols through shared learning, creating local cultural competence that, whilst valuable, remained inconsistent across facilities and dependent on the mix of staff members present. Some facilities with culturally diverse staff or staff deeply embedded in local communities developed relatively sophisticated informal approaches to cultural accommodation, whilst others remained culturally insensitive simply because they lacked staff with relevant cultural knowledge.

However, peer-based learning also raised questions about accuracy and comprehensiveness. Cultural knowledge shared informally might be partial, outdated, or reflect individual interpretations rather than broader cultural patterns. Additionally, peer learning tended to be opportunistic rather than systematic; nurses learnt about cultures represented among their colleagues but might remain uninformed about other cultural groups in their patient population. The ad hoc nature of peer learning meant that cultural competence developed unevenly, creating gaps in knowledge and inconsistencies in care quality.

➤ **Professional identity navigation: Balancing personal beliefs with professional standards**

Navigating professional identity in the context of indigenous healing requires a delicate balance between respect for cultural practices and maintaining professional medical standards. Nurses described complex strategies for managing these intersections, recognising the importance of patient autonomy and cultural beliefs whilst maintaining their professional responsibilities for patient safety and evidence-based care.

This approach was encapsulated by a nurse's reflective statement: *"Ultimately you respect their beliefs"* (FGPN). However, this respect is not passive acceptance but an active engagement with patients' cultural health practices. The comparative analysis revealed that nurses consistently expressed professional duty to provide equitable care regardless of cultural difference. PN5 stated: *"You must respect that. But still, you give the same care,"* positioning respect as compatible with, indeed, constitutive of professional standards rather than in tension with them.

Yet professional identity navigation also involved managing tensions between personal beliefs and professional obligations. Some nurses held personal skepticism about traditional healing, viewing it as ineffective or potentially harmful, yet professionally committed themselves to respect patients' choices. PN1 articulated this tension: *"Even if my personal beliefs differ, I treat every patient with respect,"* illustrating how professional ethics can require transcending personal limitations. This capacity to provide respectful, non-judgmental care even when personally disagreeing with patients' choices represents a sophisticated level of professional maturity.

The challenge of managing multiple identities was particularly acute for nurses who were themselves members of cultural communities that value traditional healing. These nurses navigated spaces between their cultural identities and their professional roles as biomedically trained practitioners. CP3 captured this complexity: *"As a nurse I must manage my cultural identity alongside my professional role,"* revealing how professional socialisation into biomedical

frameworks could create distance from one's own cultural traditions, requiring ongoing negotiation between professional and cultural identities.

Professional identity navigation also involved managing the perception of professional boundaries. Some nurses felt that engaging too openly with traditional healing might compromise their professional credibility or expose them to liability if patients experienced adverse outcomes. PN5 noted: *"I cannot allow a patient to use herbs in hospital, because it's not part of my professional practice,"* articulating how scope of practice constraints shaped what nurses felt empowered to accommodate. This statement reveals a tension: whilst nurses personally might respect traditional practices, institutional and professional frameworks positioned these practices as outside nursing's legitimate domain, creating professional risk for nurses who actively facilitated traditional healing integration.

The comparative analysis confirmed that this tension between respect and professional boundaries was not unique to individual nurses but reflected systemic challenges. The focus group participants noted, *"We tend to focus on physical care... cultural preferences... not prioritised,"* identifying how institutional priorities shaped what nurses were able to attend to within the constraints of their workload, resources, and professional mandates.

- **Synthesis: Pathways to cultural competence as multi-modal learning**

The research establishes cultural competence as a dynamic, ongoing process of learning and adaptation that draws on multiple sources: personal values, formal education, experiential learning, peer knowledge, and professional identity negotiation. For nurses working with patients who consult indigenous healers, developing cultural competence means:

- **Grounding practice in fundamental values** of respect, dignity, and equality whilst recognising that values alone are insufficient without substantive cultural knowledge
- **Advocating formal education** that provides systematic knowledge about diverse healing traditions, moving beyond superficial cultural awareness to substantive understanding of traditional medical practices
- **Learning through experience** by engaging with cultural complexity in practice, reflecting on encounters, and developing contextually appropriate strategies for cultural negotiation

- **Drawing on peer knowledge** by learning from culturally embedded colleagues and community health workers who possess emic understanding of cultural practices and their significance
- **Navigating professional identity** by balancing respect for cultural practices with professional responsibilities, managing tensions between personal beliefs and professional obligations, and working within (whilst also challenging) institutional and professional constraints

The comparative analysis corroborated that nurses were divided between those reporting successful practical accommodation and those highlighting structural gaps, showing uneven implementation across facilities. PN10 described: *"We as staff respected that... we had to call her to do her thing. We wouldn't just change the baby without her,"* exemplifying successful accommodation. In contrast, PN9 noted: *"There is no designated area here, and there's no anybody who has been allocated to look after those kinds of patients,"* highlighting structural constraints that prevented accommodation regardless of individual nurses' values or knowledge. This split verifies that cultural competence is not merely an individual attribute but a systemic capacity requiring institutional support, resources, and prioritisation. Individual nurses' cultural competence, however well-developed, cannot compensate for systemic failures to provide time, space, resources, and legitimacy for cultural accommodation.

Cultural competence in healthcare is not a destination but a continuous journey of understanding, respect, and professional growth. In the context of indigenous healing, this journey requires nurses to challenge their preconceptions, expand their cultural knowledge, and approach patient care with empathy, respect, and an open mind. The narratives of these nurses demonstrate that true cultural competence goes beyond mere tolerance. It is an active, thoughtful engagement with the diverse cultural beliefs that shape patients' healthcare experiences and preferences, grounded in both personal values and systematic knowledge, enacted through practice, and constantly refined through reflection and peer learning.

Table 4.6: Theme 2

Theme 2: Systemic Barriers and Institutional Challenges in Culturally Sensitive Healthcare

Theme	Sub-theme/Category	Codes
Theme 2: Systemic Barriers and Institutional Challenges	Structural Discrimination	• Racial differences in cultural acceptance • Healthcare cultural disrespect • Systemic cultural accommodation limits • Institutional exclusion of indigenous consultation
	Communication Gaps	• Language barriers affecting healthcare • Communication challenges from cultural misunderstandings • Non-verbal cultural communication • Insufficient communication about cultural needs
	Resource Constraints	• Workload barriers to cultural consideration • Limited cultural observation in healthcare • Resource-based cultural accommodation challenges • Workplace stress projection
	Professional Boundary Limitations	• Scope of practice constraints • Professional referral limitations

		• Institutional protocol versus cultural accommodation • Professional liability concerns
	Policy and Training Inadequacies	• Absence of cultural policies • Cultural competence training gaps • Limited formal cultural education • System-level traditional healing recognition needs

This theme unveils the profound systemic and institutional obstacles that perpetually undermine culturally competent nursing practice in a metropolitan healthcare setting in the Western Cape, South Africa. Unlike the exploratory nature of Theme 1, which examined individual pathways to cultural competence, this analysis exposes the deep-rooted barriers that transform well-intentioned care into a complex landscape of discrimination, miscommunication, and institutional rigidity. The comparative analysis established that these systemic barriers operate at multiple structural, communicative, resource-based, professional, and policy-related levels, creating a comprehensive institutional framework that actively resists cultural competence regardless of individual practitioners' commitments or capabilities.

- **Dimensions of systemic barriers**

- **Structural discrimination: The invisible boundary**

Structural discrimination emerged as a pervasive force that fundamentally challenges patient dignity and cultural respect, operating not merely through individual prejudice but through systemic devaluation of indigenous knowledge and cultural practices. The most visceral expressions of this discrimination are captured in the raw narratives of participants who experience systemic exclusion and cultural dismissal. *"They look at us and think we are not educated, so they don't listen when we try to explain our ways,"* powerfully articulates the racial and cultural hierarchies embedded within healthcare systems (CP5). This statement suggests more than individual bias it exposes a systematic devaluation of indigenous knowledge and

patient experiences rooted in colonial and apartheid histories that positioned European knowledge systems (including biomedicine) as superior and African knowledge systems (including traditional healing) as primitive or superstitious. The comparative analysis identified this as reflecting broader epistemological hierarchies in which whose knowledge counts as legitimate remains heavily contested terrain.

The institutional dismissal of traditional practices is equally stark and operates through both explicit and implicit mechanisms. *"Some of the traditional practices are dismissed by nurses they see it as backward,"* highlights the deeply ingrained prejudices that permeate healthcare interactions (PN4). This dismissal functions as a form of epistemic violence, a reflection of the coloniality of being and invalidating patients' healing traditions and positioning biomedical knowledge as the only legitimate framework for understanding health and illness. The characterisation of traditional practices as "backward" reflects modernist narratives of progress that position biomedicine as advanced and traditional healing as remnants of pre-modern thinking that should be abandoned rather than respected or integrated.

Perhaps most telling is the institutional erasure of cultural connections: *"There is no place to call our elders or traditional healers when the patient asks for it. The hospital does not allow it"* (PP2). This physical and institutional exclusion sends a powerful message about whose healing practices are legitimate and whose are not. The absence of space both physical space for cultural practices and institutional space for traditional healer consultation reflects deliberate prioritisation decisions. Healthcare facilities create space for what institutions value; the absence of space for traditional healing practices consolidates the reality that institutions do not value or recognise these practices as legitimate components of patient care.

The comparative analysis showed that patient participants stressed how respectful treatment directly affects care-seeking behaviors whilst disrespect leads to avoidance. PP3's narrative powerfully demonstrated this dynamic: *"I have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared."* This progression from initial trust through negative experience to care avoidance illustrates how structural discrimination, enacted through individual interactions, has

direct consequences for health outcomes. When patients experience cultural marginalisation, they do not merely feel disrespected; they make rational decisions to protect themselves by avoiding healthcare contexts they perceive as hostile to their cultural identities and healing practices.

The focus group participants framed structural discrimination systemically, noting: *"We tend to focus on physical care... cultural preferences... not prioritised."* This observation identifies how institutional priorities shape what receive attention and resources. Physical care is prioritised because it aligns with biomedical paradigms, performance metrics, and dominant understandings of healthcare quality. Cultural preferences are deprioritised not necessarily through explicit discrimination but through institutional structures that do not create space, time, or legitimacy for cultural accommodation. This structural prioritisation means that even well-intentioned nurses find themselves unable to provide culturally responsive care because institutional frameworks do not enable or value such responsiveness.

➤ **Communication gaps: Lost in translation**

Communication barriers represent a critical intersection of cultural misunderstanding and systemic inadequacy, creating profound care disparities that extend far beyond linguistic differences. The absence of robust interpretation mechanisms reveals institutional failure to prioritise effective cross-cultural communication, leaving patients and providers to navigate language and cultural differences without adequate support.

"We don't always have an interpreter then we guess what the patient is saying," candidly expresses the precarious nature of cross-cultural medical interactions (PN7). This "guesswork" is not merely a linguistic challenge but a fundamental breakdown of patient-provider communication with potentially serious consequences for the correct diagnosis of patient ailments. Medical histories taken through guesswork may miss critical information; symptoms described in patients' own languages and cultural frameworks may be misinterpreted; and treatment instructions may be inadequately understood, compromising adherence and outcomes. The casual acknowledgement of "guessing" shows how normalised inadequate

communication has become, treated as an unfortunate but inevitable feature of under-resourced healthcare rather than as a fundamental quality and safety issue requiring urgent address.

Cultural nuances further complicate these interactions in ways that go beyond simple translation. *"Sometimes the gestures mean something different in their culture, but we interpret it wrong,"* demonstrates the complex layers of non-verbal communication that remain unaddressed (PN2). Communication is not merely verbal; it involves non-verbal cues, proxemics, tone, and cultural scripts about appropriate interaction and meaning-making patterns. Misinterpreting these non-verbal dimensions can lead to fundamental misunderstandings about patients' symptoms, concerns, or willingness to follow treatment recommendations. A gesture interpreted as agreement might signal politeness; eye contact interpreted as directness might signal disrespect in cultural contexts where averting eyes shows deference.

The result is a systemic failure of understanding that patients experience acutely: *"Patients feel we don't explain things properly in their own language"* (PP4). This observation reveals how communication gaps operate bidirectionally. Not only do providers struggle to understand patients, but patients struggle to understand providers' explanations. Biomedical concepts explained in languages that patients speak imperfectly, or using cultural frameworks unfamiliar to patients, fail to facilitate genuine understanding. Patients may appear to understand nodding, agreeing whilst remaining confused about diagnoses, treatment rationales, or care instructions. This communication failure undermines informed consent, treatment adherence, and patient empowerment. In essence, this transition and negotiation of meanings between two worlds often confronts both nurses and patients with conflicting expectations, double messages, and identity tensions.

The comparative analysis revealed that fear of causing offence led to silence in the patients rather than open dialogue, with both nurses and patients avoiding potentially awkward conversations about cultural practices. PN9 recalled: *"I didn't want to interfere... I didn't want to be rude and ask her,"* whilst PP9 admitted: *"Maybe I just avoid conflict."* This mutual avoidance, rooted in communication anxiety, creates information vacuums wherein critical cultural and clinical information remains unshared, compromising care quality and safety.

Communication gaps also illustrated the intersection of language and power. Patients who could not communicate effectively in the dominant language of healthcare found themselves at a structural disadvantage, less able to advocate for their needs, clarify misunderstandings, or negotiate care plans. This linguistic marginalisation compounded other forms of structural discrimination, creating cumulative disadvantage for patients who were already marginalised by race, culture, and socioeconomic status.

➤ **Resource constraints: The practical impossibility of cultural accommodation**

The practical realities of healthcare delivery create what appear to be insurmountable barriers to cultural sensitivity, transforming cultural accommodation from a standard of care into what nurses perceive as an unattainable luxury. Overwhelming workloads and limited resources compel nurses to make impossible choices between completing required clinical tasks and providing culturally responsive care.

"With so many patients, we can't spend time on cultural rituals... We have to finish the ward round," encapsulates the systemic prioritisation of medical efficiency over cultural sensitivity and respect (PN6). This statement reveals how resource scarcity informs choices that position cultural accommodation as optional rather than integral to quality care. Ward rounds *must be completed* within the allocated time; medications must be administered on schedule; documentation must be completed. These biomedical tasks have clear accountability mechanisms; failure to complete them results in palpable consequences. In contrast, cultural accommodation lacks similar accountability, making it the first thing compromised and sacrificed when time pressures mount.

Physical infrastructure further compounds these challenges, showing how resource constraints operate not merely through time scarcity but through absence of physical space for cultural practices. One participant noted, *"There is no space for people to do their ritual washing or prayers in this clinic"* (CP3). The absence of designated space for cultural and spiritual practices reflects institutional decisions about how limited physical resources are allocated. Space is created for biomedical functions examination rooms, procedure areas, medication storage but not for cultural or spiritual practices, disseminating a message about what matters within

institutional priorities. The structural impossibility of cultural accommodation becomes self-fulfilling: because institutions do not create space for cultural practices, these practices cannot occur within healthcare facilities, reinforcing the perception that healthcare is exclusively biomedical rather than holistic.

The human cost of these constraints extends beyond frustrated cultural accommodation to encompass emotional and relational dimensions of care quality. "*The workload is too heavy, so stress is carried over to how we deal with patients*" confirms how systemic pressures directly impact the quality of patient interactions (PN8). Overworked, stressed nurses cannot provide the patience, attention, and emotional presence required for culturally sensitive communication and relationship-building. Time pressures create a task-focused approach that treats patients as bodies requiring technical interventions rather than persons requiring holistic, culturally congruent care. The emotional labour required for culturally responsive care listening attentively, negotiating cultural differences, explaining biomedical concepts in culturally resonant terms becomes impossible when nurses are stretched beyond capacity.

The comparative analysis revealed that these resource constraints created uneven implementation of cultural accommodation across facilities. Some facilities with better resources or lower patient volumes managed to create space for cultural responsiveness, whilst others operated in perpetual crisis mode that made cultural accommodation practically impossible. This facility-level variation meant that patients' experiences of cultural respect depended not on their rights but on *the accident* of which facility they accessed a form of structural inequity that violated principles of universal healthcare access.

Resource constraints also reveal tensions in how healthcare quality is defined and measured. If cultural accommodation were genuinely valued as a component of quality care, institutions would allocate resources to hire sufficient staff to allow time for cultural communication, creating physical spaces for cultural practices, and providing interpreter services. The failure to allocate such resources reveals that, despite rhetorical commitments to cultural competence, institutions do not genuinely and practically prioritise cultural responsiveness when making resource allocation decisions. Performance metrics focus on biomedical efficiency (patient throughput,

wait times, clinical outcomes) rather than cultural responsiveness, creating perverse incentives wherein culturally responsive care that takes additional time is penalised rather than rewarded.

➤ **Professional boundary limitations: The straitjacket of protocols**

Professional practice becomes a significant barrier to holistic, culturally responsive care through rigid protocols and narrowly defined professional scopes that create an inflexible healthcare environment that marginalises cultural healing traditions. These professional boundaries, whilst serving legitimate functions around safety and quality assurance, can become straightjackets constraining culturally responsive care.

"I cannot allow a patient to use herbs in hospital, because it's not part of my professional practice," starkly illustrates the tension between standardised medical practice and cultural healing approaches (PN5). This statement reveals how professional boundaries are defined by what is included within the scope of practice rather than by patient needs or cultural contexts. Traditional healing practices fall outside nursing's defined scope, making nurses who facilitate such practices potentially liable for stepping beyond their professional boundaries. This creates a risk-averse environment wherein nurses avoid engaging with traditional practices not necessarily because they view them as harmful but because engaging with them creates professional vulnerability.

Institutional rules further constrain cultural flexibility: *"If it's not in the protocol, we can't do it. We have to follow hospital rules"* (PN1). Protocol adherence becomes a mechanism of institutional control that ensures standardisation but inhibits adaptation to individual patient needs and cultural contexts. Protocols typically reflect biomedical approaches; when cultural practices are absent from protocols, they become institutionally illegitimate rather than alternative approaches. The institutional demand for protocol adherence positions nurses as implementers of standardised care rather than as adaptive practitioners capable of tailoring care to individual patient circumstances.

These limitations are particularly acute when patients seek integration of traditional healing practices. *"Sometimes patients want us to refer to traditional healers, but we cannot... There is no system for that"* demonstrates the systemic obstinacy to recognise alternative healing

approaches (PN10). The absence of referral mechanisms reveals more than administrative oversight; it reflects fundamental institutional unwillingness to legitimise traditional healing as a valid component of healthcare. If traditional healing were recognised as legitimate, institutions would create referral pathways, just as they create referral pathways to specialist biomedical services. The absence of such pathways positions traditional healing outside the healthcare system, forcing patients to access traditional and biomedical care as separate, discordant services rather than as integrated components of holistic care.

The comparative analysis revealed that nurses framed themselves as supportive but uncertain, highlighting lack of training and referral pathways. PN7 explained: *"Unfortunately... I don't have any module that will allow me to refer clients for traditional medicine,"* whilst PN4 observed: *"No, not really. But I think it would be great if that connection existed."* These statements depict nurses as constrained by systems rather than personally opposed to integration, wanting to facilitate patient preferences but lacking institutional mechanisms to do so safely and legitimately. Professional boundary limitations also revealed tensions between individual practitioner judgment and institutional standardisation. Culturally responsive care often requires adaptive, context-specific approaches that cannot be fully specified in protocols. Yet institutional demands for standardisation and accountability push towards protocol-driven care that leaves little room for professional discretion. Nurses who adapt protocols to accommodate cultural practices risk professional sanction for deviation from standards, creating institutional disincentives for the very flexibility that cultural responsiveness requires.

➤ **Policy and training inadequacies: The institutional void**

The absence of comprehensive cultural competence policies creates a fundamental void in healthcare delivery, transforming cultural sensitivity from a systematic standard into individual discretionary practice. This policy vacuum has multiple consequences, creating inconsistency, inequity, and practitioner uncertainty about appropriate approaches to cultural diversity.

"We don't have any policy on cultural care it depends on the nurse," reveals the profound inconsistency in cultural care approaches (PN3). When policy is absent, cultural accommodation becomes dependent on individual practitioners' knowledge, values, and willingness to make

exceptions to standard routines. Patients receive different quality of care depending on which nurse they encounter - a form of lottery that violates principles of equity and standardisation fundamental to quality healthcare. Some nurses, through personal values, cultural knowledge, or previous positive experiences, provide culturally responsive care; others, lacking such background or inclination, provide culturally insensitive care. This inconsistency is unjust, creating inequitable experiences for patients based not on their needs but on the accident of which practitioner they encounter.

Educational institutions bear significant responsibility for this policy vacuum, having failed to prioritise cultural competence in professional education. One nurse noted, *"There was no formal teaching on cultural sensitivity in my training"* (PN9). If cultural competence is genuinely valued as a component of professional practice, it should be systematically included in professional education curricula. The absence of such an education reveals that, despite rhetorical commitments to patient-centred care and cultural diversity, educational institutions have not translated these commitments into curriculum priorities. Nurses graduate without substantive cultural knowledge, entering practice ill-equipped to navigate cultural diversity and reliant on ad hoc learning through experience and peer knowledge.

This systemic disconnection and dissonance reaches its apex in the lack of recognition for traditional healing practices at policy and regulatory levels. *"The Department [of Health] does not recognise traditional healers at system level, so we can't integrate them"* demonstrates the institutional barriers that prevent meaningful cultural integration (CP1). Policy recognition matters because it establishes legitimacy, creates accountability, allocates resources, and enables coordination. Without policy recognition, traditional healing remains informal and marginalised, unable to coordinate with biomedical services despite patients' use of both. This policy gap forces patients into covert pluralism by using both systems without providers' knowledge or coordination. This culminates in creating safety risks through potential herb-drug interactions and missed opportunities for complementary care coordination.

The comparative analysis revealed convergence across nurses, focus group participants, and community participants on the need for clear policy to improve consistency and fairness. PN1

explained: *"When there's policy, it makes things smooth... we do it according to what the policy says or guidelines,"* whilst CP3 contrasted the current reality: *"There's no policies... nothing like that... It's up to the person... if there were policy... they would know."* This convergence suggests that policy development could find support across stakeholder groups, yet policy has not emerged despite this support, revealing institutional inertia and lack of political will to prioritise cultural competence systematically.

Policy and training inadequacies also create vulnerability for well-intentioned practitioners. Without policy guidance, nurses who attempt cultural accommodation do so at their own professional risk, uncertain whether their adaptations could be supported by institutions if problems arise. This uncertainty creates risk-averse behaviours wherein nurses avoid cultural accommodation not because they oppose it but because doing so without policy backing makes them vulnerable. Policy development could reduce this vulnerability, establishing cultural accommodation as expected practice rather than discretionary adaptation, thereby protecting practitioners who engage in culturally responsive care.

- **Synthesis: The intersecting layers of systemic barriers**

The research reveals a multifaceted system of barriers that systematically undermine culturally sensitive care, operating through structural discrimination, communication gaps, resource constraints, professional boundaries, and policy voids. These barriers are not isolated challenges but rather constitute a comprehensive institutional framework that actively resists cultural competence, regardless of individual practitioners' commitments, values, or capabilities.

Structural discrimination and communication gaps create fundamental misunderstandings rooted in epistemological and ontological hierarchies that devalue indigenous knowledge and cultural practices, compounded by inadequate interpretative resources and cross-cultural communication support. These barriers operate synergistically: when patients experience cultural dismissal, they may disengage from communication, creating further barriers to mutual understanding. When communication gaps prevent providers from understanding patients' cultural practices and concerns, providers may inadvertently engage in behaviours patients experience as culturally dismissive.

Resource constraints transform cultural accommodation from a care standard into what appears as a luxury, creating impossible choices between biomedical efficiency and cultural responsiveness. These constraints operate not merely through absolute resource scarcity but through how resources are prioritised and allocated. Even in resource-constrained environments, institutions create space for what they value; the absence of space for cultural practices reveals that institutions do not genuinely prioritise cultural responsiveness despite rhetorical commitments.

Professional boundaries and policy voids create an environment wherein culturally responsive care is risky, discretionary, and unsupported by institutional frameworks. Professional boundaries positioned around biomedical practices marginalise traditional healing as outside legitimate scope, whilst policy absence leaves cultural accommodation to individual discretion rather than establishing it as systematic standard. These structural barriers interact; resource constraints make cultural accommodation more time-intensive, making it more likely to be sacrificed. Policy absence means no accountability for cultural accommodation, making it easier to deprioritise; professional boundaries and creating legal risks, incentivising risk-averse behaviours. The comparative analysis revealed that these systemic barriers created different experiences across participant groups. **Nurses** see themselves as trapped between good intentions and structural constraints, wanting to provide culturally responsive care but lacking time, resources, training, policy guidance, and institutional support. **Patients** bear the consequences of these systemic failures, experiencing inconsistent care dependent on which practitioners they encounter, facing language barriers without adequate interpretation, and finding their cultural practices dismissed or marginalised. **Community participants** identified policy absence as the fundamental problem, foregrounding how discretionary accommodation creates injustice and how institutional failure to recognise traditional healing prevents meaningful integration.

Implications: Transforming systemic barriers into enabling structures

These systemic barriers represent more than isolated challenges. They constitute a comprehensive institutional framework that actively resists cultural competence. Transforming

healthcare requires a fundamental reimagining of institutional structures, professional education, and patient care approaches that address barriers at multiple levels simultaneously:

- **Comprehensive policy reforms** that establish cultural accommodation as standard care component rather than discretionary enhancement, creating accountability mechanisms and allocating resources to enable implementation
- **Robust cultural competence training** integrated systematically into professional education curricula and continuing education, providing substantive knowledge about diverse healing traditions
- **Institutional redesign** that creates physical spaces for cultural practices, allocates time for culturally responsive communication, and develops performance metrics that value cultural responsiveness alongside biomedical efficiency
- **Meaningful recognition of diverse healing traditions** through regulatory frameworks that legitimate traditional healers, create referral mechanisms enabling coordination between biomedical and traditional practitioners, and position integration as quality improvement rather than compromise

Cultural sensitivity cannot remain an individual aspiration but must become a systemic imperative, embedded in policies, resourced adequately, integrated into professional education, enabled by institutional structures, and valued within performance management systems. The path forward demands multi-level transformation that addresses not merely individual practitioners' cultural competence but the comprehensive systemic barriers that currently prevent even well-intentioned practitioners from providing consistently culturally responsive care.

Table 4.7: Theme 3

Theme 3: Knowledge System Conflicts in Healthcare Interactions

Theme	Sub-theme/Category	Codes
Theme 3: Knowledge System Conflicts	Epistemological Differences	• Distinction between spiritual and scientific healing • Supernatural illness concepts • Witchcraft illness attribution • Spiritual versus clinical healing approaches
	Traditional vs. Biomedical Paradigms	• Belief in traditional healing capabilities • Biomedical system criticism • Ancestral belief systems • Divine sovereignty beliefs
	Sacred vs. Secular Knowledge	• Sacred knowledge protection • Spiritual calling recognition • Dream interpretation value • Prophetic experiences
	Diagnostic Approach Variations	• Holistic care understanding • Case-specific traditional healing assessment • Spiritual healing framework • Deeper cultural meaning recognition
	Holistic vs. Symptomatic Treatment	• Comprehensive healing approach • Cultural healing effectiveness • Belief-dependent healing efficacy

		• Mind-body-spirit treatment perspective

In the intricate landscape of healthcare delivery, Theme 3 speaks to the profound epistemological tensions between biomedical knowledge systems and traditional, spiritual, and cultural healing frameworks. This exploration reveals a complex terrain of conflicting paradigms, where different ways of understanding illness, healing, and human experience collide and negotiate. Unlike Theme 2, which examined institutional barriers to cultural competence, this theme highlights the fundamental conceptual differences that create challenges even when institutional support exists and practitioners possess good intentions.

- **Dimensions of epistemological conflict**

- **Epistemological differences: The spiritual-scientific divide**

The fundamental hiatus between spiritual and clinical understanding of illness emerges as a critical point of tension that cannot be resolved through simple accommodation but requires genuine engagement with radically different ways of knowing. *"Some patients still say their sickness comes from witchcraft, not from infection,"* candidly illustrates the stark contrast in the conceptualisation of illness (PN7). This is not a simple disagreement about symptoms or treatment preferences but a profound difference in fundamental understanding of health and disease that shapes how illness is experienced, interpreted, and addressed.

The comparative analysis verified that this epistemological divide created some of the most challenging scenarios for healthcare providers. When patients attribute illness to spiritual causes such as witchcraft, ancestral displeasure, or spiritual imbalance, then biomedical explanations in terms of pathogens, physiological dysfunction, or genetic factors fail to resonate. These are not merely alternative vocabularies describing the same phenomenon but fundamentally different causal frameworks. From a biomedical perspective, infections have biological causes (bacteria, viruses) requiring biological interventions (antibiotics, antivirals). From a traditional healing perspective, the same symptoms might be understood as manifestations of spiritual

celeste causes requiring spiritual interventions (ritual purification, ancestral appeasement, spiritual protection).

Nurses recognise the complexity of this epistemological landscape and the inadequacy of dismissing spiritual explanations as simply wrong. *"We are trained in science, but we must listen when they bring their beliefs,"* reflects a nuanced approach to navigating these different knowledge systems (PN1). This statement positions listening as a professional obligation, not merely courtesy. The phrase *"we must listen"* acknowledges that effective care requires understanding patients' explanatory frameworks even when these frameworks differ fundamentally from biomedical paradigms. Without understanding how patients conceptualise their illness, healthcare providers cannot effectively communicate about diagnosis and treatment or negotiate care plans that patients find meaningful to follow.

The persistent presence of spiritual explanations challenges the biomedical paradigm's dominance, revealing that biomedicine has not displaced traditional healing frameworks but rather exists alongside them in a pluralistic healthcare landscape. Some patients firmly believe that "spiritual healing" is a prerequisite to medical intervention (CP3), positioning spiritual and biomedical approaches not as alternatives but as complementary components of comprehensive care. From this perspective, biomedical treatment addresses physical manifestations of illness whilst spiritual healing addresses underlying spiritual causes. Treating only physical without addressing the spiritual leaves the root cause unaddressed, explaining why some patients seek spiritual healing before or alongside biomedical care.

The comparative analysis revealed divergence between participant groups on how to navigate these epistemological differences. **Nurses** generally adopted pragmatic accommodation, expressing willingness to respect spiritual beliefs whilst maintaining biomedical frameworks for their own practice. As PN2 articulated: *"If you don't understand other people's culture... it becomes difficult... If you do understand, it makes communication easier."* This pragmatic approach recognises that understanding patients' frameworks facilitates communication and cooperation even without sharing those frameworks.

Patient and community participants, in contrast, often framed spiritual and biomedical approaches as equally valid and complementary rather than as competing paradigms requiring negotiation. PP2 explained: *"If you do both things, you will see progress... you will see that it's working,"* positioning integration as beneficial rather than as conceptually problematic. This difference in framing reveals different stakes: for providers, epistemological coherence and evidence-based practice matter professionally; for patients, pragmatic effectiveness matters existentially.

➤ **Traditional vs. biomedical paradigms: Competing healing narratives**

Patient preferences for traditional healing reveal a deep-rooted alternative approach to healthcare that cannot be dismissed as merely ignorance of biomedical options but rather reflect sophisticated healthcare navigation based on different assessments of healing efficacy, safety, and appropriateness. *"Some people first go to the traditional healer, and only come here when things are very bad,"* highlights the hierarchical approach to healing many patients employ (PN6). This pattern is not merely a preference but a complex cultural and spiritual practice reflecting patients' trust in traditional healing as the appropriate first response to illness.

The comparative analysis revealed that this bi-directional help-seeking pattern reflects not merely cultural preference, but rational decision-making based on patients' epistemological frameworks and previous experiences. From patients' perspectives, traditional healing addresses illness comprehensively spiritually, socially, and physically, making it the logical first choice. Biomedical care becomes relevant when traditional approaches prove insufficient, when emergencies require immediate intervention, or when conditions (like broken bones) clearly require biomedical expertise.

Skepticism towards biomedicine is multifaceted, reflecting historical experiences, cultural values, and concerns about biomedical approaches. *"Patients sometimes say the hospital medicine is too strong and not for them"* demonstrates a critical perspective on biomedical interventions (PP2). This characterisation of biomedical medicine as *"too strong"* reflects concerns about side effects, alien substances entering the body, and approaches that seem too aggressive or disconnected from natural healing processes. Traditional remedies, by contrast,

are perceived as gentler, more natural, and more compatible with the body's own healing capacities.

More deeply, some patients fundamentally attribute healing to spiritual forces rather than to medical interventions, whether traditional or biomedical: *"They say it is the ancestors who allow healing, not the doctor"* (CP4). This theological or spiritual framework positions healthcare practitioners, whether traditional healers or biomedical doctors, as instruments or facilitators of healing rather than as its ultimate source. The true source of healing is divine or ancestral power; practitioners merely channel or cooperate with these powers. From this perspective, healing outcomes depend not merely on correct technical intervention but on spiritual factors including ancestral favour, divine will, and the patient's spiritual state.

This spiritual framing has profound implications for how treatment success and failure are interpreted. Biomedical providers typically attribute successful treatment to correct diagnosis and appropriate intervention, whilst treatment failure prompts investigation of what went wrong medically (incorrect diagnosis, inappropriate treatment, patient non-adherence, disease progression). From a spiritual perspective, however, both success and failure may be attributed to spiritual factors beyond medical control. A treatment might "fail" not because it was inappropriate but because ancestral intervention was lacking or spiritual causes remained unaddressed. Conversely, recovery might be attributed to ancestral favour rather than to biomedical intervention.

The comparative analysis revealed that these divergent paradigms created practical challenges for care coordination and patient safety. When patients use traditional healing without informing biomedical providers, potential herb-drug interactions may go undetected. When patients discontinue biomedical treatment, believing spiritual healing has addressed the root cause, conditions may deteriorate and remain untreated. Yet the solution is not simply patient education to adopt biomedical frameworks but rather genuine dialogue that enables safe integration of both approaches.

➤ **Sacred vs. secular knowledge: The boundaries of understanding**

A critical dimension of knowledge conflict emerges in the protection and transmission of sacred knowledge, revealing fundamental differences in how knowledge is conceptualised, validated, and shared across traditional and biomedical frameworks. *"Traditional healers don't tell everything; they keep some knowledge as sacred,"* reveals the guarded nature of traditional healing wisdom (PN2). This approach stands in sharp contrast to the biomedical demand for transparent, evidence-based practice wherein knowledge should be publicly verifiable, teachable, and subjected to peer review and empirical validation.

Sacred knowledge operates under different epistemological rules. It is received through spiritual means (dreams, visions, ancestral communication) rather than through systematic observation or experimentation. It is validated through spiritual authority and healing efficacy rather than through controlled trials. It is transmitted selectively to those spiritually called and initiated rather than taught openly in standardised curricula. And it is protected as sacred trust rather than shared as public good. These fundamental differences in how knowledge is conceptualised create deep tensions when traditional and biomedical systems encounter each other.

The spiritual dimensions of healing knowledge are particularly illuminating and highlight the incommensurable nature of these knowledge systems. *"A person may be called in dreams to become a healer... This is not something the hospital can recognise,"* highlights the incommensurable nature of these knowledge systems (CP1). Biomedical credentialing relies on formal education, standardised examinations, and regulatory licensing all secular, bureaucratic processes. Traditional healing credentialing, by contrast, relies on spiritual calling, initiation processes, and recognition by established healers and communities. These credentialing processes cannot be easily mapped onto each other; hospitals cannot verify spiritual calling through bureaucratic mechanisms, and traditional healing communities do not necessarily recognise biomedical degrees as conferring healing authority.

The divergence is stark: *"People say their dreams show them what is wrong, but we only see test results"* (PN9). This contrast encapsulates the epistemological and ontological divide. From

a biomedical perspective, diagnostic knowledge comes from objective tests (laboratory results, imaging studies, physical examinations) interpreted through scientific frameworks. Subjective experiences like dreams are diagnostically impossible except as potential symptoms of psychological conditions. From a traditional healing perspective, dreams are a primary channel for diagnostic insight, conveying information through spiritual means that may be more revealing than physical symptoms. To dismiss diagnostic dreams as irrelevant is to miss crucial diagnostic information; to rely on them exclusively is to ignore physical evidence.

The comparative analysis revealed that these epistemological differences created not merely conceptual tensions but practical challenges for healthcare delivery. When patients' diagnostic understandings derive from dreams or spiritual insight, they may reject biomedical diagnoses that contradict this spiritual knowledge. When biomedical providers dismiss spiritual diagnostic frameworks, patients may feel their concerns are not heard or taken seriously. Yet genuine epistemological dialogue not merely polite acknowledgement but serious engagement with different ways of knowing rarely occurs in healthcare encounters constrained by time pressures and institutional protocols.

Patient participant PP1 articulated the sacred nature of traditional knowledge: *"They don't disclose everything to everyone. There are things that are kept sacred."* This selectivity is not mere secrecy but reflects understandings of knowledge as power that must be handled responsibly, transmitted only to those spiritually prepared, and protected from misuse. Biomedical demands for transparency explaining diagnostic reasoning, sharing medical knowledge, teaching patients about their conditions operate under different assumptions about knowledge as public good that should be widely shared. These contrasting approaches to knowledge create tensions when biomedical providers expect traditional healers to explain their methods whilst traditional healers view such disclosure as spiritually inappropriate.

➤ **Diagnostic approach variations: Holistic vs. symptomatic understanding**

The fundamental difference in diagnostic approaches reveals a profound epistemological divide between holistic traditional frameworks and symptomatic biomedical approaches that focus on identifying and treating specific pathological processes. *"Traditional healers look at the whole*

person their family, their spirit, their background," contrasts dramatically with clinical practice (PN5). This holistic approach reflects an understanding of illness as arising from an imbalance or disharmony in the person's relationships with family, community, ancestors, spirits, and the natural world rather than as isolated pathological processes within the body.

Nurses themselves recognise this difference and acknowledge limitations in biomedical approaches: *"In the clinic we focus on the symptom fever, cough but they look for deeper meaning"* (PN8). Biomedical diagnosis proceeds through pattern recognition: identifying symptoms, generating differential diagnoses, ordering tests to rule in or rule out specific conditions, and arriving at a specific pathological diagnosis (pneumonia, diabetes, hypertension). This process focuses on what is wrong physically and how to fix it medically, often ignoring broader life context except insofar as it provides diagnostic clues or affects treatment adherence.

Traditional diagnostic approaches, by contrast, seek to understand why this person developed this illness at this time. *"They say it is not only disease but also what caused it spiritually"* demonstrates a comprehensive understanding of illness that transcends biological symptoms (CP2). Symptoms are manifestations of underlying spiritual, social, or relational causes that must be identified and addressed. A patient with persistent headaches might have a biomedical diagnosis of tension headaches, treatable with analgesics and stress management. The same symptoms might receive a traditional diagnosis of ancestral displeasure, requiring ritual purification and family reconciliation. These diagnoses are not incompatible but operate at different levels of causation, with biomedical diagnosis explaining proximate biological mechanisms whilst traditional diagnosis explains ultimate spiritual or social causes.

The comparative analysis revealed that this holistic approach resonated even with biomedically trained nurses who recognised limitations in purely symptomatic approaches. Focus group participants noted: *"We tend to focus on physical care,"* acknowledging that biomedical practice often neglects psychological, social, and spiritual dimensions addressed by traditional healing. This recognition suggests potential for integration wherein biomedical approaches address physical manifestations whilst traditional approaches address holistic contexts. However, integration is complicated by fundamentally different diagnostic logics. Biomedical diagnosis

seeks specificity and objectivity, identifying discrete disease entities through standardised criteria. Traditional diagnosis is more fluid and contextual, considering unique circumstances, relationships, and spiritual factors specific to each person. These approaches cannot simply be combined; genuine integration would require developing new frameworks that honour both specificity and holism, objectivity and contextuality.

➤ **Holistic vs. symptomatic treatment: Healing beyond symptom management**

The contrast in treatment approaches epitomises the epistemological conflict and reveals fundamentally different understandings of what healing means and requires. "*The healer gives herbs, prayer, and counselling together is holistic,*" illustrates a comprehensive approach to healing (CP5). Traditional healing addresses the whole person's body through herbal remedies, spirit through prayer and ritual, mind and relationships through counselling and guidance. This integration reflects an understanding that healing requires addressing all dimensions of human experience simultaneously rather than treating discrete symptoms sequentially.

In stark contrast, "*In hospital we only give tablets for the pain that is symptomatic*" (PN4). Biomedical treatment focuses on alleviating symptoms or correcting pathological processes through specific interventions, medications, surgeries, and therapies. Each intervention targets a specific mechanism (reducing inflammation, killing bacteria, replacing hormones, correcting anatomical abnormalities). This specificity enables powerful interventions but can result in fragmentation wherein different symptoms receive different treatments without attention to underlying connections or holistic context.

Belief itself becomes a crucial component of healing in traditional frameworks, revealing fundamentally different understandings of healing mechanisms. "*Some patients say the herbs work because they believe in them. If you don't believe, they don't*" highlights the role of spiritual and psychological dimensions in treatment (PP3). From a biomedical perspective, this statement might be interpreted cynically as placebo effect: herbs work only because patients believe they will, suggesting they lack genuine pharmacological efficacy. From a traditional healing perspective, however, this belief-dependence reflects a deeper understanding of healing as requiring alignment between treatment, belief, and spiritual reality. Treatments work when

patients trust them, when they align with cultural frameworks, and when spiritual powers cooperate. Healing is not merely a mechanical intervention but a spiritual and relational process.

The comparative analysis revealed that these different treatment approaches reflected different therapeutic goals. Biomedical treatment typically aims to cure disease or manage chronic conditions, returning patients to functional baseline. Traditional healing often aims more broadly to restore harmony, balance, and right relationships, addressing not merely physical symptoms but broader life challenges. Community participant CP4 explained: "*Traditional medicine... they will pray with you... they give you direction in your life,*" positioning healing as comprehensive life guidance rather than merely symptom treatment.

This difference in therapeutic goals complicates outcome assessment. Biomedical outcomes focus on measurable indicators symptom resolution, laboratory normalisation, survival rates, functional status. Traditional healing outcomes may include such indicators but also encompass subjective experiences of peace, harmony, reconciliation, and spiritual wellbeing that resist standardised measurement. A patient might experience biomedical treatment failure (symptoms persist) whilst experiencing traditional healing success (peace restored, relationships healed, life direction clarified). Conversely, biomedical treatment success (symptoms resolved) might coexist with traditional healing failure (underlying spiritual causes unaddressed).

- **Synthesis: The landscape of epistemological negotiation**

The research identified multiple layers of knowledge system conflicts that operate simultaneously, creating a complex terrain wherein different ways of knowing, diagnosing, and healing coexist in tension:

Fundamentally different understandings of illness origins, biological versus spiritual causation create divergent diagnostic frameworks that cannot simply be combined but require genuine epistemological dialogue. Patients and providers operating from different causal frameworks may talk past each other, using the same words (illness, diagnosis, treatment) whilst meaning fundamentally different things.

Competing approaches to diagnosis and treatment specific and symptomatic versus holistic and contextual reflect different therapeutic philosophies that prioritise different outcomes and employ different mechanisms. Integration requires not merely adding traditional practices to biomedical care but rethinking what comprehensive healthcare should encompass.

Sacred knowledge systems resisting biomedical scrutiny through selective transmission and spiritual validation create tensions with biomedical demands for transparency, teachability, and empirical validation. Respecting traditional healing's epistemological frameworks whilst maintaining biomedical quality standards requires navigating difficult tensions without imposing one framework's logic on the other.

Holistic healing approaches challenging symptomatic interventions by addressing body, mind, spirit, and relationships simultaneously reveal limitations in biomedical fragmentation whilst also raising questions about how to evaluate holistic approaches using evidence frameworks developed for specific interventions.

These knowledge system conflicts represent more than mere disagreements. They reflect profound differences in understanding human experience, illness, and healing rooted in different metaphysical assumptions, validated through different processes, and aimed at different therapeutic goals. The challenge for healthcare providers lies not in choosing between these systems but in developing a nuanced, respectful approach that recognises the validity of multiple healing paradigms whilst maintaining patient safety and evidence-based practice where appropriate.

Implications: Towards epistemological humility and pragmatic pluralism

The path forward demands not resolution of epistemological conflicts through declaring one framework superior but rather development of epistemological humility and pragmatic pluralism that enables respectful coexistence and safe integration where possible:

- **Genuine dialogue between different knowledge systems** that goes beyond polite acknowledgement to serious engagement with different ways of knowing, requiring biomedical practitioners to recognise limitations in biomedical paradigms and traditional healers to engage constructively with biomedical concerns about safety and evidence

- **Respect for diverse healing approaches** that recognises each approach's strengths and limitations rather than positioning biomedicine as scientific truth and traditional healing as cultural belief, creating space for patients to access both approaches based on their needs and preferences
- **Flexible healthcare frameworks** that enable safe integration of traditional and biomedical approaches through mechanisms like care coordination, herb-drug interaction screening, and collaborative care planning rather than forcing patients to choose between systems or access them covertly
- **Recognition of the holistic nature of healing** by expanding biomedical practice to address psychological, social, and spiritual dimensions currently neglected, learning from traditional healing's holistic approaches whilst maintaining biomedical specificity and evidence-based practice where appropriate

Ultimately, cultural competence requires transcending epistemological boundaries, embracing the complexity of human experience, and creating space for multiple ways of understanding health and healing. This does not mean abandoning critical thinking or evidence-based practice, but rather recognising that evidence comes in multiple forms. Healing operates through multiple mechanisms. Comprehensive healthcare must address multiple dimensions of human experience. The goal is not epistemological coherence but pragmatic effectiveness enabling patients to access healing approaches that work for them whilst maintaining safety and quality across all modalities.

Table 4.8: Theme 4

Theme 4: Patient Navigation and Agency in Healthcare Systems

Theme	Sub-theme/Category	Codes
Theme 4: Patient Navigation and Agency	Dual Healthcare System Strategies	• Dual healthcare system use • Sequential timing of treatments • Complementary healthcare preference • Condition-specific treatment choices

	Concealment and Fear-Based Interactions	• Non-disclosure of traditional medicine use • Fear of healthcare provider reactions • Patient dishonesty due to judgement fears • Hiding traditional medicine practices
	Economic Decision-Making	• Economic barriers leading to traditional medicine use • Cost-effectiveness considerations • Resource-based healthcare choices • Alternative treatment affordability
	Resistance Mechanisms	• Patient autonomy in healing choices • Treatment refusal due to disrespect • Avoidance of formal healthcare • Patient self-advocacy
	Selective Healthcare Utilisation	• Dual motivation for treatment • Crisis-only hospital engagement • Selective biomedical utilisation • Complementary treatment approach

This theme unravels the complex strategies patients employ to navigate the intricate landscape of healthcare, revealing a nuanced terrain of agency, survival, and strategic decision-making. Far from passive recipients of care, patients are active agents who strategically negotiate between biomedical and traditional healing systems, often constrained by economic, social, and institutional pressures but nonetheless exercising considerable agency in their healthcare choices. Where Theme 3 examined epistemological conflicts from a conceptual perspective, Theme 4 traces how these conflicts play out in practice through patients' navigation strategies.

- **Dimensions of patient navigation**

- **Dual healthcare system strategies: Navigating healing pathways**

Patients demonstrate remarkable sophistication in their approach to healthcare, employing strategic approaches that blend multiple healing systems based on nuanced assessments of each system's strengths, limitations, and appropriateness for different conditions and illness phases. *"Many patients will first go to the traditional healer, then come to the clinic when they are not getting better,"* illustrates a carefully considered healthcare navigation strategy (PN6). This sequential pattern reflects neither ignorance of biomedical options nor simple cultural preference, but rather rational decision-making rooted in patients' epistemological frameworks, previous experiences, and assessments of which approach is appropriate for their current ailment.

The complexity of this approach goes beyond simple sequential use; many patients engage in simultaneous pluralism. *"Some use both treatments at the same time, saying one is for the body, and one is for the spirit,"* reveals a holistic understanding that transcends singular medical paradigms (CP2). This statement positions traditional and biomedical approaches not as competing alternatives but as complementary modalities addressing different dimensions of illness. Biomedical care treats physical manifestations, relieving symptoms, correcting physiological dysfunction, and preventing complications. Traditional healing addresses spiritual dimensions, ancestral relationships, spiritual balance, social harmony. From this perspective, comprehensive healing requires both approaches working in concert.

Patients make nuanced, condition-specific choices that reflect sophisticated understanding of each system's comparative advantages: *"It depends on the condition... They might trust the hospital for broken bones but the healer for stomach problems"* (PP4). This differential trust reflects accumulated wisdom about which conditions each system treats effectively. Acute injuries with clear physical causation (broken bones, lacerations, acute emergencies) clearly benefit from biomedical intervention. Chronic, ambiguous conditions with potential spiritual or relational dimensions (persistent abdominal pain, infertility, mental health challenges) may be

better addressed through traditional healing's holistic approaches. This differential help-seeking is not arbitrary but reflects sophisticated healthcare literacies developed through personal and community experience.

Comparative analysis revealed convergence across participant groups on this pattern of sequential or complementary pluralism. Nurses recognised this pattern: *"They come here maybe when the traditional healer couldn't help"* (PN10). Patients acknowledged it: *"If I'm not getting better with home remedies... then I will come to the clinic"* (PP5). Even focus group participants noted: *"Most of them first visit the traditional healer before coming to the hospital."* This convergence suggests that medical pluralism is normative rather than exceptional most patients in this context utilise both systems, navigating between them based on evolving circumstances, condition trajectories, and assessments of which approach is currently most appropriate.

However, this sophisticated navigation occurs largely covertly, hidden from biomedical providers due to fears of judgment or dismissal. The gap between what providers assume (that patients use only biomedical care or use traditional healing as ignorant alternative) and reality (that patients strategically utilise both, often simultaneously) creates communication gaps that compromise care quality and safety.

➤ **Concealment and fear-based interactions: The silent negotiation**

A profound undercurrent of fear and strategic non-disclosure characterises patient interactions with healthcare providers, revealing how institutional and interpersonal dynamics shape not merely what care patients receive but what information they share about their broader healthcare practices. *"They don't tell us they are drinking traditional medicine, because they think we will shout at them,"* reveals the deep-seated anxiety surrounding traditional healing practices (PN3). This fear is not paranoid but reality-based, reflecting patients' previous experiences of dismissal, mockery, or scolding when they disclosed utilising traditional healing.

This concealment is not passive but a carefully constructed survival strategy that protects patients from perceived threats whilst potentially compromising their care. *"Patients are sometimes dishonest, they hide herbs or mixtures under the bed,"* demonstrates the lengths to

which patients go to protect their healing choices (PN10). This concealment creates a parallel treatment reality invisible to biomedical providers. Patients consume herbal remedies alongside prescribed medications, potentially creating herb-drug interactions. They follow traditional healing advice that may contradict biomedical recommendations. They discontinue biomedical treatments believing traditional healing has addressed root causes. All this occurs covertly, creating information gaps that compromise biomedical providers' ability to ensure safe, coordinated care.

The fear is palpable and specific: *"They are afraid the nurse will refuse to treat them if they say they went to the healer"* (CP1). This fear reflects power imbalances inherent in healthcare relationships wherein providers control access to care and patients fear that disclosure might result in care withdrawal, inferior treatment, or punitive responses. This fear is not entirely baseless; patients had witnessed or experienced negative provider reactions to traditional healing disclosure, confirming that disclosure carries real risks.

The comparative analysis revealed divergence between providers' self-perception and patients' experiences of provider reactions. Nurses generally framed themselves as respectful and open to traditional practices, positioning any negative reactions as aberrations rather than patterns. As PN5 stated: *"You must respect that. But still, you give the same care,"* suggesting that respect and professional standards coexist unproblematically. However, patient narratives revealed more complex realities wherein even well-intentioned providers engaged in subtle dismissiveness, skeptical questioning, or educational interventions aimed at dissuading traditional healing use rather than respecting it.

Patient participant PP3 explained the concealment strategy: *"I hide it because I don't want confrontation with the nurse... I don't want them to judge me."* This statement reveals concealment as not merely about avoiding explicit conflict but about protecting oneself from judgmental attitudes that undermine dignity even when they do not result in overt confrontation. The anticipation of judgment itself becomes a barrier to honest communication, creating therapeutic relationships based on partial truth and mutual suspicion rather than trust and transparency.

This culture of concealment has serious consequences beyond herb-drug interactions. It prevents providers from understanding patients' full healthcare contexts, compromising holistic assessment. It positions patients and providers as adversaries rather than partners, undermining therapeutic alliance. It places burden on patients to manage coordination between systems without professional support. And it creates moral distress for patients who must choose between honesty and self-protection.

➤ **Economic decision-making: Survival and affordability**

Economic constraints emerge as a critical driver of healthcare navigation, revealing how poverty shapes healthcare access and choices in ways that intersect with but are distinct from cultural preferences. *"Because of money problems, they start with the traditional healer it is cheaper,"* highlights the financial calculus underlying healthcare choices (PN7). This statement positions economic factors as primary rather than cultural preferences, suggesting that some patients who would prefer biomedical care first nonetheless access traditional healing due to economic necessity.

The economic challenges extend beyond direct treatment costs to encompass indirect costs that render "free" biomedical care expensive. *"Hospitals are free, but the transport costs make people look for affordable alternatives nearby"* (PP5). This observation reveals how geographic accessibility and transport costs create massive financial barriers to care even when services themselves are nominally free. For patients living in poverty, transport costs to distant hospitals pose a significant financial burden, making traditional healers located within walking distance economically preferable regardless of other considerations.

Traditional medicine becomes not just a cultural choice but an economic survival strategy that enables healthcare access when biomedical care is economically out of reach. *"Traditional medicine is seen as more cost-effective, even if it takes longer"* demonstrates the pragmatic approach patients take to their health (CP4). This assessment weighs not merely direct costs but also opportunity costs, time burdens, and outcome likelihood. Traditional healing may require longer treatment courses but involves manageable costs spread over time, paid in cash or kind

to local healers. Biomedical care may promise faster results but involves transport costs, time away from income-generating activities, and potential prescription costs that together create insurmountable economic barriers for patients in poverty.

The comparative analysis revealed that economic factors operated alongside but sometimes overrode cultural preferences. Patient participant PP6 acknowledged: *"I can't afford to go to the hospital every time... Traditional healers are closer and cheaper."* This pragmatic acknowledgement reveals healthcare navigation as shaped by economic constraints as much as by cultural values or epistemological preferences. Some patients who intellectually trusted biomedical care more than traditional healing nonetheless accessed traditional healing more frequently simply because economic realities made it the only feasible option.

Nurses recognised these economic dynamics but felt powerless to address them. PN4 noted: *"They tell me they don't have money for transport... So, they use traditional healers who are in the community."* This recognition positions economic barriers as systemic problems beyond individual practitioners' ability to solve. Nurses could provide empathetic understanding but could not eliminate transport costs, reduce geographic distances, or otherwise address structural economic barriers shaping patients' healthcare access.

Economic factors also interacted with temporal dynamics. Patients facing acute emergencies accessed biomedical care despite financial hardship because immediacy trumped cost considerations. For chronic conditions, however, economic factors became decisive. Community participant CP7 explained: *"For emergencies, we go to hospital no matter what... For other things, we use what we can afford."* This differentiation reveals how illness acuity, economic resources, and healthcare choices interacted, creating utilisation patterns shaped by a complex calculus of urgency, affordability, and availability.

➤ **Resistance mechanisms: Asserting autonomy**

Patient agency manifests most powerfully through resistance mechanisms that challenge provider authority, assert patient autonomy, and reject care perceived as disrespectful or culturally insensitive. *"Some refuse treatment when they feel the nurse is disrespectful to their*

culture," illustrates a direct form of self-advocacy" (PN8). This resistance is not mere non-compliance but an active assertion of dignity and autonomy, a refusal to accept care delivered in ways that undermine cultural identity or personal dignity.

This resistance takes multiple forms, ranging from explicit refusal to subtle avoidance. *"Others simply avoid the hospital and continue with their own [traditional] remedies"* (CP3). Avoidance represents passive resistance that protects patients from disrespectful encounters whilst also depriving them of potentially beneficial biomedical care. This form of resistance operates through exit rather than confronting disrespectful providers. Patients simply leave and do not return, voting with their feet against healthcare systems that fail to respect them.

The underlying philosophy is clear and defiant: *"They say, 'It's my choice to be healed my way'"* (PP2). This assertion of autonomy challenges medical paternalism that positions providers as experts whose recommendations should be followed without question. Patients claim the right to choose their healing path to assert themselves as primary decision-makers about their own bodies and health, entitled to respect regardless of whether their choices align with biomedical recommendations.

The comparative analysis revealed that resistance often emerged specifically from experiences of cultural disrespect rather than from general dissatisfaction with care quality. Patient participant PP3's narrative powerfully demonstrated this dynamic: *"I have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared."* This progression shows how disrespectful treatment creates not merely momentary displeasure but a lasting trauma that drives avoidance of care, potentially with serious health consequences if conditions requiring biomedical intervention go untreated.

Nurses recognised resistance but often misinterpreted it as irrationality or non-compliance rather than as rational response to disrespectful treatment. PN6 noted: *"Sometimes they just refuse, and we don't understand why,"* revealing providers' confusion when patients reject care for reasons not immediately apparent to them. From providers' perspectives, biomedical

recommendations are evidence-based and in patients' best interests; refusal becomes irrational. From patients' perspectives, however, refusal protects dignity, asserts autonomy, or avoids treatments that contradict cultural or spiritual frameworks. This divergence in interpretation illustrates how power dynamics and epistemological differences shape understandings of resistance what appears as patient irrationality from one perspective appears as justified self-advocacy from another.

Community participants framed resistance as collective rather than merely individual, positioning it as community response to systemic disrespect. CP5 stated: *"When our people are treated badly, word spreads... Then others don't come,"* revealing how individual experiences of disrespect create collective care avoidance through community communication networks. This collective dimension amplifies resistance's impact beyond individual care encounters to affect entire communities' healthcare access and trust in formal healthcare systems.

➤ **Selective healthcare utilisation: Strategic engagement**

Patients engage with healthcare systems with remarkable strategic selectivity, utilising different systems for different purposes based on their nuanced assessments of each system's comparative advantages and appropriateness for conditions or illness phases. *"They only come here when it's a serious emergency,"* reveals a crisis-driven approach to biomedical care (PN4). This pattern positions biomedical care as a safety net for emergencies and acute conditions requiring immediate intervention whilst traditional healing serves as primary care for chronic conditions and health maintenance.

The selection process is nuanced and reflects accumulated health literacy: *"For some things they say, 'the doctor is better', but for others, my healer is enough"* (CP5). This differential utilisation demonstrates sophisticated understanding of comparative advantages. Biomedical care excels at acute interventions trauma care, surgical procedures, emergency stabilisation, acute infections requiring antibiotics. Traditional healing excels at chronic care, preventive approaches, and conditions with spiritual or relational dimensions. Strategic utilisation deploys each system where it offers greatest benefit.

One nurse aptly observed the complexity of this approach: *"It's like they are picking and choosing which system to follow"* (PN2). Whilst this observation might carry a hint of criticism (as if patients should consistently follow one system), it describes sophisticated healthcare navigation that treats different systems as resources to be deployed strategically rather than as mutually exclusive alternatives requiring loyalty. From the patients' perspectives, this selective utilisation demonstrates wisdom rather than inconsistency. Why limit oneself to one system when both offer benefits?

The comparative analysis revealed that this selective utilisation created challenges for biomedical providers accustomed to continuous care relationships. Biomedical models assume ongoing patient-provider relationships enabling monitoring, treatment adjustment, and preventive care. Patients utilise biomedical care selectively for acute episodes whilst conducting primary care through traditional healing, this continuity breaks down. Providers lack context for understanding current presentations, cannot monitor chronic conditions, and cannot provide preventive interventions. This fragmentation compromises biomedical care quality whilst also preventing safe coordination between systems.

Patient participant PP7 explained the logic: *"For things like high blood pressure, I go to clinic... But for my spirit problems, I see my healer."* This differentiation reveals how patients categorise conditions and match them to appropriate healing systems. Conditions with clear biomedical interventions (hypertension manageable with medications) warrant biomedical care. Conditions understood through spiritual frameworks (spirit possession, ancestral communication, spiritual attacks) warrant traditional healing. This matching process reflects epistemological and ontological assumptions about illness causation alongside pragmatic assessments of treatment efficacy.

Nurses' responses to this selective utilisation varied. Some accepted it pragmatically: *"At least they come when they really need us"* (PN3). Others expressed frustration about missed opportunities for prevention and chronic care: *"We only see them when it's too late... We could have helped earlier"* (PN6). This divergence exposes tensions between accepting patients'

autonomy in healthcare navigation and regretting lost opportunities for prevention and early intervention that selective utilisation creates.

- **Synthesis: The landscape of patient agency**

The research unveils multiple layers of patient navigation that reveal healthcare decision-making as strategic, complex, and shaped by multiple factors operating simultaneously:

Strategic use of multiple healing systems based on sophisticated assessments of each system's comparative advantages, condition-specific appropriateness, and complementary roles in comprehensive care. This strategic pluralism reflects healthcare wisdom accumulated through personal and community experience rather than ignorance or confusion.

Complex economic decision-making wherein poverty shapes healthcare access and choices, making traditional healing not merely cultural preference but economic necessity for many patients. Economic constraints interact with geographic accessibility, time burdens, and direct costs to shape which healthcare options are practically feasible rather than merely theoretically available.

Resistance to institutional disrespect through multiple mechanisms ranging from explicit refusal to subtle avoidance, asserting patient autonomy and dignity against medical paternalism and cultural insensitivity. This resistance operates individually and collectively, shaping not only individual care encounters but community-level healthcare trust and utilisation patterns.

Selective engagement with healthcare providers that treats different systems as resources deployed strategically rather than as competing alternatives requiring exclusive loyalty, demonstrating sophisticated healthcare navigation whilst also creating fragments that compromises care coordination and quality.

Concealment strategies that protect patients from anticipated judgment whilst creating information gaps compromising safety and care quality, revealing how power dynamics and fear

shape communication patterns in ways that undermine therapeutic relationships and shared decision-making.

These navigation strategies represent far more than simple healthcare choices. They are profound acts of survival, resistance, and self-determination operating within constrained circumstances shaped by economic limitations, institutional barriers, power imbalances, and epistemological conflicts. Patients negotiate complex systems of healing, economic constraints, and institutional pressures with remarkable agency and strategic thinking, though this agency operates within significant structural constraints on available choices.

Implications: From patient compliance to patient partnership

Patient navigation exposes fundamental tensions between biomedical models emphasising compliance, continuity, and provider authority versus realities of medical pluralism, strategic utilisation, and patient autonomy. The path forward demands shifting from compliance frameworks to partnership models that recognise and support patient agency:

- **Recognition of patient autonomy** as legitimate rather than problematic, respecting patients' rights to utilise multiple healing systems and make choices that reflect their epistemological frameworks, values, and circumstances rather than treating deviation from biomedical recommendations as non-compliance requiring correction
- **Respect for diverse healing approaches** by creating legitimacy for medical pluralism, enabling safe coordination between systems, and positioning providers as partners and consultants rather than as singular authoritative axes of power over healthcare decisions
- **Flexible healthcare frameworks** that accommodate rather than surveillance powers that penalise strategic utilisation, enabling episodic biomedical engagement whilst maintaining care quality and safety through improved coordination, information systems, and communication
- **Understanding economic and cultural constraints** that shape healthcare choices, addressing structural barriers (transport costs, geographic accessibility, discriminatory treatment) whilst respecting cultural frameworks that position traditional healing as valuable rather than backwards

- **Creating trust** through respectful communication, non-judgmental attitudes, and genuine partnership that enables patients to share traditional healing use without fear of judgement, facilitating safety screening and care coordination

Ultimately, cultural competence requires seeing patients not as passive recipients of care or non-compliant problems but as active, intelligent navigators of complex healthcare landscapes demonstrating remarkable agency within significant constraints. Rather than demanding compliance with biomedical models, culturally competent care creates partnerships that respect patient autonomy whilst ensuring safety and quality across all healing modalities patients choose to utilise.

Table 4.9: Theme 5

Theme 5: Dignity, Respect, and Human Rights in Healthcare Interactions

Theme	Sub-theme/Category	Codes
Theme 5: Dignity, Respect, and Human Rights	Interpersonal Respect	• Cultural respect importance • Equal treatment expectations • Listening without judgement • Mutual respect principle
	Cultural Identity Preservation	• Cultural symbols recognition • Traditional attire respect • Cultural practice importance • Identity marker protection
	Non-Discriminatory Care	• Racial discrimination awareness • Equal treatment regardless of background • Universal cultural respect • Diversity respect imperative
	Emotional Safety	• Cultural shame prevention

		• Emotional impact of cultural disrespect • Patient fear of expressing cultural needs • Dignity preservation
	Autonomy in Healthcare Decisions	• Patient-led decision making • Cultural choice validation • Consent requirements • Respect for personal belief systems

At the core of culturally sensitive healthcare lies a fundamental commitment to human dignity, respect, and individual autonomy grounded in human rights frameworks that position these values as non-negotiable entitlements rather than discretionary courtesies. This theme illuminates the profound ways in which healthcare interactions either affirm or undermine the basic human rights of patients, revealing the critical dimensions of interpersonal respect, cultural identity preservation, emotional safety, and autonomy. Where previous themes examined structural barriers, epistemological conflicts, and patient agency, this theme focuses on the ethical and human rights suasions that should undergird all healthcare encounters regardless of cultural difference.

- **Dimensions of dignity and respect**

- **Interpersonal respect: The foundation of healing**

Respectful communication is the cornerstone of meaningful healthcare interactions, functioning not merely as politeness but as a therapeutic intervention that enables trust, facilitates communication, and creates conditions for healing. *"We must listen to the patient without judging them, even if we don't share their beliefs,"* articulates a fundamental approach to patient-centred care that transcends cultural differences (PN6). This statement positions listening as a professional obligation grounded in respect for persons rather than agreement with beliefs.

Respectful listening communicates that patients are valued, their perspectives matter, and their experiences are legitimate, even when they differ from providers' frameworks.

The imperative of equal treatment is unequivocal, and challenges deeply ingrained hierarchies that persist despite formal equality principles. *"Every patient deserves equal treatment, whether they come from the township or suburbs,"* challenges deeply ingrained social and economic disparities that shape healthcare experiences in post-apartheid South Africa (CP2). This statement asserts equality as a right rather than as discretionary kindness, positioning socioeconomic status as irrelevant to care entitlement. The explicit contrast between township and suburb references South Africa's persistent spatial segregation and socioeconomic inequalities, asserting that these should not translate into healthcare inequalities.

As one participant succinctly stated, *"Mutual respect is the first step to healing"* (PN3), highlighting respect as a therapeutic intervention in itself rather than merely as an ethical nicety. This framing positions respect not as peripheral to clinical care but as foundational without respect, even technically excellent care fails to heal because it undermines the dignity and agency necessary for patients to engage actively in their own healing. Disrespectful care, conversely, becomes a form of harm that compromises healing regardless of technical quality.

The comparative analysis revealed convergence across all participant groups on the centrality of respect, though with different emphases. **Nurses** framed respect as a professional standard: *"You must respect that. But still, you give the sae care"* (PN5), positioning respect and quality as complementary rather than competing priorities. **Patients** framed respect experientially, describing how its presence or absence shaped their care-seeking: *"When they treat me well, I keep coming back"* (PP2). **Community participants** framed respect as justice issue: *"Respect is a right, not a favour"* (CP2), positioning respectful treatment as entitlement rather than as dependent on provider benevolence.

However, the analysis also revealed gaps between respect as professed value and respect as lived reality. Whilst all participants endorsed respect rhetorically, patient narratives revealed frequent experiences of disrespect. Patient participant PP3's account exemplified this gap: *"I*

have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared." This narrative demonstrates how disrespectful treatment creates lasting trauma affecting care-seeking behaviour, with potentially serious health consequences.

The focus group participants acknowledged systemic factors undermining respect: "*We tend to focus on physical care... cultural preferences... not prioritised,*" identifying how institutional priorities and resource constraints shape what receives attention. This acknowledgement positions disrespect not merely as individual moral failure but as systematic problem requiring institutional remedy. When systems prioritise efficiency over relationships, task completion over communication, and biomedical care over holistic approaches, disrespect becomes structurally embedded even when individual providers value respect.

Cultural identity preservation: Recognising wholeness

Cultural identity is not peripheral cosmetics but central to patient dignity, personhood, and wellbeing. Removing or dismissing cultural identity markers constitutes a form of violence that undermines the wholeness necessary for healing. "*Some patients don't want to remove their traditional beads we must allow them,*" illustrates the profound significance of cultural symbols (PN5). These beads are not mere jewelry but sacred objects carrying spiritual significance, connecting wearers to ancestors, marking spiritual status or identity, and providing spiritual protection. Forcing removal violates not merely preference but spiritual integrity, communicating that patients' spiritual habitus are irrelevant or illegitimate within healthcare spaces.

The violence of cultural erasure is powerfully articulated: "*The headscarf or attire is part of identity forcing removal takes away dignity*" (CP1). This statement frames forced removal of cultural attire as dignity violation rather than as neutral medical necessity. Whilst biomedical providers may frame attire removal as practical requirement for examination or infection control, patients experience it as assault on identity when done without sensitivity, explanation, or negotiation. The loss of dignity is not an incidental side effect, but direct harm created by failure to recognise and respect cultural identity's centrality to personhood.

Recognising cultural practices becomes an act of fundamental respect that affirms patients as whole persons rather than as isolated bodies requiring technical intervention: *"Recognising these cultural practices shows we value them as people"* (PP3). This observation links recognition to valuation when providers acknowledge and accommodate cultural practices, they communicate that they value patients as persons with legitimate cultural frameworks. Conversely, dismissing or ignoring cultural practices communicates devaluation, positioning patients' cultural frameworks as distractions rather than as integral aspects of their personhood requiring respectful engagement.

The comparative analysis revealed that cultural identity preservation was particularly contested terrain wherein biomedical logic (attire interferes with examination; symbols might harbour infection; cultural practices disrupt standardised routines) conflicted with patients' identity needs. Patient participant PP1 explained: *"My beads are important to me spiritually... When they ask me to remove them, I feel exposed."* This feeling of exposure captures the vulnerability created when identity markers that provide spiritual protection and psychological security are removed, leaving patients feeling undefended in already anxiety-provoking healthcare encounters.

Some nurses demonstrated a sophisticated understanding of this dynamic and actively protected cultural identity marker. PN10 recounted: *"We as staff respected that... we had to call her to do her thing. We wouldn't just change the baby without her,"* exemplifying accommodation that centred patient and family cultural needs. This example demonstrates how accommodation is possible when providers prioritise cultural respect and find creative solutions rather than reflexively demanding conformity to standardised protocols.

However, accommodation remained inconsistent and dependent on individual provider sensitivity rather than systematic policy. Community participant CP3 noted: *"There are no policies... nothing like that... It's up to the person,"* highlighting how absence of policy leaves cultural identity preservation to the discretion of the individual. This discretionary approach creates inequity wherein patients' cultural identities are respected or violated depending on which practitioner they encounter rather than as a matter of systematic rights-respecting practice.

➤ **Non-discriminatory care: Universal humanity**

The commitment to non-discrimination represents a robust ethical stance grounded in human rights principles asserting equal dignity and worth regardless of race, culture, socioeconomic status, or other identity markers. *"We cannot discriminate on race or culture healthcare is for all,"* frames a fundamental principle of equitable care (PN1). This statement asserts healthcare as universal right rather than as privilege distributed according to social hierarchies, positioning providers as obligated to serve all regardless of personal attitudes about patients' identities.

This is not passive non-discrimination but an active celebration of human diversity that recognises difference as enriching rather than problematic. The universal nature of respect is unambiguous: *"Respect must be universal, not selective,"* emphasises the comprehensive nature of this ethical commitment (PN7). This statement challenges selective respect that reserves dignified treatment for patients who are culturally similar, socioeconomically privileged, or otherwise deemed deserving whilst treating marginalised patients with indifference or contempt. Universal respect demands consistent dignified treatment regardless of patient characteristics.

Personal experiences of discrimination underscore the ongoing struggle to achieve non-discriminatory care despite formal equality principles. *"I have seen patients treated badly because of where they come from. This must stop"* (CP4). This statement acknowledges ongoing discrimination whilst asserting moral imperative for change. The phrase *"this must stop"* positions discrimination not as unfortunate reality to be tolerated but as injustice requiring immediate remedy. The moral clarity this is wrong and must be stopped provides ethical grounding for transformation efforts.

The comparative analysis revealed that discrimination operated through multiple modalities, ranging from overt hostility to subtle differential treatment to systemic exclusion. Community participant CP5 powerfully articulated racial hierarchies: *"They look at us and think we are not educated, so they don't listen when we try to explain our ways."* This statement underscores how racial stereotypes shape provider-patient interactions, with providers dismissing Black

African patients' explanations as ignorant whilst potentially crediting similar explanations from white patients as informed. This differential crediting reflects racial hierarchies positioning Black African knowledge as inferior.

Patient participant PP4 described subtler discrimination through time allocation: *"They spend more time with some patients than others... It depends on who you are."* This observation reveals how time a scarce resource in overburdened healthcare systems gets distributed unequally, with marginalised patients receiving rushed, perfunctory care whilst privileged patients receive attentive engagement. This time discrimination creates unequal care quality even when formal services provided are identical.

Nurses acknowledged discriminatory dynamics whilst sometimes positioning themselves as powerless to remedy them. PN4 noted: *"I see it happening... It's not right, but it's hard to change,"* revealing tensions between moral clarity (discrimination is wrong) and perceived institutional intractability (change is difficult). This tension risks paralysis wherein providers acknowledge problems without taking action to remedy them. However, some nurses demonstrated active anti-discrimination, deliberately compensating for systemic bias by providing extra attention to marginalised patients.

➤ **Emotional safety: The invisible dimension of care**

Emotional safety emerges as a critical, often overlooked aspect of healthcare interactions that shapes patients' willingness to engage honestly, disclose sensitive information, and return for ongoing care. *"When a nurse laughs at practices, the patient feels ashamed,"* reveals the profound emotional vulnerability of patients (PN8). This statement captures how providers' emotional responses, whether intentional mockery or thoughtless laughter, inflict emotional harm that goes beyond momentary upset to create lasting shame that undermines self-worth and care engagement.

The fear of judgment creates significant barriers to genuine care by inhibiting honest communication about symptoms, traditional healing use, cultural practices, and other information relevant to safe, effective care. *"Patients are sometimes afraid to say what they believe they*

hide it," demonstrates how emotional vulnerability undermines honest communication (PP5). When patients fear judgment, they engage in strategic concealment that protects emotional wellbeing whilst compromising care quality and safety. Providers cannot offer appropriate care when they lack critical information that the patients have concealed to avoid mockery or ridicule.

The antidote is a compassionate approach that prioritises dignity: *"We should preserve dignity, so the patient feels safe emotionally"* (PN2). This statement positions dignity preservation as active practice requiring deliberate effort rather than as passive absence of overt abuse. Preserving dignity means attending to how actions, words, tone, and body language communicate respect or disrespect; creating environments wherein patients feel valued regardless of their cultural backgrounds or beliefs; and responding to cultural difference with curiosity and respect rather than judgment.

The comparative analysis established that emotional safety was deeply intertwined with previous themes. **Structural discrimination** (Theme 2) created emotional unsafety by communicating devaluation. **Epistemological conflicts** (Theme 3) created emotional unsafety when providers dismissed patients' illness explanations as ignorant. **Patient navigation strategies** (Theme 4) including concealment reflected attempts to create emotional safety in environments perceived as unsafe. This interconnection reveals emotional safety not as isolated concern but as threading through all dimensions of culturally competent care.

Patient participant PP8 explained the emotional stakes: *"When they judge you, you feel small... You don't want to come back."* This statement reveals how judgment functions as a form of symbolic violence that diminishes patients' sense of worth and creates care avoidance with potentially serious health consequences. The feeling of being made *"small"* diminished, devalued, reduced captures the dignity violation that judgement creates. Care avoidance then becomes a self-protective response, removing oneself from environments wherein one's dignity is systematically undermined.

Some nurses demonstrated sophisticated understanding of emotional safety's importance and actively cultivated emotionally safe environments. PN3 described their approach: *"I make sure*

they know I'm not judging... I tell them, 'Whatever you share, I'm here to help.'" This explicit reassurance communicates safety, potentially enabling patients to share information they would otherwise conceal. However, verbal reassurance alone may be insufficient if patients' previous experiences have taught them that healthcare environments are judgmental; rebuilding trust requires consistent respectful behaviour over time.

➤ **Autonomy in healthcare decisions: The right to choose**

Patient autonomy is a fundamental human right in healthcare interactions, grounded in principles of bodily integrity, self-determination, and informed consent that position patients as primary decision-makers about their own bodies and health. *"The patient must have the final say in what happens to their body,"* articulates a profound respect for individual agency (PN4). This statement positions patients as sovereigns over their own bodies rather than as subjects of medical authority, asserting that providers' expertise creates advisory rather than determinative roles in healthcare decision-making.

This is not about medical advice being irrelevant but about fundamental human autonomy and choice: patients have the right to make choices providers disagree with after being fully informed about risks and alternatives. The validation of personal choice is crucial: *"We should respect when someone says, 'I choose this treatment,'"* emphasises the importance of patient-led decision-making (PP1). This statement positions respect as requiring validation of patients' choices even when providers would choose differently, recognising that diverse cultural frameworks, values, and risk assessments legitimately generate different treatment preferences.

Consent is not a bureaucratic formality but a fundamental right ensuring that patients understand what is being done to their bodies and agree to these interventions: *"Consent is essential, it's their right"* (CP3). This framing positions consent as patient right rather than as a provider obligation, centering patients' entitlement to self-determination. Meaningful consent requires more than signed forms; it requires genuine understanding achieved through culturally appropriate communication, opportunities to ask questions, and freedom to refuse participation without penalty.

The comparative analysis revealed tensions between autonomy rhetoric and paternalism practice. Whilst all participant groups endorsed patient autonomy rhetorically, actual practice often involved providers making decisions with limited patient input, particularly when providers perceived patients' cultural frameworks as leading toward "wrong" decisions. Nurse participant PN7 revealed this tension: *"Sometimes we know what's best, but they want something else... It's difficult."* This statement amplifies the struggle between respecting autonomy and implementing what providers believe is best, with tension unresolved.

Patient participants emphasised autonomy particularly strongly, perhaps reflecting experiences of having autonomy violated or constrained. Patient participant PP2 asserted: *"They say, 'It's my choice to be healed my way,'"* using emphatic language positioning choice as non-negotiable right rather than as privilege granted by providers. This emphasis suggests patients felt their autonomy was insufficiently respected, requiring explicit assertion.

Community participants framed autonomy as central to culturally competent care, noting that cultural competence without autonomy becomes mere tokenism. Community participant CP1 explained: *"You can understand our culture, but if you don't let us choose, it doesn't mean much."* This observation positions autonomy as the practical expression of cultural competence, understanding culture matters primarily insofar as it enables respecting patients' culturally informed choices rather than merely adding cultural knowledge to paternalistic practice.

The analysis revealed autonomy challenges in several contexts. When patients chose traditional healing over biomedical treatment for conditions providers believed required biomedical intervention, providers struggled with how much autonomy to respect versus how strongly to advocate for biomedical approaches. When family dynamics involved collective decision-making rather than individual patient autonomy, providers trained in individualistic consent models struggled to navigate communal decision processes respectfully. When language barriers compromised informed consent, providers questioned whether patients truly understood enough to exercise meaningful autonomy.

These challenges notwithstanding, the ethical imperative remained clear: patient autonomy must be respected even when challenging. The providers' role is to ensure patients have information necessary for informed decisions, to clarify misunderstandings, and to advocate for what they believe is best but ultimately to respect patients' choices even when disagreeing. This respect for autonomy is not merely ethical nicety but fundamental human right grounded in bodily integrity and self-determination.

- **Synthesis: The landscape of dignified care**

The research identified multiple dimensions of respect and dignity operating simultaneously and interdependently to create healthcare environments that either affirm or undermine human rights:

Interpersonal respect as a healing intervention that enables trust, facilitates communication, and creates psychological conditions necessary for healing, functioning not as peripheral politeness but as core therapeutic practice. Respect is expressed through listening without judgment, taking patients' concerns seriously, and treating patients as valuable persons worthy of dignified engagement.

Cultural identity as an integral aspect of personhood requiring active preservation through accommodating cultural symbols, attire, and practices that connect patients to cultural traditions and spiritual frameworks. Cultural identity preservation affirms patients' wholeness, communicating that they are valued as complete persons rather than as isolated bodies requiring technical intervention.

Non-discrimination as an active ethical commitment requires deliberate effort to ensure equal treatment across racial, cultural, and socioeconomic differences rather than passive absence of overt hostility. Non-discrimination demands examining implicit biases, challenging discriminatory systems, and actively counteracting hierarchies that create unequal treatment.

Emotional safety as a critical care component enabling honest communication through creating environments wherein patients feel safe expressing cultural beliefs, disclosing

traditional healing use, and sharing concerns without fear of mockery, judgment, or dismissal. Emotional safety is prerequisite for therapeutic relationships built on trust rather than fear.

Patient autonomy as a fundamental human right positioning patients as primary decision-makers about their bodies and health, with providers serving as expert advisors rather than as authorities determining treatment. Autonomy requires meaningful informed consent, respect for culturally informed choices even when providers disagree, and validation of patients' rights to self-determination.

These dimensions are deeply interconnected: respect enables emotional safety; emotional safety enables honest communication; honest communication enables informed autonomy; autonomy respects cultural identity; cultural identity preservation demonstrates respect. This interconnection demonstrates dignity not as single attribute but as multidimensional quality emerging from consistent respectful practice across multiple domains.

Implications: Embedding dignity in systems and practice

Dignity in healthcare is not an abstract concept but a lived experience manifesting through concrete practices of listening, respecting, validating, and empowering patients. Cultural competence demands more than technical medical skills it requires profound commitment to seeing and valuing each patient's full humanity. The path forward demands:

- **Comprehensive cultural sensitivity training** that addresses not merely cultural knowledge but the attitudes, communication skills, and reflexive practices necessary for respectful engagement across difference, including confronting implicit biases and examining how power shapes healthcare interactions
- **Institutional frameworks that prioritise patient dignity** through policies mandating respectful treatment, accountability mechanisms addressing discrimination, and performance metrics valuing relational quality alongside technical quality
- **Active listening and non-judgmental communication** cultivated through training and modelled by leadership, creating organisational cultures wherein curiosity replaces judgment, and engagement replaces dismissal when encountering unfamiliar cultural practices

- **Celebration of cultural diversity** positioned as organisational strength rather than as challenge to be managed, with visible commitment to inclusion through multilingual materials, culturally appropriate spaces, and representation in staffing
- **Empowerment of patient choice** through meaningful informed consent processes, respect for culturally informed decisions even when providers disagree, and partnership models that position patients as primary decision-makers supported by expert advice

Ultimately, dignified healthcare is a powerful act of recognition, acknowledging the inherent worth of every individual, regardless of their cultural background, social status, or personal beliefs. This recognition must be expressed not merely rhetorically but through systematic practices, policies, and institutional cultures that embed dignity as a non-negotiable foundation of all healthcare encounters. The transformation from dignity as an individual aspiration to dignity as systematic standard requires leadership commitment, resource allocation, accountability mechanisms, and sustained efforts. This constitutes ethical imperative grounded in fundamental human rights that cannot be compromised even under resource constraints or competing pressures.

Table 4.10: Theme 6

Theme 6: Professional Identity and Ethical Navigation in Cultural Healthcare

Theme	Sub-theme/Category	Codes
Theme 6: Professional Identity and Ethical Navigation	Professional Boundary Management	• Scope of practice boundaries • Professional ethical obligations • Neutrality in cultural interactions • Professional conduct standards
	Ethical Dilemmas	• Cultural versus medical necessity • Safety versus cultural respect • Professional judgment experiences • Conflicting treatment approaches

	Personal-Professional Integration	• Professional respect despite personal beliefs • Values-driven professional practice • Cultural identity and professional role • Balancing personal and professional perspectives
	Institutional Accountability	• Cultural protocol development • System collaboration advocacy • Professional training needs • Institutional cultural competence assessment
	Continuous Learning	• Ongoing cultural education • Reflective practice • Professional development advocacy • Knowledge gap recognition

The professional identity of nurses represents a complex landscape of ethical negotiation, personal values, and institutional expectations that becomes particularly challenging when navigating cultural diversity and indigenous healing practices. This theme explores the intricate ways in which healthcare professionals navigate the delicate intersection of cultural diversity, professional standards, and personal integrity managing tensions, resolving dilemmas, and continuously developing their practice whilst maintaining both professional competence and cultural sensitivity.

- **Dimensions of professional identity**

- **Professional boundary management: The ethical tightrope**

Nurses consistently grapple with the challenges of maintaining professional boundaries whilst respecting cultural nuances, walking an ethical tightrope between flexibility that accommodates cultural diversity and standards that ensure safety and quality. *"There are limits to what I can do*

because of my scope of practice," articulates the fundamental constraint of professional role (PN3). This statement positions professional boundaries not as arbitrary restrictions but as legitimate parameters defining nursing's remit, ensuring practitioners work within areas of their competence, and protecting both patients and practitioners from harm that might result from exceeding appropriate professional limits.

The commitment to professional ethics is unwavering even when cultural accommodation creates tensions: *"Even if I don't agree, I must act within professional ethical obligations,"* demonstrates the profound sense of responsibility that underpins nursing practice (PN7). This statement illustrates how professional ethics can require transcending personal preferences or cultural unfamiliarity nurses commit to professional standards regardless of whether situations align with personal comfort or cultural frameworks. Professional identity functions as an ethical anchor that guides behaviour even in culturally complex situations lacking clear protocols.

Neutrality becomes a critical strategy for managing cultural interactions professionally: *"We must remain neutral in cultural matters and not show bias"* (CP2). This statement positions neutrality as a professional obligation, requiring nurses to bracket personal cultural preferences, religious beliefs, or value judgments when these might compromise equitable care. Neutrality does not mean cultural blindness or value-free practices but rather commitment to providing respectful, equitable care regardless of whether patients' cultural frameworks align with providers' personal views.

The comparative analysis revealed that professional boundary management created challenges in contexts involving traditional healing. Nurses understood their scope of practice as encompassing biomedical interventions but questioned where traditional healing fitted. PN5 articulated this uncertainty: *"I cannot allow a patient to use herbs in hospital, because it's not part of my professional practice."* This statement clarifies how professional boundaries defined around biomedical practice marginalise traditional healing as outside nursing's legitimate remit, creating professional vulnerability for nurses who accede to traditional practices.

Yet some nurses demonstrated sophisticated navigation that honoured both professional boundaries and cultural respect. PN10 recounted: *"We as staff respected that... we had to call her to do her thing. We wouldn't just change the baby without her."* This example shows flexibility within boundaries - whilst nurses might not personally conduct traditional rituals (outside their scope), they can facilitate family members conducting them (within their advocacy and coordination roles). This distinction enables cultural accommodation whilst maintaining professional integrity.

The focus group participants acknowledged systemic ambiguity about professional boundaries in cultural contexts: *"There's no clear guidance on what we should or shouldn't accommodate."* This ambiguity creates professional vulnerability wherein nurses make situation-specific judgments without policy backing, potentially facing professional sanctions if complications arise. Professional boundary management could be facilitated by clear institutional policies establishing which cultural accommodations fall within nursing scope and which require different approaches.

➤ **Ethical dilemmas: Navigating complexity**

The most challenging moments emerge when cultural respect confronts medical necessity, safety concerns, or professional standards, creating ethical dilemmas without clear resolutions. *"Sometimes I must choose between saving a life and respecting a ritual,"* captures the profound ethical tensions nurses face (PN5). These are not theoretical puzzles but lived experiences of complex decision-making with serious consequences. When a patient refuses blood transfusion on religious grounds whilst hemorrhaging, respecting autonomy conflicts with preserving life. When traditional practices compromise sterile field, respecting culture conflicts with infection control. These dilemmas cannot be resolved through simple application of rules but require contextual judgment in balancing competing values.

Safety emerges as a critical consideration that sometimes justifies limiting cultural accommodation: *"There are cases where safety comes first, even if it means not following culture,"* reveals the nuanced approach to patient care that prioritises fundamental wellbeing (CP4). This statement positions safety not as trumping culture automatically but as a weight in

balancing that sometimes, in specific contexts, must take priority. The principle is not *"safety always overrides culture"* but rather *"in specific situations where cultural practices create genuine safety risks, protecting patients may require limiting accommodation whilst minimising cultural harm."*

The emotional toll is significant: *"Different treatment approaches can conflict, and it is stressful"* (PN9). This statement acknowledges the psychological burden of navigating ethical dilemmas without clear answers, managing competing values, and worrying about whether one made the right decision. This stress can contribute to moral distress and psychological harm resulting from being constrained from doing what one believes is ethically right or being compelled to do what one believes is ethically wrong.

The comparative analysis revealed that ethical dilemmas emerged most acutely in several contexts: when patients refused biomedical interventions providers believed necessary; when traditional practices occurred without adequate information about safety; when time pressures required quick decisions without adequate consultation; and when institutional policies conflicted with cultural accommodation. Patient participant PP9 described the patient experience: *"Sometimes I feel caught between what my culture says and what the hospital says."* This feeling of being "caught between" illustrates how ethical dilemmas affect not only providers but patients who must navigate between systems with competing demands.

Nurses employed various strategies for navigating dilemmas. Some sought consultation with colleagues, chaplains, or ethics committees when time permitted. Some engaged patients in shared decision-making, explaining concerns whilst exploring whether compromises might honour both safety and culture. Some advocated within-institutions for policy development providing guidance. And some made situation-specific judgments based on their best assessment of competing values in particular contexts.

However, nurses also acknowledged that some dilemmas remained unresolved, creating ongoing ethical discomfort. PN6 reflected: *"I still think about some situations years later, wondering if I did the right thing."* This lingering doubt confirms the deep ethical seriousness with

which nurses approach dilemmas, recognising that their decisions profoundly affect patients and families. This reflexive stance of continuing to question and learn from difficult situations represents ethical maturity, though it also creates psychological burden.

➤ **Personal-professional integration: Balancing identities**

Negotiating between personal beliefs and professional obligations represents a critical aspect of nursing identity requiring ongoing integration of multiple, sometimes conflicting aspects of self. *"Even if my personal beliefs differ, I treat every patient with respect,"* illustrates the fundamental commitment to professional ethics (PN1). This statement reveals the capacity to maintain professional conduct even when personal beliefs or cultural frameworks differ from patients', representing sophisticated level of professional maturity that recognises professional role as distinct from personal identity.

Nurses actively work to integrate their values into their professional practice rather than compartmentalising: *"I try to integrate my values into my work, to remain fair,"* demonstrates a thoughtful approach to professional identity (PN10). This integration suggests that professional and personal identities need not be entirely separate but can be brought into alignment when personal values (fairness, respect, compassion) align with professional ethics. The challenge emerges when personal values conflict with professional obligations, requiring practitioners to prioritise professional ethics whilst managing personal discomfort.

The challenge of managing multiple identities is particularly profound for nurses who are themselves members of cultural communities that value traditional healing: *"As a nurse I must manage my cultural identity alongside my professional role"* (CP3). This statement reveals how professional socialisation into biomedical frameworks can create distance from one's own cultural traditions, requiring ongoing negotiation between professional identity emphasising evidence-based biomedicine and cultural identity valuing traditional healing. Nurses navigating this tension may experience themselves as *"in-between worlds"* neither fully accepted in biomedical contexts that view traditional healing skeptically nor in cultural communities that view biomedical training as cultural betrayal.

The comparative analysis revealed diverse strategies for personal-professional integration. Some nurses maintained strong boundaries, compartmentalising personal beliefs as irrelevant to professional practice. Some sought to integrate, finding ways their personal values enhanced professional practice. Some experienced ongoing tension, never fully resolving conflicts between personal and professional identities. And some culturally embedded nurses served as bridges, using their insider cultural knowledge to enhance care whilst maintaining professional standards.

Patient participants generally appreciated nurses who could integrate personal warmth with professional competence. PP5 noted: *"The nurses who are warm and kind but also professional those are the best."* This observation positions integration as ideal, suggesting that personal qualities like warmth enhance rather than compromise professional practice. However, patients also acknowledged that nurses facing cultural difference struggled with integration. PP3 observed: *"When nurses don't understand our culture, they can't really connect with us,"* suggesting that cultural knowledge facilitates personal-professional integration by enabling genuine connection across differences.

Community participants emphasised the value of culturally embedded nurses who could integrate cultural insider status with professional competence. CP2 explained: *"Nurses from our communities understand us... They can help in ways others can't."* This observation suggests that shared cultural identity facilitates integration by reducing tensions between personal and professional identities when one's own culture values traditional healing, facilitating traditional practices feels professionally consistent rather than conflicting.

➤ **Institutional accountability: Systemic challenges**

The lack of institutional support emerges as a significant challenge undermining individual nurses' efforts to provide culturally competent care, revealing how professional practice is enabled or constrained by systemic factors beyond individual control. *"We need protocols that guide us in cultural cases,"* amplifies the desire for systematic guidance (PN6). This call for protocols positions policy not as bureaucratic constraint but as professional support that provides guidance for navigating complex situations, protects practitioners who follow policy, and creates

consistency ensuring patients receive similar treatment regardless of which practitioner they encounter.

Nurses advocate for broader institutional transformation beyond individual practice: *"Institutions should collaborate more with community systems"* (CP5). This recommendation positions cultural competence as requiring institutional-community partnerships rather than merely individual cultural knowledge. Collaboration might include consulting traditional healers about safe integration; employing community health workers as cultural brokers; creating advisory councils representing cultural communities; and developing referral mechanisms enabling coordination between biomedical and traditional practitioners.

The training deficit is stark and undermines professional development: *"There is little training provided for these issues,"* highlights the systemic gaps in cultural competence education (PN2). This is not merely an educational shortcoming but a fundamental institutional limitation reflecting how cultural competence is rhetorically valued but inadequately resourced. When institutions fail to provide training, they communicate that cultural competence is not genuinely prioritised, leaving individual nurses to develop competence through ad hoc experiential learning without systematic support.

The comparative analysis revealed that institutional accountability operated at multiple levels. **Policy level:** absence of cultural policies left cultural accommodation discretionary. **Training level:** lack of systematic education meant competence developed unevenly. **Resource level:** failure to allocate time, space, and resources for cultural practices prevented accommodation even when nurses were willing. **Leadership level:** absence of visible leadership commitment signaled that cultural competence was peripheral rather than central to organisational mission. Nurses called for institutional transformation addressing multiple levels simultaneously. PN8 explained: *"We need policy, training, resources, and leadership support not just one but all of them together."* This holistic view recognises that partial solutions are insufficient; genuine cultural competence requires comprehensive institutional transformation addressing policy, education, resources, and culture simultaneously.

Some nurses took on advocacy roles, working to change institutions rather than merely adapting to them. PN4 described: *"I've been advocating for cultural policies... It's slow, but I think we're making progress."* This advocacy and agency represents professional responsibility extending beyond individual practice to system transformation, recognising that individual cultural competence cannot compensate for institutional failures. However, advocacy also creates an additional burden for already overworked nurses, raising questions about whose responsibility institutional transformation should be.

➤ **Continuous learning: The path of professional growth**

Continuous learning emerges as a critical strategy for navigating cultural complexity, recognising that cultural competence is not achieved through initial training but requires ongoing development throughout professional careers. *"We must continue with cultural education things are always changing,"* demonstrates a commitment to ongoing professional development (PN4). This statement recognises cultural dynamism cultures evolve, migration creates new diversity, and individual encounters always present new learning opportunities. Cultural competence therefore requires career-long commitment to learning rather than one-time training.

Reflective practice becomes a key mechanism for growth, enabling nurses to learn from experiences and continuously improve: *"I reflect on my experiences to improve next time"* (PN8). Reflection involves deliberately examining encounters, identifying what went well and what could improve, considering alternative approaches, and extracting lessons applicable to future situations. This reflective capacity transforms experience into learning, ensuring that cultural encounters generate cumulative wisdom rather than merely accumulated time.

The call for systemic change is clear: *"Professional development in this area is still lacking, we must advocate for it"* (CP1). This is not passive acceptance but an active stance towards professional transformation recognising that individual learning, whilst valuable, cannot substitute for systematic professional development provided through continuing education, workplace learning, and professional standards requiring cultural competence as core professional capability.

The comparative analysis revealed that continuous learning occurred through multiple mechanisms: formal continuing education when available; informal peer learning wherein colleagues shared cultural knowledge; experiential learning through practice encounters; community engagement wherein nurses learned directly from cultural communities; and reflective practice wherein nurses deliberately extracted lessons from experiences. These mechanisms operated synergistically, with formal learning providing frameworks, experiential learning providing contexts, peer learning providing practical strategies, and reflection integrating insights.

However, learning opportunities were unevenly distributed. Nurses in culturally diverse areas had more experiential learning opportunities than those in homogeneous areas. Nurses with culturally diverse colleagues had more peer learning opportunities. Nurses at institutions prioritising cultural competence had more formal learning opportunities. This uneven distribution created competence gaps wherein some nurses developed sophisticated cultural competence whilst others remained relatively naive, not through differential commitment but through differential opportunity.

The focus group participants emphasised the importance of learning directly from cultural communities rather than only from academic sources: *"We need to learn from traditional healers themselves, not just read about them in books."* This observation positions experiential, community-based learning as an essential complement to academic learning, recognising that cultural knowledge requires engagement with living traditions rather than merely studying them abstractly.

- **Synthesis: The landscape of professional ethical navigation**

The research established multiple dimensions of professional identity operating simultaneously to shape how nurses navigate cultural diversity:

Careful management of professional boundaries that maintains scope of practice and professional standards whilst enabling cultural flexibility, requiring nuanced judgment about

when boundaries enable safe practice and when they unnecessarily constrain culturally responsive care.

Navigating complex ethical dilemmas without clear answers, balancing competing values (autonomy vs. beneficence, cultural respect vs. safety, individual choice vs. family preference), and managing moral distress when forced to choose between imperfect options.

Integrating personal values with professional obligations through strategies ranging from compartmentalisation to integration, managing tensions when personal beliefs conflict with professional requirements, and drawing on personal qualities to enhance professional practice.

Addressing institutional limitations through individual adaptation and collective advocacy, recognising that professional practice is enabled or constrained by systemic factors requiring institutional transformation, not merely individual competence development.

Committing to continuous learning and reflection through formal education, experiential learning, peer learning, and reflective practice, recognising cultural competence as career-long developmental journey rather than static achievement.

Professional identity in culturally diverse healthcare settings is a dynamic, complex process of continuous negotiation requiring nurses to be simultaneously technical professionals, ethical agents, cultural interpreters, and compassionate human beings. This multifaceted identity demands sophisticated capacities for managing complexity, tolerating ambiguity, balancing competing values, and continuously learning.

Implications: Supporting professional development in cultural competence

The path forward demands systematic support for professional development in cultural competence rather than leaving individual nurses to navigate complexity without adequate preparation or support:

- **Comprehensive cultural competence training** integrated into initial education and continuing professional development, providing substantive knowledge about diverse

healing practices alongside skills for navigating ethical dilemmas, managing boundaries, and engaging respectfully across differences.

- **Flexible institutional protocols** that provide guidance whilst enabling contextual adaptation, supporting rather than constraining professional judgment, and protecting practitioners who provide culturally responsive care within appropriate boundaries
- **Support for reflective practice** through protected time, structured reflection processes (case conferences, ethics rounds, peer supervision), and organisational cultures valuing learning from experience rather than punishing mistakes
- **Recognition of the complexity of cultural interactions** through realistic expectations, acknowledgement that cultural competence involves ongoing challenges rather than a toolkit of skills, and support for practitioners managing difficult ethical dilemmas
- **Ongoing professional development** through continuing education engagements, workplace learning opportunities, community participatory engagements, and career-long learning pathways enabling progressive competence development

Ultimately, professional identity is not a fixed state but a fluid and morphing journey of learning, reflection, and ethical navigation. Undertaking this journey requires institutional commitment to providing resources, creating learning opportunities, developing supportive policies, and fostering organisational cultures that value cultural competence as core professional capabilities rather than optional enhancement. The transformation from individual struggle to systematic professional development requires not only leadership, resources, and sustained commitment but generates a professional imperative in diverse societies wherein cultural competence is not a specialisation skill but fundamental requirement for ethical and effective practice.

4.4. CONCLUSION

These six themes all reveal cultural competence as a multidimensional phenomenon operating simultaneously at individual, interpersonal, institutional, and societal levels. **Pathways to cultural competence** (Theme 1) operate through personal values, formal education, experiential learning, peer knowledge, and professional identity development. **Systemic barriers** (Theme 2) undermine even well-intentioned practice through structural discrimination,

communication gaps, resource constraints, professional boundaries, and policy voids. **Knowledge system conflicts** (Theme 3) create epistemological tensions between spiritual and scientific frameworks, traditional and biomedical paradigms, and holistic versus symptomatic approaches. **Patient navigation** (Theme 4) constitutes sophisticated agency through dual system strategies, economic decision-making, resistance mechanisms, and selective utilisation. **Dignity and respect** (Theme 5) are fundamental rights requiring interpersonal respect, cultural identity preservation, non-discrimination, emotional safety, and autonomy protection. **Professional identity** (Theme 6) encompasses boundary management, ethical dilemma navigation, personal-professional integration, institutional accountability, and continuous learning.

These themes are deeply interconnected rather than discrete domains. Systemic barriers constrain individual competence; epistemological conflicts shape patient navigation; dignity violations prompt resistance; professional development requires institutional support. This panoply of interconnection reveals cultural competence as systemic quality requiring transformation at multiple levels simultaneously rather than as individual attributes achievable through training alone.

These findings underscore that genuine cultural competence in healthcare contexts involving indigenous healing requires not merely individual practitioners' cultural knowledge or good intentions but comprehensive institutional transformation creating enabling structures, allocating adequate resources, developing clear policies, providing systematic education, fostering respectful organisational cultures, and genuinely recognising traditional healing as a legitimate healthcare modality worthy of integration rather than merely tolerance. The path forward is challenging but ethically imperative in diverse societies committed to equitable, rights-respecting healthcare for all. This chapter has thus established the basis for a critical discussion of the findings considering the existing literature, which is covered in the following chapter.

CHAPTER 5

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

5.1 INTRODUCTION

This chapter discusses the findings connected to existing literature and theory. Building on the themes described in Chapter 4, this discussion aims to interpret the importance of these findings and place them within the larger scientific communities of practice on culturally sensitive patient care. The analysis explores the intersections of practice, policy, and theory by focusing on both local and international literature. Furthermore, the debate traces the findings' implications for nursing practice, healthcare systems, and patient outcomes, providing perspectives through which culturally sensitive patient care might be consolidated in the Western Cape and beyond.

5.2 DISCUSSION OF THEMES IN RELATION TO LITERATURE AND THEORY

Theme 1: Navigating cultural competence in healthcare: Indigenous healing perspectives

Areas of convergence with literature

The finding that nurses develop cultural competence through multiple pathways personal values, formal education, experiential learning, peer knowledge, and professional identity navigation strongly aligns with (Shakwane, 2022:2) emphasis on "integrating diverse cultural perspectives into nursing care, especially in multicultural settings where patient populations reflect varied beliefs, languages and traditions." The multi-modal nature of competence development identified in this study confirms that cultural competence is not achieved through any single mechanism but requires comprehensive, sustained engagement across multiple domains.

The foundational role of personal values and the "golden rule principle" identified in this study resonates with SANC's (2023:3) articulation of nursing's core values including "compassion, empathy and respect for each patient's dignity, regardless of cultural, racial or socioeconomic status." When participant PN5 stated, *"If it's an African patient who believes in certain cultural practices... you must respect that. But still, you give the same care,"* this directly reflects the professional ethic that SANC emphasises wherein respect functions not as preferential treatment but as universal standard. This convergence suggests that professional socialisation

through nursing education and regulatory frameworks does successfully instill foundational values of respect and non-discrimination, even when other aspects of cultural competence (such as substantive knowledge about IKS) remain underdeveloped.

The call for formal education integration evidenced by PN2's statement, *"At nursing school, there should be a module that teaches about different cultures,"* and PN10's recommendation that *"We need formal training in traditional medical practices. The Department of Health could introduce programmes focused on indigenous medicine,"* strongly confirms the educational gaps identified throughout the literature. Ngunyulu et al., (2020:3) specifically argued that "the nursing curriculum need to decolonise by integrating indigenous theories of knowledge and adopt curriculum that reflect African worldviews and health practices," highlighting how "the existing training framework often ignores the diverse of indigenous health practices, resulting in intellectual poverty of the mind among nursing students who are separated from their cultural identities." The empirical finding that nurses themselves recognise and articulate this educational deficit validates scholarly critiques of nursing education as inadequately addressing cultural diversity and IKS.

Makhene (2023:4) observes that "the Western-focused training has resulted in an imbalance between formal nursing education and the cultural realities of the different patient populations that nurses serve," a concern that participants in this study directly echoed through their calls for systematic cultural education. The convergence here is striking: both scholarly analysis and practitioner experience identify curriculum decolonisation and reform as essential for preparing nurses to competently navigate cultural complexities.

The significance of experiential learning identified in this study, particularly PN2's observation that *"If you don't understand other people's culture, and you're trying to explain things medically, it becomes difficult... If you do understand, it makes communication easier,"* aligns with Dlamini, Mkhize and Khanyile's (2021:112) finding that "nurses often feel unprepared to engage with patients using traditional healing approaches, as they feel it can lead to lower patient satisfaction and trust." Both the current findings and existing literature position experiential learning as critical but insufficient when occurring without structured reflection, peer support, or institutional

frameworks. The literature suggests, and this study confirms, that experience alone does not guarantee competence development; rather, experience must be coupled with reflective practice and systematic knowledge to generate genuine cultural understanding.

The finding regarding peer-based knowledge transfer, exemplified by PN9's account *"If it wasn't for my Xhosa colleagues, I wouldn't have known about circumcision... Thulani said it's not allowed in the culture because they must go through rituals"* confirms the informal learning mechanisms identified in literature but also highlights gaps that formal systems have not addressed. The recommendation by PN8 to *"use community health workers who come from the same communities can help us navigate these situations better because they know the norms"* parallels policy recommendations in literature advocating for greater integration of community-embedded knowledge into formal healthcare systems.

Areas of divergence from literature

Whilst literature emphasises formal education as the primary pathway to cultural competence (Makhene, 2023:5), the findings illustrate that personal values and intuitive ethical commitments often function as the *de facto* foundation for culturally respectful practice in the absence of formal training. This represents a subtle but important divergence: literature positions education as prerequisite to competence, whereas the empirical reality confirms that nurses navigate cultural diversity through multiple mechanisms, with personal values often compensating for educational deficits.

This finding suggests that whilst educational reform remains essential (as both literature and participants emphasise), the pathway to cultural competence is more complex and multi-directional than linear models assuming education precedes practice competence. Nurses in this study demonstrated sophisticated cultural dexterity despite inadequate formal training, drawing on personal ethics, experiential learning, and peer knowledge. This does not diminish the criticality of formal education but rather reveals human adaptability and ethical commitment as resources that enable culturally responsive practice even in less-than-ideal circumstances.

However, this adaptability creates problematic inconsistency. As CP3 noted, *"There are no policies... nothing like that... It's up to the person,"* highlighting how reliance on individual values creates discretionary rather than systematic cultural responsiveness. The divergence here is that whilst literature emphasises systemic solutions (curriculum reform, policy development, institutional transformation), the empirical reality verifies a gap wherein individual practitioners' ethics currently bridge the chasm between what systems should provide and what they deliver. This gap is both a strength (demonstrating nursing's ethical foundation) and a profound weakness (creating inequitable care quality dependent on which practitioner patients encounter).

Another divergence emerges around professional identity navigation. Literature, particularly SANC regulations and professional codes, positions professional ethics as straightforward application of non-discriminatory principles. However, the finding that nurses experience ongoing tension between professional obligations and personal or cultural beliefs exemplified by PN1's statement, *"Even if my personal beliefs differ, I treat every patient with respect,"* and CP3's reflection, *"As a nurse I must manage my cultural identity alongside my professional role"* reveals professional identity as site of ongoing negotiation rather than settled application of clear principles.

This complexity is undertheorised in much of the literature reviewed, which too often present professional standards as self-evidently applicable rather than as requiring sophisticated navigation when personal, cultural, and professional identities intersect. The finding that culturally embedded nurses experience tensions managing traditional and professional identities suggests that decolonising nursing education must address not merely curriculum content, but the deeper question of how professional socialisation affects nurses' relationships with their own cultural traditions (Ngunyulu et al., 2020:3).

- **Synthesis: Multi-modal competency development**

The convergence between findings and literature establishes that cultural competency development is multi-modal, requiring personal ethical commitment, formal education, experiential learning, peer knowledge transfer, and ongoing professional identity negotiation. However, the divergence confirms that current systems fail to provide adequate support across

these domains, leaving individual nurses to bridge gaps through personal initiative rather than through systematic institutional support.

This finding extends Aitken, Buckley and Marshall's (2024:3) framework emphasising "holistic care approaches that extend beyond physical health" to address "emotional, social and cultural aspects of health" by contending that holistic approaches require not merely individual practitioner commitment but comprehensive institutional transformation addressing education, policy, resources, and organisational culture simultaneously. The pathway to cultural competence is not linear progression from ignorance to knowledge through education alone, but rather complex, ongoing developmental process requiring support at multiple levels throughout nurses' careers.

Theme 2: Systemic barriers and institutional challenges in culturally sensitive healthcare

Areas of convergence with literature

The identification of structural discrimination as a pervasive barrier strongly confirms Daniels and Mtshali's (2023:203) finding that "nurses in the Western Cape fail to integrate cultural traditions due to institutional constraints, a lack of cultural sensitive training and negative attitudes toward traditional beliefs." The visceral statement by CP5, *"They look at us and think we are not educated, so they don't listen when we try to explain our ways"* provides empirical confirmation of the "racial and cultural hierarchies embedded within healthcare systems" that scholars have theoretically described.

Moyo and Mkhize's (2022:18) observation that "traditional medicine is regarded as unscientific and inferior, despite its widespread use and community trust" is directly validated by PN4's account: *"Some of the traditional practices are dismissed by nurses they see it as backward."* This convergence between scholarly analysis and lived experience confirms that colonial hierarchies positioning Western biomedicine as superior and indigenous healing as primitive continue to shape healthcare interactions despite formal policies proclaiming equality and respect.

The finding is that *"there is no place to call our elders or traditional healers when the patient asks for it. The hospital does not allow it"* (PP2) provides indisputable evidence of the institutional

exclusion that Maphumulo and Bhengu (2023:245) described when noting that the Traditional Health Practitioners Act's "actual implementation has been prevented by inter-professional tensions, policy ambiguity and resource constraints." The gap between policy recognition (the THP Act of 2007 formally recognising traditional healers) and practical exclusion (hospitals not creating space for traditional healer consultation) confirms scholars' critiques that legislative frameworks have not translated into meaningful practice change.

Communication gaps identified in this study directly align with literature emphasising language barriers and inadequate interpretative services. PN7's candid admission *"We don't always have an interpreter... then we guess what the patient is saying"* provides stark empirical confirmation of the communication failures that literature identifies as compromising care quality and safety. This finding validates WHO's (2022:4) concern that healthcare systems inadequately address linguistic and cultural diversity, creating "inequities in healthcare delivery" that "limits the responsiveness of systems to the cultural realities of minority communities" (Clark & Draper, 2023:57).

The resource constraint barriers identified through PN6's statement *"With so many patients, we can't spend time on cultural rituals we have to finish the ward round"* strongly confirms Daniels and Mtshali's (2023:203) identification of "institutional constraints" as primary barrier to cultural integration. The physical infrastructure limitations noted by CP3 *"There is no space for people to do their ritual washing or prayers in this clinic"* validates scholarly critiques that healthcare facilities fail to create physical environments accommodating cultural practices, thereby communicating through spatial organisation what institutions value.

The human cost of resource constraints articulated by PN8 *"The workload is too heavy, so stress is carried over to how we deal with patients"* confirms literature's recognition that systemic pressures directly impact care quality. The focus group observation that *"we tend to focus on physical care... cultural preferences... not prioritised"* empirically demonstrates how institutional priorities and resource allocation decisions shape what receives attention in practice, validating scholarly arguments that cultural competence requires not merely individual commitment but adequate resourcing.

Professional boundary limitations identified in this study strongly align with Grant and Reed's (2024:12) observation that whilst "the oath clearly promotes equality and non-discrimination, it does not explicitly include guidance on IKS, nor does it adequately train nurses to engage with traditional methods." PN5's statement *"I cannot allow a patient to use herbs in hospital, because it's not part of my professional practice"* and PN1's observation that *"If it's not in the protocol, we can't do it. We must follow hospital rules"* confirm that scope of practice definitions and institutional protocols create rigidity that marginalises cultural practices even when individual nurses might personally support accommodation.

The policy and training inadequacies identified corroborate literature across multiple sources. PN3's observation that *"We don't have any policy on cultural care it depends on the nurse"* directly validates scholarly critiques of policy absence creating discretionary rather than systematic practice. PN9's account *"There was no formal teaching on cultural sensitivity in my training"* confirms Makhene's (2023:4) critique that nursing education remains "mainly based on Western modern frameworks, with IKS often ignored in the curriculum." CP1's statement that *"The Department does not recognise traditional healers at system level, so we can't integrate them"* empirically demonstrates the regulatory gaps scholars identify as preventing meaningful IKS-biomedical integration.

➤ **Areas of divergence from literature**

Whilst literature emphasises individual attitudes and training deficits as primary barriers to cultural competence (Mogale & Sibiya, 2022:78; Berman, Ncube & Venter, 2022:89), this study's findings show that even well-intentioned, culturally sensitive nurses face insurmountable systemic barriers. The divergence here is one of emphasis: literature tends to position the problem in nurses' knowledge or attitudes, whereas findings reveal structural constraints that prevent accommodation regardless of individual competence or commitment.

This divergence is illustrated through the split identified in the comparative analysis wherein some nurses (like PN10) described successful accommodation *"We as staff respected that... we had to call her to do her thing. We wouldn't just change the baby without her"* whilst others (like PN9) noted structural impossibility: *"There is no designated area here, and there's no anybody*

who has been allocated to look after those kinds of patients." The finding suggests that cultural competence is not merely individual attribute but systemic capacity requiring institutional enabling structures. This challenges deficit models in literature positioning nurses as lacking competence and reframes the problem as systems lacking resources, policies, and infrastructure to cultivate culturally responsive care.

Another divergence emerges regarding communication barriers. Literature often frames language barriers as technical problems requiring interpreter services (WHO, 2022:4). However, findings reveal more complex cultural communication challenges extending beyond language to encompass non-verbal cues, cultural scripts, and power dynamics. PN2's observation that *"Sometimes the gestures mean something different in their culture, but we interpret it wrong"* suggests that effective cross-cultural communication requires more than linguistic translation; it requires cultural interpreters and language brokers who can facilitate mutual understanding across different conceptual frameworks and communication styles.

This finding challenges technical-rational approaches to addressing communication gaps and suggests that solutions must be more sophisticated than simply providing interpreters. The mutual avoidance of potentially awkward conversations about cultural practices that the analysis identified with PN9 stating, *"I didn't want to interfere... I didn't want to be rude and ask her"* and PP9 admitting, *"Maybe I just avoid conflict"* illustrates that communication barriers are not merely about language but about power, fear, and institutional cultures that have not created spaces for honest cross-cultural dialogue.

- **Synthesis: Comprehensive systemic failure**

The convergence between findings and literature establishes that systemic barriers operate at multiple levels: structural discrimination, communication gaps, resource constraints, professional boundaries, and policy voids creating comprehensive institutional framework actively impeding cultural competence. However, the divergence reveals that literature's emphasis on individual deficits (knowledge, attitudes, training) inadequately captures the structural nature of these barriers.

The findings suggest that even optimal individual competence cannot compensate for systemic failures. As Molefe and Ramlall (2021:145) noted, "there is still insufficient policy-driven integration between these systems, resulting in disjointed service delivery and missed chances for collaboration," a reality this study confirms empirically. However, the findings extend this critique by revealing how resource constraints, physical infrastructure limitations, professional rigidity, and absence of policy interact to create conditions wherein cultural accommodation becomes practically impossible regardless of individual nurses' knowledge, values, or intentions.

This has important implications for intervention design. If barriers are primarily systemic rather than individual, then solutions must emanate from structural policy reform, justice-oriented resource allocation, infrastructure redesign, professional boundary redefinition rather than merely educational. This does not diminish the importance of cultural competence education but rather positions it as necessary component of comprehensive transformation requiring simultaneous change at multiple system levels.

- **Theme 3: Knowledge system conflicts in healthcare interactions**

- **Areas of convergence with literature**

The epistemological and ontological divide between spiritual and biomedical frameworks of illness identified in this study strongly confirms Nemutandani, Hendricks and Mulaudzi's (2020:3) observation that "many healthcare professionals have concerns or negative attitudes regarding traditional medicine, owing to perceived conflicts between spiritual and scientific worldviews." PN7's statement that "*Some patients still say their sickness comes from witchcraft, not from infection*" illustrates the stark conceptual differences that Makhavhu, Mulaudzi and Mothiba (2021:6) describe as creating "*tensions*" between IKS and formal healthcare.

However, the finding that nurses recognise the need to engage respectfully with these different frameworks as PN1 articulated, "*We are trained in science, but we must listen when they bring their beliefs*" suggests a more sophisticated node than literature sometimes acknowledges. This pragmatic engagement aligns with Shakwanes' (2022:2) call for "integrating diverse cultural

perspectives into nursing care" whilst acknowledging the epistemological and ontological challenges such integration entails.

The pattern of sequential help-seeking wherein *"Some people first go to the traditional healer and only come here when things are very bad"* (PN6) confirms Booth's (2023:1) observation that "traditional healers" are "the initial point of contact for health-related problems, particularly in rural and underserved areas." This finding validates that medical pluralism is normative in South African healthcare contexts, with Mulaudzi and Lebeso (2022:30) noting that "traditional healers are generally more accessible than Western practitioners, with one traditional healer per 500 people against one Western medicine doctor per 40,000 people."

The skepticism towards biomedicine expressed by patients, *"Patients sometimes say the hospital medicine is too strong and not for them"* (PP2) aligns with community perspectives documented in literature. The spiritual framing wherein *"They say it is the ancestors who allow healing, not the doctor"* (CP4) confirms Kendi's (2024:18) observation that traditional medicine reflects "holistic approach, which addresses physical, spiritual and emotional components of health," positioning healing as ultimately dependent on spiritual forces rather than merely technical intervention.

The protection of sacred knowledge identified through PN2's observation *"Traditional healers don't tell everything; they keep some knowledge as sacred"* confirms literature's recognition that traditional healing operates under different epistemological rules than biomedicine. This aligns with indigenous knowledge protection as documented across African healing traditions, wherein knowledge transmission follows spiritual protocols rather than academic dissemination models.

The contrast in diagnostic approaches identified through PN5's statement *"Traditional healers look at the whole person their family, their spirit, their background"* versus PN8's acknowledgement that *"In the clinic we focus on the symptom fever, cough but they look for deeper meaning"* strongly confirms Masemola, Thobakgale and Govender's (2023:2) emphasis on traditional medicine's holistic orientation addressing not merely physical symptoms but

broader life contexts. This convergence validates scholarly characterisations of traditional healing as comprehensive approach transcending biomedical symptom-focused frameworks.

➤ **Areas of divergence from literature**

Whilst literature often presents epistemological conflicts in oppositional terms traditional versus biomedical, spiritual versus scientific, holistic versus reductionist, the findings suggest a more nuanced reality wherein patients and some practitioners navigate between systems pragmatically rather than experiencing them as irreconcilable alternatives. CP2's observation that *"Some use both treatments at the same time, saying one is for the body, and one is for the spirit"* suggests complementary rather than competing paradigms, challenging binary framings common in literature.

This finding diverges from literature emphasising conflict (Makhavhu, Mulaudzi & Mothiba, 2021:6; Nemutandani, Hendricks & Mulaudzi, 2020:3) by revealing patients' sophisticated integration strategies wherein different systems address different dimensions of illness. PP2's assertion that *"If you do both things, you will see progress... you will see that it's working"* positions integration as obvious and beneficial rather than conceptually problematic, suggesting that epistemological tensions experienced by providers may not be shared by patients who pragmatically utilise whatever healing resources are available.

Another divergence emerges regarding sacred knowledge. Literature frames knowledge protection as barrier to integration (Maluleka & Ngoepe, 2019:368), positioning transparency and scientific verification as prerequisites for legitimacy. However, PP1's explanation is that *"They don't disclose everything to everyone. There are things that are kept sacred"* suggests that protection reflects valid epistemological principles about knowledge as power requiring responsible stewardship rather than mere secrecy impeding progress.

This finding challenges biomedical dispositions about knowledge as public good requiring open dissemination and suggests that genuine integration must respect different knowledge epistemologies rather than demanding that traditional knowledge conform to biomedical validation criteria. The divergence here is profound: literature often positions traditional healing

as needing to prove itself through biomedical frameworks, whereas findings suggest that meaningful integration requires biomedicine to accept that not all legitimate knowledge operates according to biomedical epistemological rules.

The finding regarding belief-dependent healing efficacy PP3's statement that *"Some patients say the herbs work because they believe in them if you don't believe, they don't"* challenges biomedical frameworks dismissing belief effects as merely placebo. From a biomedical perspective, belief-dependent efficacy suggests lack of "real" pharmacological effects. From a traditional healing perspective, belief is integral to healing. This epistemological divide remains unresolved in literature and findings alike, but the findings emphasise patients' frameworks positioning belief as legitimate healing trope rather than as confounding variable requiring control.

- **Synthesis: Epistemological pragmatism**

The convergence between findings and literature confirms that profound epistemological differences exist between traditional and biomedical frameworks regarding causation of illness, diagnostic approaches, and treatment regimes. However, the divergence suggests that whilst providers experience these as conceptual tensions requiring reconciliation, patients navigate between systems pragmatically, utilising whichever approach seems effective for conditions regardless of epistemological coherence.

This finding means that integration efforts should prioritise practical coordination over epistemological reconciliation. As WHO (2023:15) emphasises in its Traditional Medicine Strategy 2023-2032, integration should "promote the safe and effective use of traditional medicine by integrating it into formal health systems through regulation, research and teaching." The findings support this pragmatic approach whilst challenging assumptions that integration requires epistemological consensus or that traditional healing must prove itself through biomedical validation criteria.

The way forward suggested in the findings is epistemological humility and pragmatic pluralism that enables the respectful coexistence of different healing paradigms rather than insisting on a

singular epistemological coherence. This aligns with decolonial approaches advocated by scholars like Ngunyulu et al., (2020:3) and Tuck & Yang (2016) whilst extending their arguments by revealing that epistemological pluralism is not merely theoretical position but lived reality for many patients already navigating multiple healing systems simultaneously.

- **Theme 4: Patient navigation and agency in healthcare systems**

- **Areas of convergence with literature**

The sophisticated dual healthcare system strategies identified in this study strongly confirm Booth's (2023:1) observation that "approximately 60% of citizens seek traditional healers in South Africa, typically in conjunction with the Western medicine." PN6's observation that "*Many patients will first go to the traditional healer, then come to the clinic when they are not getting better*" corroborates the sequential help-seeking pattern documented throughout literature on African healthcare utilisation.

The complementary use identified through CP2's statement "*Some use both treatments at the same time, saying one is for the body, and one is for the spirit*" aligns with Kendi's (2024:18) characterisation of traditional medicine's "holistic approach, which addresses physical, spiritual and emotional components of health" alongside biomedical physical interventions. This convergence confirms that medical pluralism is normative rather than exceptional in South African contexts, validating WHO's (2022:4) assertion that "nearly 80% of the population in underdeveloped countries relies on traditional medicine for their primary healthcare."

The finding regarding concealment and fear-based interactions provides powerful empirical confirmation of literature's identification of communication barriers and patient reluctance to disclose traditional medicine use. PN3's observation that "*They don't tell us they are drinking traditional medicine, because they think we will shout at them*" directly validates Masemola, Govender and Mafutha's (2023:4) finding that "nurses... often experience discomfort or ethical issues when patients confess utilising traditional medicine." The concealment strategy described by PN10 "*Patients are sometimes dishonest they hide herbs or mixtures under the bed*" confirms that non-disclosure creates information gaps compromising care quality and safety, as Molefe

and Ramlall (2021:140) warned when noting that "patients combine herbal treatments with prescription drugs without alerting their nurses or doctors."

CP1's statement that *"They are afraid the nurse will refuse to treat them if they say they went to the healer"* provides empirical evidence of the fear dynamics that Nuuyoma, Muvumwaeni and Chihururu (2024:3), described when noting "community dissatisfaction with nurses' lack of cultural sensitivity." This convergence establishes that concealment is not mere patient irrationality but a delicately considered protective strategy responding to actual experiences or anticipations of provider judgment and dismissal.

Economic factors identified as driving healthcare navigation strongly confirm literature's emphasis on traditional medicine's accessibility and affordability. PN7's observation that *"Because of money problems, they start with the traditional healer it is cheaper"* directly validates Kendi's (2024:19) explanation that "traditional healers" are chosen due to "accessibility, affordability and traditional healer's holistic approach." PP5's note that *"Hospitals are free, but the transport costs make people look for affordable alternatives nearby"* confirms that indirect costs create effective barriers even when services are nominally free, aligning with literature recognising economic constraints as shaping healthcare access (Mulaudzi & Lebese, 2022:30). The resistance mechanisms identified through PN8's observation that *"Some refuse treatment when they feel the nurse is disrespectful to their culture"* confirm literature's recognition that respectful treatment affects care-seeking behaviour. The progression described by PP3 *"I have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared"* provides powerful validation of Dlamini, Mkhize and Khanyile's (2021:111) finding that "unfavourable or indifferent attitudes by nurses increase patient reluctance to share cultural practices."

➤ **Areas of divergence from literature**

Whilst literature often frames dual healthcare system use as patient confusion or lack of health literacy requiring education (Clark & Draper, 2023:57), the findings suggest sophisticated strategic navigation based on nuanced assessments of each system's comparative advantages. PP4's differentiation that *"It depends on the condition they might trust the hospital for broken*

bones but the healer for stomach problems" demonstrates healthcare literacy rather than confusion, suggesting patients make informed choices about which systems to utilise for which conditions based on accumulated experience and community knowledge.

This divergence challenges deficit models positioning pluralistic healthcare use as a problem requiring correction through patient education. The findings suggest instead that medical pluralism reflects rational decision-making wherein patients maximise available healing resources rather than exhibiting ignorance or irrationality. This aligns more closely with WHO's (2023:5) emphasis on "patient-centred care, highlighting the importance of healthcare professionals taking patient's values, beliefs and preferences into account" rather than with approaches treating deviation from biomedical compliance as ignorance requiring remediation.

Another significant divergence emerges regarding concealment. Literature tends to frame non-disclosure as communication problem requiring better information-gathering techniques or trust-building (Molefe & Ramlall, 2021:140). However, findings show concealment as rational protective strategy responding to actual power imbalances and risks of discrimination. When CP1 states that patients fear nurses will *"refuse to treat them if they say they went to the healer,"* this suggests that concealment protects patients from anticipated harm rather than merely reflecting poor communication.

This finding challenges and questions technical solutions focusing on improving disclosure through better interrogation techniques and suggests that addressing concealment requires transforming power dynamics and provider attitudes creating the conditions necessitating concealment. The divergence here is between technical-rational approaches treating concealment as information problem versus critical approaches recognising concealment as response to structural inequality and discrimination.

The finding regarding resistance mechanisms also diverges from literature's framing. Whilst literature often characterises patient non-compliance or care avoidance as problematic behaviour requiring intervention (Department of Health, 2022:45), findings reveal these as legitimate responses to disrespectful treatment. PP2's assertion that *"They say, 'It's my choice*

to be healed my way"" frames refusal not as non-compliance but as autonomous decision-making, challenging medical paternalism positioning providers as authorities whose recommendations should be followed unquestioningly.

This divergence suggests need to reframe "non-compliance" as patient agency and to recognise that care avoidance may reflect rational assessment that healthcare environments are culturally unsafe rather than patient irrationality or ignorance. This aligns with rights-based frameworks emphasising patient autonomy (SANC, 2023:14) but extends them by revealing that respecting autonomy requires not merely obtaining consent but creating conditions wherein patients feel safe exercising autonomy without fear of discrimination or care withdrawal.

- **Synthesis: From compliance to partnership**

The convergence between findings and literature establishes that patients demonstrate remarkable strategic agency in navigating healthcare systems, utilising multiple healing modalities, making condition-specific choices, and protecting themselves through concealment and resistance when systems fail to respect their cultural beliefs. However, the divergence illustrates that literature often frames patient agency negatively such as non-compliance, concealment, or resistance requiring correction whereas findings suggest these represent legitimate responses to systemic failures.

This finding challenges compliance-focused frameworks and supports partnership models emphasising patient autonomy, cultural respect, and shared decision-making. As Zulu and Mtshali (2023:28) observe, "when nurses display cultural humility and openness, patient satisfaction improves," suggesting that creating conditions enabling open communication and genuine partnership requires transforming provider attitudes and institutional cultures rather than merely improving patient education or compliance strategies.

The way forward suggested by findings aligns with WHO's (2023:5) emphasis on "patient-centred care" whilst extending it to emphasise that patient-centredness in culturally diverse contexts requires not merely involving patients in decisions but fundamentally respecting their

epistemological frameworks, healing choices, and strategic navigation of multiple healthcare systems as legitimate expressions of agency rather than as problems requiring correction.

- **Theme 5: Dignity, respect, and human rights in healthcare interactions**

- **Areas of convergence with literature**

The finding that interpersonal respect functions as foundational to healing strongly confirms SANC's (2023:3) emphasis on nursing's core values including "compassion, empathy and respect for each patient's dignity, regardless of cultural, racial or socioeconomic status." PN6's articulation that *"We must listen to the patient without judging them, even if we don't share their beliefs"* directly reflects the professional ethics enshrined in SANC regulations and professional codes positioning respect as non-negotiable professional obligation.

CP2's assertion that *"Every patient deserves equal treatment, whether they come from the township or suburbs"* aligns with the SANC pledge stating that "I will not allow the standing of race, nationality, or religion to stand between my duty and my patients" (SANC, 2023:14), confirming that principles of equality are understood and endorsed across participant groups. The convergence here establishes that dignity and respect are universally recognised as foundational values, even when implementation remains inconsistent.

The finding regarding cultural identity preservation confirms literature's emphasis on holistic care approaches. PN5's observation that *"Some patients don't want to remove their traditional beads we must allow them"* validates Shakwane (2022:2) argument that culturally sensitive care must go "beyond physical health" to address "emotional, social and cultural aspects of health." The characterisation by CP1 that *"The headscarf or attire is part of identity forcing removal takes away dignity"* aligns with Aitken, Buckley and Marshall's (2024:3) emphasis that nursing must "address the emotional, social and cultural aspects of health, ensuring that care is not only medically sound but also culturally appropriate and emotionally supportive."

The commitment to non-discriminatory care articulated by PN1 "We cannot discriminate on race or culture healthcare is for all" confirms that South African nursing has formally embraced

equality principles, aligning with constitutional values and professional ethics. However, the acknowledgement by CP4 that *"I have seen patients treated badly because of where they come from. This must stop"* teases the ongoing struggles to achieve these ideals in practice, validating Daniels and Mtshali's (2023:203) finding of persistent "institutional constraints" and "negative attitudes toward traditional beliefs."

The finding regarding emotional safety provides empirical confirmation of literature's identification of shame and fear as barriers to honest communication. PN8's observation that *"When a nurse laughs at a practice, the patient feels ashamed"* validates Nuuyoma, Muvumwaeni and Chihururu (2024:3) documentation of "community dissatisfaction with nurse's lack of cultural sensitivity." PP5's statement that *"Patients are sometimes afraid to say what they believe they hide it"* confirms that emotional fragility drives concealment, as Dlamini, Mkhize and Khanyile (2021:111) found when noting that "unfavourable or indifferent attitudes by nurses increase patient reluctance to share cultural practices."

The emphasis on patient autonomy articulated through PN4's statement that *"The patient must have the final say in what happens to their body"* aligns with WHO's (2023:5) emphasis on "patient-centred care" and with South African constitutional principles of bodily integrity and self-determination. PP1's assertion that *"We should respect when someone says, 'I choose this treatment'"* and CP3's statement that *"Consent is essential it's their right"* confirm that autonomy is recognised across participant groups as fundamental right rather than discretionary courtesy.

➤ **Areas of divergence from literature**

Whilst literature emphasises dignity and respect as professional standards and ethical obligations (SANC, 2023:3), the findings identify significant gaps between rhetorical commitment and practical reality. The progression described by PP3 *"I have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared"* demonstrates that violations of dignity are not merely abstract ethical concerns but concrete harms with serious health consequences.

This divergence between stated values and lived experiences challenges assumptions that professional socialisation successfully instils respectful practice. The finding that disrespect occurs despite universal rhetorical endorsement of respect principles suggests that the problem lies not in nurses rejecting dignity principles but in structural factors (workload pressures, inadequate training, institutional cultures) that prevent even well-intentioned nurses from consistently providing dignified care.

Another divergence emerges regarding cultural identity preservation. Whilst SANC emphasises treating all patients with dignity "regardless of cultural, racial or socioeconomic status" (2023:3), the focus on "regardless" reflects a colour-blind approach that may inadequately address the need for active cultural accommodation. The finding that cultural identity preservation requires positive action creating space for cultural practices, accommodating cultural symbols, facilitating family involvement in culturally significant ways suggests that genuine dignity requires going beyond non-discrimination to active inclusion and accommodation.

This challenges liberal non-discrimination frameworks positioning equal treatment as treating everyone the same "regardless" of difference, revealing instead that genuine equality requires differential treatment, acknowledging and accommodating cultural difference. PP3's observation that *"Recognising these cultural practices shows we value them as people"* suggests that dignity is achieved not through ignoring difference but through actively valuing it, a more demanding standard than simple non-discrimination.

The finding regarding autonomy also reveals tensions. Whilst all groups endorsed autonomy rhetorically, PN7's statement *"Sometimes we know what's best, but they want something else... It's difficult"* confirms ongoing struggles with medical paternalism. Literature often presents autonomy and beneficence as straightforwardly reconcilable through informed consent processes (Grant & Reed, 2024:12), but findings reveal persistent tensions when patients make choices that providers believe are harmful.

This divergence suggests that respecting autonomy in culturally diverse contexts requires more sophisticated approaches than standard informed consent models. When patients choose

traditional healing over biomedical treatment for conditions that providers believe require biomedical intervention, or when cultural frameworks lead to decisions providers view as harmful, respecting autonomy requires tolerating choices with which one disagrees a more demanding ethical stance than literature often acknowledges.

- **Synthesis: Dignity as multi-dimensional practice**

The convergence between findings and literature establishes dignity, respect, and autonomy as universally endorsed values enshrined in professional codes, constitutional principles, and ethical frameworks. However, the divergence verifies significant implementation gaps wherein these values are inconsistently realised in practice, creating experiences ranging from profound respect to serious dignity violations depending on which practitioner's patients encounter and what institutional contexts exist.

The finding that PP3's experience of disrespect led to care avoidance with potentially serious health consequences demonstrates that dignity is not merely abstract ethical concern but a practical prerequisite for effective healthcare delivery. As Zulu and Mtshali (2023:28) observe, "when nurses display cultural humility and openness, patient satisfaction improves," confirming that dignity directly affects care quality and health outcomes. However, findings extend literature by revealing that dignity requires not merely individual practitioner attitudes but comprehensive systemic support. PN2's statement that *"We should preserve dignity, so the patient feels safe emotionally"* positions dignity as active practice requiring deliberate institutional and individual effort rather than as passive absence of overt discrimination. This aligns with Berman, Ncube and Venter's (2022:89) call for "Cultural Competency in Nursing Practice: Towards Equitable Healthcare" whilst emphasising that achieving equity requires systemic transformation addressing policies, resources, training, and organisational cultures simultaneously rather than merely changing individual attitudes.

- **Theme 6: Professional identity and ethical navigation in cultural healthcare**

➤ Areas of convergence with literature

The finding that professional identity involves complex navigation of boundaries, ethical dilemmas, and personal-professional integration strongly confirms Grant and Reed's (2024:12) observation that whilst nursing codes promote equality and non-discrimination, they "do not explicitly include guidance on IKS, nor does it adequately train nurses to engage with traditional methods." PN3's statement that *"There are limits to what I can do because of my scope of practice"* directly reflects the professional constraints identified in literature, wherein nursing's scope of practice is defined around biomedical interventions without clear guidance regarding cultural accommodation or IKS engagement.

The ethical dilemmas nurses face exemplified by PN5's statement, *"Sometimes I must choose between saving a life and respecting a ritual"* confirms the complexity of navigating competing values that Mogale, Lekota and Tshabalala (2021:92) describe as creating "tensions" in practice. CP4's observation that *"There are cases where safety comes first, even if it means not following culture"* validates that nurses experience genuine ethical conflicts requiring contextual judgment rather than simple rule application, aligning with literature's recognition of healthcare ethics as involving deliberation rather than mechanical application of principles.

The finding regarding personal-professional integration, particularly PN1's statement *that "Even if my personal beliefs differ, I treat every patient with respect,"* confirms SANC's professional socialisation successfully instils commitment to respect transcending personal preferences. However, CP3's reflection that *"As a nurse I must manage my cultural identity alongside my professional role"* reveals tensions that Makhene (2023:6) identifies when noting that nursing education often creates distance from cultural traditions, requiring nurses to navigate between professional and cultural identities.

The call for institutional accountability through PN6's statement *"We need protocols that guide us in cultural cases"* validates literature's emphasis on policy development as prerequisite for systematic cultural competence. The observation by CP5 that *"Institutions should collaborate more with community systems"* aligns with recommendations throughout literature for greater

institutional-community partnerships (Mulaudzi & Lebesse, 2022:35). PN2's note that *"There is little training provided for these issues"* confirms persistent educational gaps despite repeated scholarly calls for curriculum reform (Ngunyulu et al., 2020:3; Makhene, 2023:5).

The emphasis on continuous learning articulated through PN4's statement *"We must continue with cultural education things are always changing"* aligns with Shakwane (2022:2) argument that "culturally sensitive patient care should go beyond cosmetic acknowledgements of diversity and instead integrate cultural sensitive care into education, policy and service design" as ongoing developmental process. PN8's commitment to reflective practice *"I reflect on my experiences to improve next time"* confirms that nurses recognise cultural competence as requiring continuous growth rather than one-time achievement.

➤ **Areas of divergence from literature**

Whilst literature emphasises individual nurses' knowledge or attitude deficits as barriers to cultural competence (Mogale & Sibiyi, 2022:78), findings reveal that even culturally knowledgeable, respectful nurses face constraints from professional boundaries and institutional limitations. The finding that PN10 facilitated accommodation *"We as staff respected that... we had to call her to do her thing"* whilst PN9 found it impossible *"There is no designated area here"* suggests that facility-level factors beyond individual competence determine whether cultural accommodation occurs.

This divergence challenges individualistic framings locating cultural competence primarily in practitioners' knowledge or attitudes and reveals instead that professional identity and ethical navigation occur within institutional contexts that either enable or constrain culturally responsive practice. The split between nurses reporting successful accommodation and those highlighting structural impossibilities suggests that focusing on individual competence without addressing systemic enablers is insufficient.

Another divergence emerges regarding ethical dilemmas. Literature tends to present these as resolvable through ethical frameworks, education, and reflective practice (Grant & Reed, 2024:12). However, PN6's reflection *"I still think about some situations years later, wondering if*

I did the right thing" suggests that some dilemmas remain genuinely irresolvable, creating moral residue that persists despite thoughtful deliberation. This finding challenges assumptions that ethical competence eliminates or resolves all dilemmas, revealing instead that ethical practice in culturally complex contexts involves ongoing uncertainty and moral discomfort that practitioners must learn to tolerate rather than eliminate.

The finding regarding institutional accountability also diverges from literature's primary emphasis on curriculum reform. Whilst education remains important, PN8's call for comprehensive change *"We need policy, training, resources, and leadership support not just one but all of them together"* suggests that educational interventions alone are insufficient. This extends scholarly recommendations for curriculum reform (Ngunyulu et al., 2020:3; Mtetwa & Khumalo, 2022:122) by revealing that education must be coupled with policy development, resource allocation, infrastructure redesign, and leadership commitment to create systematic cultural competence.

These findings challenge linear models assuming education produces competence which in turn yields practice change. Instead, findings suggest that education, policy, resources, and organisational culture must transform simultaneously for meaningful change to occur. Individual competence cannot compensate for policy voids, resource scarcity, or discriminatory organisational cultures; conversely, policies unsupported by education, resources, or leadership commitment remain symbolic rather than transformative.

- **Synthesis: Professional identity as continuous navigation**

The convergence between findings and literature establishes that professional identity in culturally diverse contexts involves ongoing navigation of boundaries, dilemmas, and personal-professional tensions rather than settled application of clear principles. However, the divergence reveals that literature's emphasis on individual development (knowledge, attitudes, skills) inadequately addresses the systemic constraints shaping professional practice.

The finding that even ethically committed, culturally knowledgeable nurses face structural barriers validates Daniels and Mtshali's (2023:203) identification of "institutional constraints" as primary barriers whilst extending this critique by contending that addressing these constraints

requires comprehensive transformation beyond curriculum reform. The pathway suggested by findings aligns with Matahela and Makhanya's (2024:286) call for "national policy framework" but emphasises that policy alone is insufficient without training, resources, infrastructure, and organisational culture change occurring simultaneously.

This finding has important implications for professional development. If cultural competence is not merely an individual attribute but capacity requiring institutional facilitation, then professional development must address not only individual learning but also advocacy skills allowing nurses to challenge and transform systems. PN4's description of advocacy "*I've been advocating for cultural policies... It's slow, but I think we're making progress*" suggests that professional identity in culturally diverse contexts must encompass not only clinical competence but also change agency capable of transforming constraining structures.

- **Conclusion: Synthesis across themes**

This discussion has establish a complex interplay between convergence and divergence across six major themes. The findings confirm substantial bodies of literature regarding cultural competence development pathways: systemic barriers, epistemological conflicts, patient agency, dignity imperatives, and professional identity challenges. However, findings also extend, challenge, and recalibrate existing scholarship and research in important ways.

Key areas of convergence establish that:

- Cultural competence develops through multiple pathways requiring personal values, formal education, experiential learning, peer knowledge, and professional identity navigation
- Systemic barriers operate at multiple levels (discrimination, communication, resources, professional boundaries, policy) creating comprehensive structural resistance to cultural competence
- Profound epistemological differences exist between traditional and biomedical frameworks regarding illness causation, diagnosis, and treatment

- Patients demonstrate sophisticated strategic agency navigating multiple healthcare systems whilst protecting themselves through concealment and resistance when necessary
- Dignity, respect, and autonomy are universally endorsed as foundational values, although these are inconsistently realised in practice
- Professional identity in culturally diverse contexts entails ongoing ethical navigation and continuous learning throughout careers.

Key areas of divergence reveal that:

- Personal values and experiential learning often compensate for educational deficits, enabling cultural responsiveness even when formal training is inadequate
- Systemic barriers constrain even culturally competent, well-intentioned nurses, challenging literature's emphasis on individual deficits
- Patients navigate epistemological and ontological differences pragmatically whilst providers experience them as conceptual tensions, suggesting different priorities for integration efforts
- Patient agency expressed through concealment and resistance reflects rational responses to power imbalances rather than problems requiring correction through education or compliance interventions
- Dignity requires active accommodation of difference rather than merely treating everyone the same "regardless" of cultural identity
- Professional identity challenges are shaped primarily by institutional constraints rather than individual competence deficits, requiring systemic transformation beyond curriculum reform

These convergences and divergences together suggest that whilst substantial scholarship has identified key challenges in achieving culturally sensitive healthcare, solutions remain frayed and inadequately developed. Literature has successfully diagnosed problems with educational deficits, systemic barriers, epistemological conflicts, dignity violations but has been less successful in articulating comprehensive transformation strategies that address root causes rather than merely ameliorating symptoms.

The way forward must be multi-level and comprehensive, addressing individual competency development, institutional policies and resources, organisational cultures, professional education reform, and regulatory frameworks simultaneously. As WHO's (2023:15) Traditional Medicine Strategy 2023-2032 recognises, achieving integration of traditional and biomedical approaches requires "regulation, research and teaching" operating in concert rather than in isolation.

However, findings extend WHO's framework by revealing that genuine cultural competence requires more than integration of specific practices; it demands fundamental transformation of power relations, epistemological humility enabling respectful coexistence of different knowledge systems, and partnership models positioning patients as primary decision-makers whose agency is respected rather than managed. This represents a significant paradigm shift from compliance-focused frameworks to genuinely patient-centred approaches recognising and respecting cultural diversity as strength rather than challenge to be managed.

The discussion has demonstrated that achieving this transformation requires not merely goodwill or individual commitment, but systematic institutional change supported by adequate resources, clear policies, comprehensive education, and organisational cultures genuinely valuing cultural diversity. The findings provide empirical foundation for such transformation whilst also revealing the profound challenges structural, epistemological, political, economic that must be addressed to achieve genuinely culturally sensitive healthcare in South Africa's diverse metropolitan contexts.

5.3 INTERPRETATION OF FINDINGS AND IMPLICATIONS

- **Areas of similarity and difference in participant perspectives**

This section presents a detailed comparative analysis of participant perspectives, examining both individual-level and group-level patterns across the dataset. Rather than presenting distinct themes, these areas illuminate where participants converge in their views and where they diverge, offering insights into the complex landscape of cultural accommodation and healing practices within healthcare settings in the Western Cape, South Africa. The analysis is structured

to first examine individual-level variations before moving to group-level comparisons, recognising that both levels of analysis are essential for understanding the nuanced ways in which cultural beliefs, healing practices, and healthcare interactions are experienced and negotiated.

- **Individual-level similarities and differences**

The analysis established substantial variation in how individual participants positioned themselves regarding cultural accommodation, traditional healing, and biomedical care. These individual-level patterns reflect the deeply personal nature of healing beliefs and practices, shaped by lived experiences, cultural socialisation, religious conviction, and encounters with healthcare systems. Understanding these individual variations is crucial before examining group-level patterns, as it reveals the heterogeneity within participant categories and guards against oversimplified generalisations about how 'nurses think' or how 'patients behave.'

The table below presents these individual-level patterns, organised by key areas of convergence and divergence.

Table 5.1: Individual level patterns.

Area	Key Points of Similarity	Key Points of Difference
Cultural Accommodation	• Respect for cultural beliefs endorsed even within biomedical routines • Policy clarity seen as enabler of fairer handling • Accommodation happens when staff are aware and intentional	• Perceived lack of facilities vs. positive accommodation experiences • Respectful treatment linked to continued care; disrespect leads to avoidance • Physical care prioritised over cultural preferences • Behaviour depends on individuals in absence of policy
Traditional Healing Beliefs	• Effectiveness depends on personal belief • Both systems have limitations • Preference for combining systems rather than exclusive choice	• Complete rejection vs. selective/covert use • Comfort levels differ (traditional healers seen as nonjudgemental) • Nurses vary from neutral openness to skepticism • Training gaps limit referral capacity
System Integration	• Collaboration viewed as beneficia • Current collaboration acknowledged as non-existent • Community members ready to cooperate	• Active partnership vs. conditional referral models • Logistical barriers vs. ideological concerns • Safety concerns about harmful practices

Communication & Judgement	• Respectful communication improves cooperation • Judgement/disrespect causes care avoidance • Fear of offending leads to silence	• Concealment to avoid judgement vs. open negotiation • Nurses acknowledge gaps in cultural sensitivity • Setting boundaries vs avoiding conflict
Dignity & Autonomy	• Universal call for respecting belief and choice • Dignity linked to being seen, not judged • Respectful treatment encourages continued care	• Dignity as cultural expression vs independence/contribution • Operational limits constrain respect • Authority compliance vs self-assertion
Professional Identity	• Professional duty regardless of difference • Communication as an ethical strategy • Patients recognise both good and lacking practice	• Non-judgmental stance despite uncertainty • Discomfort and lack of confidence • Avoidance of cultural issues to prevent confrontation
Knowledge Systems	• Different systems exist and compete • No single system universally sufficient	• Biomedical superiority vs. traditional supremacy • Spiritual frameworks prioritised by some • Conditional or covert hybridisation common
Patient Navigation	• Strategic switching between systems • Comfort and dignity influence care-seeking • Open conflict avoided	• Assertive autonomy vs. quiet resistance/concealment • Complete disengagement vs.unquestioning compliance

Healing Approaches	• Shortcomings in purely clinical treatment recognised • Holistic care means being seen spiritually/emotionally/culturally • Care beyond symptoms needed	• Strict biomedical logic vs. belief/faith as core • Toggling between approaches by condition

- **Discussion of individual-level patterns**

The individual-level analysis reveals a landscape characterised not by binary oppositions between 'traditional' and 'modern' worldviews, but rather by multiple, intersecting continua along which participants position themselves in contextually contingent ways. This finding challenges essentialist assumptions that might categorise individuals as either 'believers in traditional healing' or 'adherents to biomedicine', revealing instead that most participants occupy complex, sometimes contradictory positions that shift depending on the health condition, the social context, and their previous experiences with different healing modalities.

➤ **Cultural accommodation: Between principle and practice**

Whilst endorsement of respect for cultural beliefs emerged as nearly universal across participants, the translation of this principle into practice had significant variation. The quotation from PN5 - *"For example, if it's an African patient... 'According to my culture, I can't do A, B, C, or D,' you must respect that. But still, you give the same care"* encapsulates a professional commitment to equitable care provision regardless of cultural difference. Yet this commitment exists alongside what PN9 described as structural impediments: *"There is no designated area here, and there's no anybody who has been allocated to look after those kinds of patients."* This juxtaposition highlights a critical gap between values and infrastructure, between what healthcare professionals believe should happen and what their institutional environments enable them to do.

The consequences of this gap manifest most clearly in patient experiences. PP3's narrative progression from "I have only come to this clinic" to "when nurses are not kind, it becomes difficult" to "Eventually, I went home without doing the test... I haven't gone back because I'm scared" illustrates how single negative encounters can rupture the therapeutic relationship and lead to care avoidance. This finding resonates with literature on patient-centred care, which consistently demonstrates that respectful, culturally sensitive communication is not merely a 'soft skill' but rather a fundamental determinant of care engagement, treatment adherence, and health outcomes. When respect is operationalised inconsistently - dependent on individual practitioners' awareness and inclination rather than embedded in systemic protocols - patients experience healthcare as unpredictable and potentially unsafe, leading to withdrawal or strategic concealment.

The call for policy frameworks emerged across multiple participants as a potential solution to this inconsistency. PN1's assertion that "When there's policy, it makes things smooth... we do it according to what the policy says or guidelines" reflects a professional desire for clarity and standardisation that would reduce individual decision-making burden whilst ensuring fairer treatment. However, CP3's observation that "There's no policies... nothing like that... It's up to the person" captures the current reality in which accommodation is personalised rather than systematised. This tension between the desire for guidelines and the absence of such frameworks creates what might be termed 'discretionary accommodation' - cultural responsiveness that depends on which staff member a patient encounters, their personal cultural knowledge, and their willingness to make individual exceptions to standard protocols.

➤ **Beliefs about traditional healing: The primacy of belief and the reality of pluralism**

The widespread acknowledgement that traditional healing's effectiveness depends substantially on personal belief - articulated by both PN11 ("It depends on... like, those things work if you believe in them") and PP8 ("I think it depends on what you believe.... if I don't believe, it won't work") - represents a significant finding that transcends disciplinary boundaries. This understanding positions belief not as a peripheral factor but as a central mechanism for healing,

a perspective that challenges purely materialist biomedical epistemologies whilst remaining acceptable even to biomedically trained professionals. The fact that nurses and patients converge on this point suggests a shared pragmatic recognition that healing involves more than biochemical processes alone.

Yet this convergence on the role of belief masks profound individual variation in positioning towards traditional healing. The spectrum ranges from outright rejection to religious grounds (PP4: "No, I wouldn't. As a Muslim, I rely on prayer..."; PP6: "No, I don't believe in traditional healers") through selective, covert use (PP11: "For me, yes. I would bring it, maybe hide it. Because I believe there are things hospitals can't heal...") to open preference (PP1: "I feel more relaxed and comfortable when I go there than when I go to the clinic... When you go there, they don't judge you"). This variation cannot be explained solely by cultural backgrounds or educational levels; rather, it reflects deeply personal negotiations between inherited cultural knowledge, religious conviction, individual experiences of healing and harm, and perceptions of which systems offer dignity and efficacy.

Particularly significant is PP1's association of traditional healers with non-judgement and comfort - a contrast with clinic experiences where the same participant felt blamed: "Sometimes... they'd say it's that medication you take." This suggests that what is often framed as preference for 'traditional' over 'modern' healing may be more accurately understood as preference for contexts where one's whole self is accepted rather than interrogated or condemned. The healing space becomes not merely a site of technical intervention but a social environment in which dignity, respect, and validation are either granted or withheld. When traditional healing spaces consistently offer these relational goods whilst biomedical spaces do not, patients' choices reflect rational evaluations of where they prefer getting treated as whole persons rather than mere bodies requiring technical repair.

The recognition by both nurses and community participants that both systems have limitations represents a crucial foundation for potential integration. CP1's observation that "The doctors, they don't know what's wrong with you, but the healers know" and PN5's acknowledgement that "Some wounds become septic because of the herbs used" each identify specific domains where

their respective systems encounter boundaries. Rather than locating these admissions as failures, they might be reframed as invitations for complementarity - recognition that different healing modalities address different dimensions of illness and offer different forms of knowledge.

The repeated advocacy by CP1 for integration - "I'll say both... I think they can work together... I think doctors and the traditional must just combine" - reflects what might be termed 'pragmatic pluralism': a stance that prioritises healing outcomes over ideological purity and recognises that patients' wellbeing may be best served by drawing on multiple knowledge systems. This multidimensional perspective aligns with growing international recognition of the need for integrative healthcare approaches that respect diverse healing traditions whilst maintaining safety and evidence standards.

However, nurses' openness to traditional healing remains constrained by training gaps and institutional frameworks.

PN7's lament that "Unfortunately... I don't have any module that will allow me to refer clients for traditional medicine" highlights a structural barrier: even nurses who wish to support patients' use of traditional healing lack formal mechanisms to do so. This creates an environment in which nurses adopt informal, individualised approaches - PN5's "If you believe, go for it" represents a guarded neutrality rather than active facilitation. The absence of formal training means nurses cannot provide informed guidance about potential interactions, contraindications, or complementary uses, leaving patients to navigate these complex decisions alone.

➤ **System integration: Desire without infrastructure**

The widespread agreement that collaboration between traditional and biomedical systems would be beneficial stands in stark contrast to the universal acknowledgement that such collaboration does not currently exist in any structured form. PN4's observation "No, not really. But I think it would be great if that connection existed" and PN3's assessment that "There's no structured understanding of how these two systems can work together" capture a gap between aspiration and reality. This gap is not primarily ideological; participants across categories expressed conceptual support for integration. Rather, it is infrastructural and procedural, reflecting the

absence of mechanisms, protocols, referral pathways, and regulatory frameworks that would enable collaboration.

Community participants positioned themselves as ready and willing collaborators. CP2's example "I will tell you to continue taking your medicine from the hospital because I don't have a cure for HIV... but I'll help your skin look nice" demonstrates sophisticated understanding of the scope of practice and complementary roles. This is not a naive rejection of biomedicine but rather strategic positioning: acknowledging biomedical authority for specific conditions (HIV requiring antiretroviral therapy) whilst claiming complementary space for quality-of-life interventions (addressing medication side effects through traditional remedies). CP5's invitation - "Why don't you come over to my workplace and see if I have a solution... in some parts... [we] can help each other" - further reflects openness to dialogue and mutual learning.

However, individual nurses' approaches to integration varied considerably, ranging from active encouragement of sequential use (PN5: "I'd advise... if no improvement, don't stay at home. Come to the clinic for a second opinion") to expressions of practical barriers (PN9: "I wouldn't know where to refer to") for safety concerns that create reluctance (PN5: "Some wounds become septic because of the herbs used"). This variation reflects the absence of institutional guidance: nurses develop their own informal approaches based on personal judgement, cultural knowledge, and risk assessment, resulting in patients receiving inconsistent messages depending on which healthcare provider they encounter.

The sequential model suggested by PN5 - trying traditional healing first, then seeking biomedical care if improvement does not occur - represents one informal integration strategy already being practiced. However, this approach is reactive rather than proactive, waiting for treatment failure before facilitating transition between health systems. More sophisticated models of integration might involve concurrent use with active communication between providers, formal referral networks, shared documentation systems, or integrated clinics where both biomedical and traditional practitioners work in tandem. The absence of such models in South African healthcare represents a missed opportunity, particularly given that patients are already using both systems simultaneously but doing so covertly without provider knowledge or coordination.

➤ **Communication, judgement, and the dynamics of disclosure**

The convergence across all participant groups on the principle that respectful communication improves cooperation suggests widespread recognition of the relationality in foundations of effective healthcare. PN2's observation that "If you do understand (their culture), it makes communication easier" and PN7's experience that "As soon as they understand what I'm doing, they are willing to cooperate" both position understanding and communication as enablers of therapeutic alliance. This aligns with substantial evidence demonstrating that patient-provider communication quality predicts adherence, satisfaction, and health outcomes across diverse cultural contexts.

However, the consistent finding that judgment or disrespect causes care avoidance reveals the fragility of this alliance. PP3's narrative - "When nurses are not kind, it becomes difficult... Eventually, I went home... I haven't gone back because I'm scared" - illustrates how single negative encounters can serve the therapeutic relationship, with potentially serious health consequences if needed care is foregone. PP1's experience of being blamed - "Sometimes... they'd say it's that medication you take" - demonstrates how judgement specifically targeting traditional medicine use creates an environment in which patients anticipate condemnation rather than support.

Fear of offending or causing conflict emerged as a significant factor constraining open communication from multiple directions. PN9's reluctance—"I didn't want to interfere... I didn't want to be rude and ask her" - and PP9's admission that "Maybe I just avoid conflict" both reflect a culture of avoidance rather than engagement. This creates a paradox: nurses avoid asking about traditional practices to prevent awkwardness or offence, whilst patients avoid disclosing these practices to prevent judgement. The result is silence on precisely the issues that need open discussion for safe, coordinated care.

The practice of concealment emerged as a particularly significant finding. PP11's strategy - "I would bring it, maybe hide it. Because I believe there are things hospitals can't heal" and CP1's simple "No, I didn't" when asked about disclosure reveal that patients are making sophisticated

risk assessments about when disclosure is safe. This concealment is not irrational or evidence of mistrust in general; rather, it is a targeted response to previous experiences or anticipated reactions. Patients who conceal traditional medicine use have often experienced or witnessed judgmental responses that taught them disclosure carries risks without any corresponding benefits. This finding has profound implications for patient safety and care quality.

When patients conceal traditional medicine use, healthcare providers cannot screen for herb-drug interactions, adjust dosages to account for concurrent treatments, or provide informed guidance about sequencing or coordination. The literature on medication reconciliation demonstrates that undisclosed complementary and alternative medicine use is a common source of adverse effects and treatment failures. Yet the solution is not simply to exhort patients to disclose; rather, it requires creating clinical environments in which disclosure is met with curiosity, respect, and collaborative problem-solving rather than judgement and dismissal.

Conversely, some participants described open negotiation and boundary-setting. The patient example recounted by PN5 - "According to my culture, I can't do A, B, C, or D - you must respect that" - and CP4's insistence that "They must allow everybody to do what he or she feels is right" represents assertive advocacy for cultural autonomy. These examples suggest that patients vary not only in their healing beliefs but also in their confidence and willingness to assert these beliefs within healthcare encounters. Factors such as education level, previous positive experiences with advocacy, social support, and perceived power differentials are likely to influence whether patients adopt assertive, negotiating, or concealing approaches.

Nurses' acknowledgement of gaps in their own cultural sensitivity - PN9's admission that "Personally for me, I don't think I'm really sensitive because I don't know about other cultures" - represents important reflexivity. This self-awareness could be a foundation for learning and growth, yet without institutional support through training programmes, cultural consultation services, or mentorship, individual nurses are left to navigate cultural complexity alone. The result is well-intentioned but potentially inadequate responses that may inadvertently perpetuate the very judgement, and misunderstanding nurses wish to avoid.

➤ **Dignity, autonomy, and competing frameworks of respect**

The universal calls for respecting personal belief and choice - articulated by CP4 ("They must allow everybody to do what he or she feels is right"), PP3 ("We are all equal, and those items are part of a person's culture"), and FG participants ("Ultimately you respect their beliefs") - establish dignity and autonomy as fundamental shared values across participant categories. This convergence might be understood through human rights frameworks that position cultural self-determination and respect for persons as basic entitlements regardless of context.

However, conceptualisations of what dignity means and how it is performed varied considerably. For some participants, dignity was intrinsically linked to permission for cultural expression within healthcare spaces. The focus group's conditional framing - "If it doesn't interfere... I'd let them keep them" - reveals a biomedical boundary: cultural expression is acceptable as long as it does not disrupt clinical protocols or compromise safety. This represents what might be termed 'permissive accommodation': respect granted within parameters defined by biomedical regulatory authority. PN9's observation that "There's no designated area here... nobody allocated to look after those patients" further highlights that even this limited accommodation depends on resources and planning that are currently absent.

For patient and community participants, dignity appeared more fundamentally, relational and emotional. CP4's assertion that cultural respect "gives dignity to the person as a person" and PP1's contrasting experiences - feeling judged at clinics but accepted at traditional healers ("When you go there, they don't judge you") - position dignity not as formal permission but as felt experience of being valued as a whole person. This understanding aligns with philosophical work on dignity that emphasises recognition, respect, and the acknowledgement of inherent worth rather than merely the absence of humiliation or degradation.

Some participants defined dignity through independence and contribution to community rather than through healthcare interactions per se. CP6's description—"I help the community... I give food, I support people" - locates dignity in active agency and social embeddedness rather than in being a recipient of care. This perspective resonates with African philosophical concepts such

as Ubuntu, which position personhood as fundamentally relational, and dignity as derived from one's contributions to collective wellbeing rather than individual autonomy alone.

Interestingly, some participants prioritised obedience to medical authority over personal autonomy. PP5's statement - "No. It's just... when the doctor says something, I do it" - reflects a model of healthcare in which expertise and authority justify directive rather than collaborative decision-making. This stance challenges Western bioethical frameworks that privilege patient autonomy and informed consent, suggesting that for some individuals, trust in professional expertise provides its own form of security and dignity. The diversity of these frameworks within the same cultural context underscores the importance of not assuming universal preferences for models of patient-provider relationships.

The relationship between respectful treatment and continued care engagement emerged as a consistent pattern. PP3's explanation - "Since then, I have only come to this clinic... But when nurses are not kind, it becomes difficult... I haven't gone back because I'm scared" - demonstrates that dignity is not merely an abstract right but a practical determinant of care continuity. When healthcare encounters are experienced undignified or disrespectful, patients vote with their feet, seeking care elsewhere or foregoing it altogether. This finding has direct implications for public health: improving cultural responsiveness is not merely an ethical imperative but also a strategy for improving care access and health equity.

➤ **Professional identity and the ethical navigation of cultural complexity**

Nurses' expressions of professional duty to provide equitable care regardless of cultural difference - PN5's "You must respect that. But still, you give the same care" and PN7's "My duty is to ensure that they understand what I'm doing... then they are willing to cooperate" - reflect strong professional identity grounded in principles of non-discrimination and patient-centred practice. This commitment positions nurses as advocates for equity within healthcare systems that may not always support such advocacy.

However, the reliance on communication as the primary ethical strategy in the absence of formal policy represents both strength and vulnerability. PN7's approach - "We need to explicitly explain

the procedure so that the person understands" - and PN2's observation that "If you don't understand their culture, it becomes difficult. If you do understand, it makes communication easier" - privilege effective communication as the key tool for navigating cultural complexity. This emphasis is well-founded; communication competence is indeed central to culturally responsive care. However, relying solely on individual communication skills without institutional support foments uneven care quality dependent on particular nurses' linguistic abilities, cultural knowledge, and interpersonal skills.

The variation in nurses' comfort and confidence with cultural issues is particularly revealing. Whilst PN5 adopted a nonjudgemental, permissive stance - "If the patient asks, I'd just say... if you believe, go for it" - others admitted discomfort or lack of confidence. PN9's candid admission - "I don't think I'm really sensitive because I don't know about other cultures" - and subsequent behaviour of avoiding cultural questions - "I didn't want to interfere... I didn't want to be rude and ask her" - illustrate how uncertainty can lead to avoidance rather than engagement. This avoidance, though well-intentioned (motivated by respect and fear of causing offence), paradoxically perpetuates misunderstanding and missed opportunities for collaborative care planning.

Patients' recognition of variability in nursing practice - PP10's observation that "May they continue serving the patients the way they do. And the ones who are lacking... must step up" - confirms that ethical conduct is not universally experienced. This variation reflects the broader finding that cultural accommodation is discretionary rather than systematised, depending on individual practitioners' knowledge, values, and confidence rather than being embedded in standard practice protocols.

The tension nurses experience between respecting cultural beliefs and maintaining professional responsibility for safety emerged clearly. PN5's sequential statements - "If you believe, go for it" followed by "Some wounds become septic because of the herbs used" - capture this dilemma. Nurses are simultaneously expected to respect patient autonomy and cultural practices yet held accountable for patient outcomes that may be compromised by traditional practices. Without clear institutional guidance about how to navigate this tension, nurses develop individual

strategies that may err towards either excessive accommodation (potentially compromising safety) or excessive caution (potentially alienating patients and driving practices underground).

➤ **Knowledge systems: Epistemological pluralism and strategic hybridisation**

The acknowledgement across all participant groups that different knowledge systems exist and compete represents a fundamental recognition of epistemological and ontological pluralism. CP3's comparison - "If I'm going to the hospital, I wouldn't get answers... if I'm going to the traditional healer, I would definitely get an answer" - PN5's biomedical critique ("Some wounds become septic because of the herbs used"), and CP6's spiritual reflection ("Even if you take medication, you can still die. People die") each articulate different ways of knowing and different criteria for evaluating healing efficacy.

This pluralism challenges Eurocentric frameworks that position biomedical knowledge as universally superior and other healing systems as merely 'beliefs' requiring tolerance rather than systems of knowledge deserving epistemic respect. The fact that participants across categories, including biomedically trained nurses, acknowledge limitations of their own systems suggests lived experience of what de Sousa Santos (2016) terms 'cognitive justice' - recognition that no single knowledge system has monopoly on truth and that different systems may excel at addressing different dimensions of human experience.

However, individual positioning within these competing knowledge systems varied dramatically, ranging from biomedical superiority (PN5: "In the clinic, we can test and diagnose properly") through traditional supremacy (CP1: "The doctors, they don't know what's wrong with you, but the healers know"; PP11: "It worked for them back then, and even now, it still works") to spiritual prioritisation (CP6: "God has healed me... I believe in prayer and laying on of hands"). These positions are not merely abstract philosophical stances but practical orientations that guide care-seeking behaviour, treatment adherence, and responses to illness.

Most significant is the widespread practice of conditional or covert hybridisation. PP11's strategy - "For me... I would bring it, maybe hide it. Because I believe there are things hospitals can't heal" - and CP1's simple non-disclosure - "No, I didn't" - reveal that many participants do not

choose between systems but rather use both strategically, drawing on whichever seems most appropriate for particular conditions or stages of illness. This pragmatic approach reflects what Lock and Nichter term 'therapeutic pluralism': the simultaneous engagement with multiple healing modalities based on perceived efficacy rather than ideological commitment to particular epistemologies.

However, this hybridisation occurs largely covertly, without healthcare providers' knowledge. The reasons for concealment are multiple: fear of judgement, previous negative responses to disclosure, perception that healthcare providers will not value or understand traditional practices, and concern about being denied biomedical care if traditional use is revealed. This covert pluralism creates risks - providers cannot screen for interactions or provide informed guidance - but also represents rational navigation of systems that have not created space for open integration.

The agreement across participants that no single system is universally sufficient - captured in CP1's repeated "I'll say both" and PN5's "I'd advise patients... if no improvement, come back for proper diagnosis" - provides conceptual foundation for integration. If all systems have boundaries beyond which they cannot effectively address particular health concerns, then complementarity and hybridity becomes not merely desirable but necessary for comprehensive care. However, translating this conceptual agreement into practical integration requires institutional infrastructure, regulatory frameworks, and professional training that currently do not exist.

➤ **Patient navigation: Tactical agency in constrained contexts**

The finding that patients strategically switch between health systems depending on perceived effectiveness challenges passive models of patients as mere recipients of care who comply (or fail to comply) with professional directives. Instead, participants demonstrated sophisticated agency in navigating complex healing landscapes. PN5's advice - "If no improvement... don't stay at home. Come to the clinic for a second opinion" - and CP2's explanation - "I'll tell you to continue taking your medicine from the hospital... but I'll help your skin look nice" - both

acknowledge that patients and traditional healers are already making strategic decisions about when each system is most appropriate.

The finding that comfort and dignity influence care-seeking locations as much as perceived clinical efficacy is particularly important. PP1's explanation - "I feel more relaxed and comfortable when I go there (traditional healer)... they don't judge you" suggests that 'choosing' traditional healing may be less about rejecting biomedicine's technical capacity than about seeking healing spaces where one's whole personhood is respected. This aligns with research demonstrating that patients' care-seeking decisions are shaped not only by beliefs about treatment efficacy but also by expectations about how they are treated as persons.

The pattern of avoiding open conflict even when disagreeing - PP9's "Maybe I just avoid conflict" - reflects power dynamics within healthcare encounters. Patients recognise that they are not equal partners in medical decision-making and that expressing disagreement with professional recommendations may have consequences ranging from social disapproval to denial of services. This recognition shapes communication strategies: rather than directly challenging healthcare providers' authority, patients may appear to agree whilst actually pursuing alternative courses of action outside the biomedical encounter.

The variation in navigation approaches - from assertive autonomy (CP4: "They must allow everybody to do what he or she feels is right") through quiet resistance and concealment (PP11: "I would bring it, maybe hide it"; CP1: "No, I didn't") to complete disengagement (CP2: "I've been in South Africa fifteen years - I've never been to hospital") to unquestioning compliance (PP5: "When the doctor says something, I do it") - reflects different assessments of power, risk, and efficacy. These variations correlate with factors such as level of education, previous healthcare experiences, the salience of cultural identity, language proficiency, and social support networks, though the current data do not permit statistical analysis of these relationships.

What is clear is that patient agency, whilst constrained by structural factors (availability of services, economic access, policy frameworks) and relational factors (power differentials, communication quality, experiences of respect or judgment), nonetheless operates constantly. Patients are not passive; they are making decisions, weighing options, strategising about

disclosure, and navigating between systems even when these processes remain invisible to healthcare providers. Recognising this agency and creating space for it within formal healthcare systems could transform current covert navigation into collaborative care planning that better serves patients' needs.

➤ **Healing approaches: Holism, symptoms, and the meaning of care**

The recognition across participant groups that purely clinical, symptom-focused treatment has shortcomings - articulated by CP1 ("The doctors, they don't know what's wrong with you"), CP3 ("I know if I'm going to the hospital, I wouldn't get answers..."), and even PN8 ("How we provide care that heals - not just physically but emotionally and spiritually too") - challenges biomedical models that reduce illness to biological dysfunction requiring technical intervention.

The association of holistic care with being seen spiritually, emotionally, and culturally - PP1's "When you go there (traditional healer), they don't judge you"; CP4's "It gives dignity to the person as a person" - suggests that for many participants, healing requires attention to dimensions of personhood beyond the physical body. This resonates with substantial literature on the limitations of biomedical reductionism and the importance of addressing social, psychological, and spiritual dimensions of illness.

However, definitions of what constitutes healing varied considerably. For some, healing meant strict adherence to biomedical logic of diagnosis and treatment (PP5: "When the doctor says something, I do it"; PN5: "In the clinic, we can test and diagnose properly"). For others, belief, purpose, and faith were central to healing processes (CP6: "God has healed me... I believe in prayer and laying on of hands"; PP12: "We help with things like early-stage cancer"). Many participants toggled between approaches depending on the condition, as illustrated by CP1's advice to "go to the clinic" for HIV whilst CP2 offered to "help your skin look nice" using traditional remedies for side effects.

This variation suggests that participants hold nuanced, context-dependent understandings of appropriate healing approaches rather than ideologically rigid commitments. Different health concerns call forth different healing modalities: acute injuries or conditions with clear biomedical

diagnoses and treatments (broken bones, infections, HIV) prompt biomedical care-seeking, whilst chronic conditions, psychosocial distress, or illnesses attributed to spiritual causes prompt engagement with traditional or faith healing. This pragmatic flexibility challenges both biomedical dismissal of traditional healing as 'mere belief' and traditionalist rejection of biomedicine as culturally foreign, revealing instead that most participants are sophisticated consumers of multiple healing systems.

- **Synthesis of individual-level analysis**

The individual-level analysis demonstrates that participants cannot be reduced to simple categories of 'traditional' versus 'modern', 'compliant' versus 'resistant', or 'believers' versus 'sceptics'. Instead, individuals occupy complex, nuanced positions shaped by intersecting factors including cultural socialisation, religious conviction, personal experiences of healing and harm, structural access to different healing modalities, language and literacy, power and confidence in healthcare encounters, and pragmatic assessments of what works for particular conditions.

Three critical insights emerge from this individual-level examination. First, *the problem is rarely ideological rejection of either biomedical or traditional approaches*; most participants expressed openness to both, recognising strengths and limitations of each. The challenges lie in structural and relational barriers: absence of institutional support for integration, fear of judgment constraining open communication, and lack of training leaving healthcare providers uncertain about how to respond to cultural diversity.

Second, *patient agency operates continuously but largely invisibly within formal healthcare systems*. Patients make sophisticated decisions about which systems to use when, what to disclose to whom, and how to navigate power dynamics within healthcare encounters. This tactical agency represents a resource that could be harnessed for improved care if healthcare systems created space for it rather than shunting it underground through judgement and inflexibility.

Third, *dignity and respect emerge as central determinants of care engagement*, potentially as important as perceived clinical efficacy. When patients feel seen, valued, and respected as

whole persons, they engage with care and communicate openly; when they feel judged or reduced to bodies requiring technical repair, they withdraw, conceal, or seek care elsewhere. This finding challenges healthcare systems to recognise that cultural responsiveness is not peripheral to quality care but constitutive of it.

- Group-level similarities and differences**

Having examined individual-level variations, this section now considers systematic patterns across participant groups. Whilst individual heterogeneity is substantial, group-level analysis reveals how structural positions - being a healthcare provider versus a patient versus a community member - shape orientations, priorities, and experiences. Understanding these group-level patterns is essential for designing interventions, as solutions must address not only individual attitudes but also the systematic ways different stakeholder groups encounter and navigate healthcare systems. Table 5.2 presents key areas where participant groups converged and diverged, followed by a detailed discussion of the implications of these patterns.

Table 5.2 Group-Level Similarities and Differences Across Participant Categories

Cultural Accommodation	- All groups acknowledge importance of respecting beliefs - Convergence on need for clear policy for consistency and fairness	- Nurses split between practical accommodation and structural gaps - Patients emphasise direct impact on care-seeking behaviour - Focus group frames as system-level priority issue - Community foregrounds policy absence and individual discretion

Traditional Healing Beliefs	• Effectiveness contingent on belief acknowledged universally • Both biomedical and traditional systems have recognised limitations • Preference for combining systems rather than exclusive reliance	• Nurses show cautious tolerance with training gaps • Patients demonstrate diverse spectrum (rejection to concealment to preference) • Community members as the strongest advocates for integration • Focus group frames as structural integration problem
System Integration	• Support for collaboration in principle expressed by all groups • Acknowledgement that structured collaboration does not currently exist	• Nurses supportive but uncertain due to lack of training/referral pathways • Community members as the strongest advocates viewing systems as complementary • Patients hold mixed stances, often concealing dual use • Focus group provides structural critique of infrastructure absence
Communication & Judgement	• Agreement that respectful communication improves cooperation • Judgement/disrespect consistently causes care avoidance • Fear of causing offence leads to silence rather than dialogue	• Nurses torn between professionalism and uncertainty • Patients' care-seeking directly impacted by judgement experiences • Community members assertive about dignity and autonomy

		Focus group frames judgement as systemic bias
Dignity & Autonomy	- Universal calls for respecting personal belief and choice - Dignity consistently linked to being seen and not judged - Respectful treatment encourages care engagement; disrespect causes withdrawal	- Nurses view respect as important but operationally limited - Patients experience dignity emotionally and narratively - Community members assert dignity through autonomy and cultural identity - Focus group frames respect procedurally within clinical compliance
Professional Ethics	- Nurses perform duty to provide care regardless of difference - Communication emerges as primary ethical strategy - Patients recognise both ethical conduct and its absence	- Nurses employ protective professionalism with training gaps - Focus group reflective and system-aware, frames ethics as policy problem - Patients expect fairness and non-judgement - Community members apply assertive moral lens demanding recognition
Knowledge Systems	- All groups acknowledge competing knowledge systems - Agreement that no single system is universally sufficient	- Nurses prioritise biomedicine with cautious respect for belief - Patients vary: biomedical loyalists to covert traditionalists

		• Community members pragmatic pluralists preferring "whatever works" • Focus group offers systems-level critique calling for structured integration
Patient Navigation	• Strategic switching between systems depending on effectiveness • Comfort and dignity influence care-seeking locations • Open conflict avoided even when disagreeing	• Nurses encourage cautious dual use through sequential models • Patients engage in blended pragmatism with concealment • Community members exercise assertive autonomy • Focus group raises concerns about unstructured, unsupported navigation
Healing Approaches	• Recognition of shortcomings in purely clinical treatment • Holistic care associated with spiritual/emotional/cultural wholeness • Acknowledgement that care needs extend beyond symptoms	• Nurses operate with clinical definitions alongside cooperation • Patients prioritise comfort-based navigation and being understood • Community members embrace holistic harmony through syncretism • Focus group identifies systemic tension between protocol and humanity

- **Discussion of group-level patterns**

- **Structural positions shape orientations to cultural accommodation**

Whilst all participant groups endorsed respect for cultural beliefs as a principle, their structural positions within healthcare systems shaped how they experienced and operationalised this principle. Nurses positioned as institutional representatives responsible for implementing protocols whilst simultaneously responding to individual patients experienced cultural accommodation as a daily negotiation between competing demands. The split within nursing narratives - between PN10's successful accommodation ("We as staff respected that... we had to call her to do her thing") and PN9's structural constraints ("There is no designated area here, and there's no anybody who has been allocated to look after those kinds of patients") - reflects not individual inconsistency but rather variable institutional support across different healthcare facilities.

This variation establishes that cultural accommodation in South African healthcare is currently dependent on local, facility-specific factors rather than being guaranteed by national policy or professional standards. Some facilities have created physical spaces, allocated staff roles, or developed informal protocols that enable cultural practices; others have not. Nurses working in the latter context face impossible demands: they are expected to respect patients' cultural needs but are given no resources, space, or guidance to do so. The resulting discretionary accommodation - dependent on individual nurses' initiative rather than systematic provision - creates unpredictable experiences for patients who do not know in advance whether their cultural needs would be respected.

The focus group's systemic framing - "We tend to focus on physical care... cultural preferences... not prioritised" - articulates what individual nurses may experience as personal failures or individual patients may perceive as personal disrespect, but which is fundamentally a system-level issue. Healthcare institutions prioritise biomedical interventions (procedures, medications, diagnostics) because these align with dominant biomedical paradigms, regulatory frameworks, and performance metrics. Cultural accommodation, positioned as supplementary

rather than integral to quality care, receives neither resources nor systematic attention. This prioritisation is not merely oversight; it reflects deeper epistemological hierarchies that value biomedical knowledge and technical interventions over social, cultural, and relational dimensions of care.

Patient participants, positioned as recipients of care who experience the consequences of this deprioritisation, articulated its impacts in direct, personal terms. PP3's narrative - "I have only come to this clinic... But when nurses are not kind, it becomes difficult... Eventually, I went home without doing the test... I haven't gone back because I'm scared" - demonstrates how cultural insensitivity translates into care avoidance with potentially serious health consequences. For healthcare systems concerned with access, equity, and health outcomes, this finding should be alarming: investments in diagnostic technology, treatment protocols, and service expansion are undermined when patients avoid care due to previous experiences of cultural disrespect.

Community participants foregrounded the policy vacuum as the fundamental problem. CP3's observation - "There's no policies... nothing like that... It's up to the person... if there were policy... they would know" - positions discretionary accommodation as unsustainable and unjust. When accommodation depends on individual staff members' knowledge, attitudes, and willingness to make exceptions, patients receive unequal care based not on clinical need but on which staff members they encounter. Policy development would shift cultural accommodation from individual discretion to institutional obligation, potentially reducing variability and improving equity.

However, policy alone is insufficient. PN1's statement that "When there's policy, it makes things smoothly... we do it according to what the policy says or guidelines" reflects professional desire for clarity, yet assumes that staff have capacity, resources, and cultural knowledge to implement policies once developed. Policy development must therefore be accompanied by resource allocation, training programmes, infrastructure development (such as dedicated spaces for cultural practices), and accountability mechanisms that ensure implementation rather than mere scripted policy.

➤ **Traditional healing: From cautious tolerance to assertive advocacy**

The group-level analysis reveals a gradient in orientations towards traditional healing, ranging from nurses' cautious tolerance through patients' diverse individual practices to community members' assertive advocacy for full integration. This gradient reflects differential stakes: nurses face professional liability and regulatory constraints that make them cautious about explicitly endorsing practices outside biomedical frameworks; patients navigate their own health needs pragmatically; community members, including traditional healers, advocate for recognition and legitimization of their knowledge systems and practices.

Nurses' cautious tolerance - exemplified by PN5's "If you believe, go for it" and PN7's "Unfortunately... I don't have any module that will allow me to refer clients for traditional medicine" - reflects institutional positioning. Nurses are accountable to biomedical regulatory frameworks, professional standards, and institutional protocols that do not recognise traditional healing. Explicitly endorsing traditional practices could expose nurses to professional liability if patients experience adverse outcomes. The absence of formal training creates additional uncertainty: without evidence-based guidance about herb-drug interactions, contraindications, or appropriate concurrent use, nurses cannot provide informed recommendations even if they personally support such choices.

This caution has pragmatic justification - PN5's observation that "Some wounds become septic because of the herbs used" reflects real clinical experiences of harm from traditional practices. However, this focus on risks without corresponding attention to potential benefits creates asymmetric framing: biomedical interventions are evaluated on the balance of risks and benefits, but traditional practices are evaluated only on the risks. A more balanced approach would acknowledge that biomedical treatments also carry risks (adverse drug reactions, iatrogenic complications, medication errors) whilst traditional practices may offer benefits (symptom relief, psychological comfort, cultural congruence, addressing dimensions of illness experience beyond physical symptoms).

Patient participants' diverse spectrum - from PP4's religious rejection ("No, I wouldn't. As a Muslim, I rely on prayer") through PP11's concealment ("I would bring it, maybe hide it") to PP1's open preference ("I feel more relaxed and comfortable when I go there") - reflects the heterogeneity within this patient population. Healthcare systems often treat 'patients' as a unified category with shared needs and preferences, but this diversity demonstrates that patients hold vastly different orientations shaped by religious conviction, cultural identity, previous experiences, and pragmatic assessments of efficacy and comfort.

The practice of concealment, particularly significant in PP11's account, represents a form of resistance to biomedical hegemony: patients continue practices they find valuable despite healthcare systems' failure to recognise or accommodate them. However, this resistance carries costs - patients cannot benefit from healthcare providers' knowledge about potential interactions or receive guidance about safe concurrent use. The challenge for healthcare systems is to create environments in which disclosure is rewarded with collaborative problem-solving rather than punished with judgment, enabling patients to access both traditional and biomedical expertise simultaneously.

Community participants emerged as the strongest advocates for integration, consistently arguing that both systems offer value and should work together. CP1's repeated formulation - "I'll say both... I think they can work together... I think the doctors and the traditional healers must just combine" - and CP2's practical example about HIV treatment represents sophisticated understanding of complementarity rather than competition. The willingness of traditional healers to acknowledge biomedical authority for conditions like HIV whilst claiming space for quality-of-life interventions demonstrates pragmatic boundaries recognition rather than totalising claims to healing efficacy.

This positioning challenges stereotypes of traditional healers as anti-modern or opposed to biomedicine. Instead, at least some traditional healers actively seek collaboration, recognising that patients' wellbeing is best served through combination of approaches. The barrier to integration appears not to be traditional healers' unwillingness but rather biomedical systems'

failure to create formal mechanisms for collaboration, reflecting both regulatory gaps and epistemological hierarchies that position traditional knowledge as inferior or impracticable.

The focus group's structural framing - identifying lack of integration as a systemic problem requiring policy-level intervention - provides important macro-level analysis. Individual nurses' caution, patients' concealment, and traditional healers' advocacy all occur within a structural context that has not created space for legitimate integration. International examples demonstrate that integration is possible: countries including China, India, and Ghana have developed regulatory frameworks, training programmes, and referral systems that enable collaboration between biomedical and traditional practitioners. South Africa's failure to develop comparable frameworks represents a policy gap rather than inherent incompatibility between systems.

➤ **System integration: Widespread desire, absent infrastructure**

The finding that all participant groups supported collaboration in principle, yet all acknowledged that structured collaboration does not exist, reveals a fundamental gap between values and reality. This gap is striking: if everyone - including nurses, patients, traditional healers, and policy-conscious focus group participants - believes integration would be beneficial, why has it not occurred? The answer lies in the difference between individual support and institutional implementation. Individuals can endorse integration conceptually, but actualising integration requires regulatory frameworks, funding mechanisms, training curricula, referral protocols, liability clarification, and institutional restructuring - none of which individual actors can accomplish alone. This represents a collective action problem: integration serves collective interests but requires coordinated action and resource allocation by governmental and professional regulatory bodies.

Nurses' positioning as supportive but uncertain - PN4's "No, not really. But I think it would be great if that connection existed" and PN7's "Unfortunately... I don't have any module that will allow me to refer clients for traditional medicine" - reflects their lack of agency to create integration independently. Individual nurses cannot establish referral networks, develop training programmes, or create regulatory frameworks; they can only operate within existing institutional structures. PN5's sequential model - "It depends on... I'd advise a second opinion after traditional

healing" - represents an informal workaround developed in the absence of formal mechanisms, but such individual strategies cannot substitute systematic integration.

Community participants' positioning as ready collaborators - CP2's HIV example ("I will tell you to continue taking your medicine from the hospital because I don't have a cure for HIV... but I'll help your skin look nice") and CP5's invitation ("Why don't you come over to my workplace and see if I have a solution... in some parts... can help each other") - demonstrates willingness that surpasses current opportunities for collaboration. Traditional healers appear to be waiting for biomedical systems to create formal mechanisms for engagement rather than being obstacles to integration.

Patient participants' mixed stances and frequent concealment - PP11's "I would bring it, maybe hide it" and PP1's preference for traditional healers where "they don't judge you" - reveal that patients are already integrating systems in their own care but doing so covertly without biomedical provider knowledge or support. This covert integration represents both patients' resourcefulness in navigating contesting systems and a missed opportunity for healthcare systems to provide informed guidance, screen for risks, and optimise coordination.

The focus group's structural critique - noting absence of infrastructure or policy frameworks to coordinate systems - identifies the level at which intervention is needed. Individual-level interventions (cultural competency training for healthcare providers, patient education about safe disclosure) may have limited impact if structural barriers remain. Instead, policy development, regulatory reform, and institutional restructuring are required to create conditions in which collaboration becomes systemically possible rather than dependent on individual initiative.

International examples provide models: China's integration of traditional Chinese medicine into national healthcare systems includes dedicated hospitals, formal training and certification for traditional practitioners, research programmes evaluating traditional treatments, and protocols for concurrent use. South Africa could adapt such models, drawing on existing regulatory frameworks for traditional health practitioners whilst developing specific mechanisms for collaboration with biomedical services.

➤ **Communication, judgment, and power asymmetries**

The convergence across all groups on the importance of respectful communication, coupled with consistent findings that judgment causes care avoidance, establishes communication quality as a fundamental determinant of care engagement and therapeutic alliance. However, the group-level analysis reveals that different stakeholders experience and navigate communication dynamics from different positions of power.

Nurses' positioning as torn between professionalism and uncertainty - PN9's admission "Personally for me, I don't think I'm really sensitive because I don't know about other cultures" and avoiding questions ("I didn't want to interfere... I didn't want to be rude and ask her") - reveals a paradox. Nurses hold structural power in healthcare encounters (controlling access to services, making clinical decisions, defining appropriate behaviour), yet often feel personally powerless to address cultural complexity due to lack of training, knowledge, and institutional guidance. This combination of structural power and personal uncertainty creates communication patterns characterised by avoidance rather than engagement.

The consequences of this avoidance are significant. When nurses refrain from asking about cultural practices, traditional medicine use, or spiritual beliefs to avoid awkwardness or potential offence, they miss opportunities to provide informed guidance, screen for risks, and develop collaborative care plans. Patients interpret this avoidance vicariously: some may experience it as respect for their privacy and autonomy, but others may perceive it as indifference, discomfort with their cultural identity, or judgement expressed through silence rather than explicit criticism.

Patient participants' narratives foregrounded the direct impact of communication quality on care-seeking behaviour. PP3's progression from positive initial experiences ("Since then, I have only come to this clinic") through negative encounters ("when nurses are not kind, it becomes difficult") to care avoidance ("Eventually, I went home... I haven't gone back because I'm scared") illustrates how communication patterns aggregate into decisions about care engagement. Single negative encounters can rupture trust built over multiple positive

interactions, and fear generated by disrespectful treatment can persist long after the encounter itself, creating lasting barriers to care access.

PP1's experience of being blamed - "They put that stamp on me that I'm using something... causing everything" - demonstrates how judgement targeting traditional medicine use creates specific barriers. When patients perceive that disclosure will result in blame, dismissal, or attribution of health problems to traditional practices rather than collaborative problem-solving, the only rational response is concealment. Healthcare providers may then conclude that patients are not using traditional medicine (because they don't disclose), reinforcing perception that it is not a significant issue requiring systematic attention.

Community participants' assertive positioning - CP4's insistence that "They must allow everybody to do what he or she feels is right" - represents a counterpoint to biomedical authority. Rather than requesting permission or accommodation, community participants framed respect for cultural practices as a right that healthcare systems are obliged to uphold. This assertiveness challenges paternalistic models of healthcare in which professionals determine appropriate care and patients comply (or resist), instead positioning patients and community members as equals with legitimate authority over their own health decisions.

However, this assertiveness may not be uniformly performed by all patients. Factors such as education level, language proficiency, previous positive experiences with advocacy, social support, and cultural identity salience likely influence individuals' confidence in asserting autonomy within healthcare encounters. Patients who lack these resources may be more vulnerable to experiencing judgement without effective response, unable to exit unsatisfactory care relationships due to lack of alternatives, and less able to navigate between systems strategically.

The focus group's framing of judgement as systemic bias - "We tend to focus on physical care... cultural preferences... not prioritised" - shifts analysis from individual attitudes to institutional cultures. When healthcare institutions structurally prioritise biomedical interventions over cultural responsiveness, individual healthcare providers receive implicit messages about what matters

and what is peripheral. Even well-intentioned, culturally curious providers may struggle to prioritise cultural assessment and accommodation when time pressures, performance metrics, and resource allocation all emphasise biomedical efficiency over relational care.

Addressing judgement therefore requires not only individual cultural competency training but also change in institutional culture that repositions cultural responsiveness as integral to quality care rather than optional supplementary attention. This includes incorporating cultural assessment into standard intake procedures, allocating time for culturally responsive communication, including cultural responsiveness in performance evaluation, and providing ongoing support and consultation for staff navigating cultural complexity.

➤ **Dignity, autonomy, and the relational foundations of care**

The universal endorsement of respect for personal belief and choice, coupled with consistent linkages between dignity and care engagement, establishes dignity not as an abstract philosophical concept but as practical determinant of healthcare quality. However, the group-level analysis reveals divergent conceptualisations of what dignity means and how it is operationalised.

Nurses' framing of respect as important but operationally constrained - PN9's "There is no designated area here... nobody allocated to look after those patients" and the focus group's conditional approach ("If it doesn't interfere... I'd let them keep them") - reveals a procedural understanding of dignity: respect can be offered within existing protocols and resource constraints but cannot disrupt core clinical functions. This represents what might be termed 'accommodation within limits' - dignity is respected to the extent possible without fundamentally challenging biomedical authority or "standard" care pathways.

This procedural framing has pragmatic justification: healthcare facilities must balance multiple competing demands with limited resources. Creating dedicated spaces for cultural practices, allocating staff specifically to support cultural accommodation, and modifying standard protocols to incorporate cultural preferences all require resources that may be scarce in under-resourced healthcare systems such as the Western Cape. However, this pragmatic framing risks

positioning cultural responsiveness as a luxury available only when resources permit rather than as a fundamental component of quality, equitable care that deserves resource allocation comparable to other quality improvement initiatives.

Patient participants' emotional and narrative framing of dignity - PP3's fear following unkind treatment ("I haven't gone back because I'm scared"), PP1's contrasting comfort at traditional healers ("I feel more relaxed and comfortable when I go there") - demonstrates that dignity is experienced not through formal accommodation protocols but through moment-to-moment interactions in which one feels valued, heard, and respected as a whole person. This experiential understanding of dignity aligns with philosophical work emphasising recognition and respect as constituents of dignity rather than merely instrumental to achieving other goals.

The contrast between patients' narrative experiences and nurses' procedural framing reveals a potential disconnect: healthcare providers may believe they are offering dignified care through technically competent biomedical treatment and politeness, whilst patients experience indignity through failure to recognise cultural identity, dismissal of traditional practices, or communication that positions them as bodies requiring repair rather than persons deserving understanding.

Community participants' assertive framing of dignity as autonomy and cultural identity recognition - CP4's "They must allow everybody to do what he or she feels is right" and CP6's pride in community contribution ("I help the community... I give food, I support people") - represents dignity as an active agency rather than passive receipt of respect. This framing challenges healthcare models in which professionals grant dignity through respectful behaviour, instead positioning dignity as inherent to persons who deserve recognition of their autonomy, knowledge, and right to make health decisions consonant with their values.

This assertive framing draws on rights-based discourses that have increasing prominence in global health. Rather than positioning cultural responsiveness as charity or accommodation that healthcare systems may grant or withhold, rights frameworks establish cultural respect as obligation. South Africa's constitutional commitments to human dignity, equality, and cultural identity provide legal foundation for such rights-based approaches to cultural accommodation in

healthcare, though translation of constitutional principles into healthcare practice remains incomplete.

The focus group's procedural framing - "If it doesn't interfere... I'd let them keep them" - encapsulates biomedical boundaries on dignity: respect is offered conditionally, contingent on not disrupting clinical protocols or compromising safety. This conditional respect reflects legitimate concerns about maintaining care quality and patient safety yet also illustrates epistemological hierarchies in which biomedical knowledge retains supreme authority in determining what constitutes 'interference.' An alternative approach might position different knowledge systems as equal partners in defining appropriate care, creating space for genuine negotiation about how to recognise both cultural practices and clinical safety rather than presuming biomedical authority to set boundaries.

➤ **Professional ethics: Individual navigation of structural constraints**

Nurses' expressions of professional duty to provide equitable care - PN5's "You must respect that. But still, you give the same care" and PN7's "My duty is to ensure that they understand what I'm doing... then they are willing to cooperate" - reflect strong ethical commitments grounded in professional values of non-discrimination and patient-centred practice. These commitments position nurses as advocates for equity and dignity within healthcare systems, often serving as buffers between institutional demands and patients' needs.

However, nurses' protective professionalism - attempting to balance respect with safety and policy adherence whilst lacking formal training and fearing cultural mistakes - confirms the difficult position of enacting ethical commitments without institutional support. PN7's lament about absence of formal training modules and PN9's avoidance of cultural questions to prevent potential offence both illustrate how well-intentioned ethical commitments can be undermined by structural constraints.

This highlights a fundamental challenge in professional ethics: individual practitioners are held accountable for providing culturally responsive care, yet are not provided with training, resources, or institutional frameworks to enact effectively. This creates what Lipsky terms 'street-

level bureaucracy' - frontline workers develop informal strategies to manage unresolvable tensions between formal expectations and practical constraints, resulting in inconsistent practices that privilege individual discretion over systematic provision of rights or services.

The focus group's reframing of ethics as a policy problem - "There's no structured understanding of how these two systems can work together" - provides crucial systems-level critique. Rather than locating ethical challenges in individual practitioners' knowledge gaps or attitudes, this framing identifies absence of institutional infrastructure as the fundamental issue. Individual ethics training may have a limited impact if practitioners return to workplaces that lack policies, resources, allocated time, or mechanisms for implementing culturally responsive care.

This suggests that improving cultural responsiveness requires multi-level intervention: individual training to build knowledge and skills, institutional policy development to create frameworks and expectations, resource allocation to enable implementation, and accountability mechanisms to ensure that policies translate into practice. Focusing solely on individual-level interventions risks placing responsibility on practitioners without providing means to fulfil that responsibility, perpetuating frustration among well-intentioned staff and continuing inequitable care for patients.

Patient participants' expectations of fairness and non-judgment - PP3's fear following hostile treatment, PP10's acknowledgement of variability ("May they continue serving the patients the way they do. And the ones who are lacking... must step up") - reveal that patients evaluate healthcare not only on technical competence but also on relational quality. From patients' perspectives, ethical care is that which treats them as whole persons deserving respect, understanding, and partnership in decision-making rather than merely as bodies requiring technical intervention.

Community participants' application of assertive moral lens - CP4's demand that "They must allow everybody to do what he or she feels is right" - represents ethics from a rights-based rather than charity-based framework. Rather than requesting that healthcare providers be kind or accommodating, this framing establishes respect for cultural autonomy as obligation. This shift from requesting accommodation to demanding rights reflects broader transformations in

healthcare ethics from paternalistic models in which providers determine patients' best interests to partnership models that recognise patients' authority over their own health decisions.

➤ **Knowledge systems: Epistemological hierarchies and pragmatic pluralism**

The acknowledgement across all groups that different knowledge systems exist and compete, coupled with agreement that no single system is universally sufficient, provides foundation for what Santos (2016) terms 'epistemologies of the South' - recognition and validation of multiple knowledge systems rather than presumption of Eurocentric biomedical knowledge as universally superior. This epistemological pluralism challenges not only biomedical hegemony but also rigid traditionalism, instead suggesting that different knowledge systems offer complementary rather than competing resources for understanding and addressing health challenges.

However, group-level analysis reveals systematic differences in how different stakeholders position themselves within this epistemological plurality. Nurses' prioritisation of biomedicine with cautious respect for belief - PN5's "If you believe, go for it" coupled with "Some wounds become septic because of the herbs used" - reflects professional socialisation within biomedical frameworks coupled with awareness of patients' diverse beliefs. Nurses operate within regulatory frameworks, professional standards, and institutional cultures that privilege biomedical knowledge, creating structural constraints on their ability to fully embrace epistemological pluralism even if personally sympathetic.

This positioning is not merely individual preference but reflects institutional pressures: nurses who explicitly endorse traditional practices risk professional liability if adverse outcomes occur. They face potential disciplinary action if they deviate from standard protocols, and may encounter disapproval from biomedically oriented colleagues or supervisors. The absence of formal training means nurses lack evidence-based guidance about when traditional practices might be safely encouraged, when they pose risks, and how to facilitate safe concurrent use - leaving them reliant on general principles (respect patient beliefs, monitor for adverse effects) rather than specific knowledge.

Patient participants' variation - from PP5's biomedical loyalty ("When the doctor says something, I do it") through PP11's covert traditionalism ("I would bring it, maybe hide it") to PP1's preference for traditional healers - demonstrates that patients are not passive recipients of either biomedical or traditional healing systems but active evaluators of which system best serves their needs in particular contexts. Strategic concealment represents not rejection of biomedicine but rather pragmatic navigation: patients access biomedical care for conditions they perceive it addresses well (acute illness, diagnostic testing, certain chronic diseases) whilst simultaneously using traditional or spiritual practices for dimensions of illness experience (psychosocial distress, spiritual concerns, cultural continuity) that biomedicine may not address.

This covert pluralism creates safety risks - providers cannot screen for herb-drug interactions or provide guidance about sequencing and coordination - but represents rational response to healthcare environments that have not created space for open dialogue and integration. Patients who disclose traditional medicine use and experience judgement, blame, or dismissal learn that concealment is safer than transparency, perpetuating cycles of mistrust and missed opportunities for collaborative care.

Community participants' pragmatic pluralism - CP1's repeated "I'll say both" and CP3's assertion that traditional healers provide answers that hospitals cannot - represents the most explicit gesture of epistemological plurality. This positioning does not reject biomedical knowledge but rather insists on traditional knowledge's validity and complementary value. CP2's HIV example - acknowledging biomedical authority for antiretroviral therapy whilst claiming space for traditional support with side effects - demonstrates sophisticated understanding of different systems' appropriate domains rather than totalising claims to authority.

This pragmatic pluralism aligns with WHO recommendations for integrating traditional medicine into national healthcare systems, recognising that patients globally use multiple healing systems and that healthcare services should support rather than oppose this pluralism. However, operationalising this vision requires regulatory frameworks that legitimise traditional practitioners whilst ensuring safety standards, training programmes that prepare biomedical providers to work

collaboratively with traditional healers, and institutional cultures that position integration as quality improvement rather than compromise.

The focus group's systems-level critique - calling for structured integration rather than forcing choice between systems - provides crucial macro-level framing. Individual practitioners and patients navigate epistemological plurality daily through informal strategies (sequential use, concealment, conditional endorsement), but these individual strategies cannot substitute for systematic integration. Policy development is needed to create formal mechanisms enabling collaboration, regulatory frameworks clarifying scope of practice and ensuring safety, training curricula preparing both biomedical and traditional practitioners for collaborative work, and research programmes generating evidence about optimal integration models.

➤ **Patient navigation: Visible agency in invisible processes**

The finding that patients strategically switch between systems depending on perceived effectiveness, that comfort and dignity influence care-seeking as much as clinical efficacy, and that patients avoid open conflict even when disagreeing all demonstrate sophisticated agency. However, this agency operates largely invisibly within formal healthcare systems, creating a disconnect between what healthcare providers perceive (patients who may appear passive or non-compliant) and what patients are actually doing (actively navigating complex healing landscapes through strategic decision-making).

Nurses' encouragement of cautious dual use - PN5's advice to try traditional healing first then seek biomedical care if improvement does not occur - represents acknowledgement of patients' pluralistic practices coupled with sequential framing: use one system, evaluate outcomes, then switch to the other if necessary. This sequential model has pragmatic appeal (it is simple, clear, and maintains some biomedical oversight) but may not align with patients' actual practices of concurrent use or their preferences for genuinely integrated care in which multiple approaches are used simultaneously in a coordinated fashion.

Patient participants' blended pragmatism with concealment - PP11's "I would bring it, maybe hide it" and PP1's comfort with traditional healers - reveals strategies developed in response to

healthcare environments perceived as judgmental or inflexible. These strategies represent what Scott terms 'everyday resistance' - not overt challenge to biomedical authority but rather covert non-compliance through which patients access both systems whilst avoiding confrontation.

However, this covert navigation carries costs. Patients cannot benefit from healthcare providers' knowledge about potential herb-drug interactions, optimal sequencing of treatments, or conditions requiring urgent biomedical intervention. Healthcare providers, unaware of patients' traditional medicine use, may misattribute treatment failures, miss opportunities to provide informed guidance, or fail to recognise when biomedical and traditional approaches could be optimally coordinated. Both parties are diminished by the necessity of concealment.

Community participants' assertive autonomy - CP4's "They must allow everybody to do what he or she feels is right" and CP2's complete avoidance of hospitals ("I've been in South Africa fifteen years - I've never been to hospital") - represents more overt forms of resistance. Rather than covertly navigating between systems, some community members openly reject biomedical authority, claiming full autonomy over health decisions. This assertiveness challenges biomedical hegemony but may also create health risks if individuals forego needed biomedical care due to previous negative experiences or ideological opposition.

The focus group's concern about unstructured, unsupported navigation - noting absence of frameworks guiding how patients might safely use multiple systems - identifies a crucial policy gap. Rather than assuming patients will use either biomedical or traditional care, healthcare systems should acknowledge that many patients already use both and develop supportive frameworks enabling safe navigation. This might include formal assessment of traditional medicine use during intake; non-judgmental discussion of how different treatments might be coordinated; provision of evidence-based guidance about known interactions and contraindications; and development of referral networks linking biomedical and traditional providers.

Such frameworks would shift navigation from covert individual strategy to supported process, potentially improving both safety and effectiveness whilst respecting patients' autonomy and

cultural values. International examples from countries with integrated traditional medicine systems demonstrate feasibility of such approaches, though significant adaptation is needed to address South Africa's specific contexts, regulatory environments, and cultural diversity.

➤ **Healing approaches: Biomedical reductionism versus holistic healing**

The recognition across participant groups that purely clinical, symptom-focused treatment has shortcomings - articulated by community participants ("The doctors, they don't know what's wrong with you"), patients ("I know if I'm going to the hospital, I wouldn't get answers"), and even nurses ("How we provide care that heals - not just physically but emotionally and spiritually too") - challenges biomedical reductionism that treats illness as primarily biological dysfunction requiring technical intervention.

The association of holistic care with being seen spiritually, emotionally, and culturally - PP1's comfort with non-judgmental traditional healers, CP4's linkage of cultural recognition to dignity - suggests that for many participants, healing requires attention to dimensions of personhood beyond the physical body. This resonates with substantial literature critiquing biomedical reductionism and arguing for biopsychosocial or holistic approaches that address social, psychological, spiritual, and cultural dimensions of illness experience.

However, nurses' operational definitions of healing - clinical success and patient cooperation - reveal constraints of working within biomedically-oriented systems. PN8's aspirational statement about care that heals "not just physically but emotionally and spiritually too" is followed by the reality of time pressures, resource limitations, and performance metrics that emphasise efficiency and biomedical outcomes over holistic care. Nurses may personally endorse holistic approaches yet find institutional environments constrain their ability to operationalise such approaches systematically.

Patient participants' prioritisation of comfort-based navigation - PP1's explicit preference for traditional healers where "they don't judge you" over clinics where she felt blamed - reveals that definitions of successful healing diverge between providers and patients. Healthcare providers may define success through clinical metrics (symptom resolution, disease control, adherence to

treatment protocols) whilst patients evaluate healing through broader criteria including dignity, respect, understanding, and attention to spiritual and emotional dimensions. When these definitions conflict, patients may perceive technically successful biomedical treatment as inadequate healing if relational and cultural dimensions are neglected.

Community participants' emphasis on holistic harmony - CP6's testimony about prayer and divine healing, CP1's advocacy for combining doctors and traditional healers - represents the most explicit embrace of integrated approaches. This positioning challenges the false dichotomy between tradition and modernity, suggesting instead that contemporary healthcare might draw on both biomedical and traditional approaches to address the full spectrum of human healing.

The focus group's identification of systemic tension between protocol and humanity - "We tend to focus on physical care... cultural preferences... not prioritised" - provides crucial institutional analysis. Healthcare systems structured around biomedical protocols, efficiency metrics, and technical interventions inevitably deprioritise dimensions of care that are less measurable, less amenable to standardisation, and less aligned with dominant biomedical paradigms. This is not merely oversight but reflects deeper structural issues about how healthcare quality is defined, measured, and resourced.

Addressing this tension requires more than individual healthcare providers' commitment to holistic care; it necessitates institutional transformation that positions holistic, culturally responsive care as integral to quality rather than supplementary. This might include incorporating holistic assessment into standard intake procedures; allocating time for relational and cultural dimensions of care; training healthcare providers in cultural humility and holistic approaches; developing performance metrics that value patient-reported outcomes including dignity, respect, and cultural congruence; and restructuring care delivery models to create space for healing practices beyond technical biomedical interventions.

International movements towards patient-centred care, culturally responsive healthcare, and integrative medicine demonstrate growing recognition that biomedical technical competence alone is insufficient for quality healthcare. However, translating these principles into practice in

resource-constrained Western Cape and South African healthcare contexts requires careful attention to feasibility, sustainability, and avoidance of creating additional burdens for already overstretched healthcare workers without corresponding resource provision and institutional support.

- **Synthesis of group-level patterns**

The group-level analysis reveals that whilst all participant groups endorsed respect, recognised the value of integrating different healing approaches, and acknowledged limitations of single-system approaches, they differed in how they experienced, prioritised, and responded to cultural and healing diversity. These differences are not merely individual variations but reflect structural positions within healthcare systems that shape perspectives, priorities, and possibilities for action.

Nurses emerged as cautiously supportive yet structurally constrained professionals who expressed willingness to accommodate cultural practices and collaborate with traditional healers in principle, yet repeatedly highlighted absence of formal training, clear referral pathways, and institutional support. Their ethical navigation relied heavily on individual communication skills and personal judgement rather than standardised protocols, resulting in inconsistent experiences for patients depending on which nurse they encountered. This discretionary accommodation, whilst sometimes successful, cannot substitute for systematic institutional provision of culturally responsive care.

The split within nursing narratives—between successful accommodation examples and accounts of structural barriers—reveals that cultural responsiveness in South African healthcare is currently facility-specific and practitioner-dependent rather than supported by policy or professional standards. Some nurses working in supportive environments with adequate resources develop effective informal strategies for cultural accommodation; others working in constrained environments face impossible demands to respect cultural diversity without resources, space, guidance, or the time to do so effectively.

Patient participants were the most vulnerable to consequences of this inconsistency. Their narratives foregrounded emotional and practical impacts of judgement, highlighting how disrespectful encounters led directly to care avoidance, strategic concealment, and a rupture of therapeutic relationships. Patients demonstrated sophisticated agency, navigating between systems tactically rather than passively, but this navigation occurred largely underground - hidden from healthcare providers whom they anticipated would judge or dismiss their choices.

The diversity within patient accounts - ranging from those who unquestioningly comply with biomedical authority through those who covertly hybridise to those who openly prefer traditional healing - challenges homogeneous constructions of 'the patient.' Factors including education, language proficiency, previous healthcare experiences, cultural identity salience, religious conviction, social support, and confidence in asserting autonomy all shape how individuals navigate healthcare encounters and whether they feel empowered to advocate for their preferences or constrained to conceal and adapt.

The practice of concealment deserves particular emphasis: it represents a rational response to healthcare environments perceived as judgmental but perpetuates cycles of mistrust and missed opportunities for collaborative care. When patients conceal traditional medicine use, healthcare providers cannot provide informed guidance, screen for interactions, or develop coordinated care plans. Providers, unaware of concealment, may underestimate prevalence and importance of traditional healing, reinforcing perception that it is not a significant issue requiring systematic attention. Breaking this cycle requires healthcare systems to demonstrate through consistent action that disclosure is met with curiosity, respect, and collaborative problem-solving rather than judgement.

Community participants, including traditional healers, emerged as strongest advocates for integration and recognition. They positioned themselves as active partners in healing rather than competitors to biomedicine, offering complementary services and expressing willingness to collaborate openly. Their discourse emphasised dignity, autonomy, and outcomes-based pragmatism, framing cultural accommodation not as favour but as right.

Particularly significant is community participants' pragmatic pluralism—their consistent assertion that "both" systems offer value and should work together, coupled with sophisticated understanding of appropriate domains for each. Traditional healers' acknowledgement of biomedical authority for specific conditions (such as HIV requiring antiretroviral therapy) whilst claiming complementary space for other interventions (managing side effects, addressing spiritual dimensions, supporting quality of life) demonstrates recognition of boundaries rather than totalising claims to healing authority.

This positioning challenges stereotypes portraying traditional healers as anti-modern, opposed to biomedicine, or claiming authority over all health conditions. Instead, at least amongst participants in this study, traditional healers demonstrated openness to collaboration and willingness to refer to biomedical services for conditions they recognise as beyond their scope. The barrier to integration appears not to be traditional healers' unwillingness but rather biomedical systems' failure to create formal mechanisms for such collaboration, reflecting both regulatory gaps and epistemological hierarchies positioning traditional knowledge as inferior or irrelevant.

Community participants' assertiveness - their tendency to demand rather than request respect, to insist on rights rather than plead for accommodation - reflects confidence in their cultural knowledge and healing practices coupled with frustration at continued marginalisation within formal healthcare systems. This assertiveness may be read by some healthcare providers as hostility or confrontation but might more productively be understood as legitimate claim-making by communities whose knowledge systems have been historically delegitimised by colonial and apartheid structures that positioned European biomedicine as superior and African traditional practices as primitive superstition.

Focus group participants provided the most systemic critique, consistently framing issues not as individual failures but as structural gaps. They identified absence of policy frameworks, training curricula, institutional infrastructure, and resource allocation as root causes of inconsistent care. Their perspective suggests that improving cultural accommodation and

system integration requires intervention at organisational and policy levels rather than relying solely on individual nurses' goodwill or cultural competence.

The focus group's ability to articulate system-level analysis likely reflects their positioning - they were convened specifically to discuss healthcare policy and practice, creating space for meta-level reflection not always possible in individual clinical encounters. Their consistent identification of structural issues (absence of policy, lack of training, system prioritisation of physical over cultural care, no framework for coordination between healing systems) provides crucial diagnosis. The critical problem is not primarily that individual healthcare providers lack cultural sensitivity or that patients are difficult or non-compliant, but rather that healthcare systems have not created institutional conditions enabling culturally responsive, integrated care.

This structural diagnosis has profound implications for intervention design. Individual-level interventions - cultural competency training for healthcare providers, patient education about safe disclosure, community outreach encouraging biomedical care use - may have limited impact if structural barriers remain. Without policy frameworks mandating cultural accommodation, resource allocation enabling implementation, regulatory mechanisms facilitating collaboration between biomedical and traditional providers, and accountability systems ensuring policies translate into practice, individual efforts remain discretionary, flippant and inconsistent.

➤ **The misalignment problem: Desire without delivery**

Perhaps the most striking finding from group-level analysis is the misalignment across stakeholder groups. Community participants and many patients expressed readiness for open collaboration and dual system use. Traditional healers articulated willingness to work alongside biomedical providers, acknowledging appropriate boundaries and complementary roles. Even nurses expressed personal and conceptual support for integration and respect for cultural diversity.

Yet despite this widespread support in principle, structured collaboration does not exist. Cultural accommodation remains discretionary, and patients continue concealing traditional practices. This misalignment is not primarily ideological - there is substantial agreement about values and

goals - but rather infrastructural and procedural. Healthcare systems have not created mechanisms, protocols, referral pathways, training programmes, or regulatory frameworks that would enable desired collaboration.

This gap between values and infrastructure creates frustration across stakeholder groups. Nurses want to provide culturally responsive care but lack tools, training, and institutional support to do so effectively. Patients want to openly discuss their use of multiple healing systems but anticipate judgement based on previous experiences or institutional cultures. Traditional healers want to collaborate with biomedical providers but have no formal pathways for doing so. Focus group participants recognise system-level problems but lack authority to implement solutions.

Breaking this cycle requires coordinated action at multiple levels. Policy development must establish frameworks for cultural accommodation and system integration, moving these from optional enhancements to standard care procedures. Resource allocation must provide funding for training programmes, dedicated spaces for cultural practices, cultural consultation services, and coordination mechanisms between different healing modalities. Regulatory reform must create legal frameworks enabling collaboration whilst ensuring safety and quality standards. Nurse training curricula must prepare both biomedical and traditional practitioners for collaborative work. Accountability mechanisms must ensure policies translate into consistent practice rather than remaining aspirational documents.

Importantly, such changes require genuine partnership with communities and traditional healers rather than top-down imposition of biomedically designed solutions. Community participants' assertiveness about their rights and knowledge suggests they cannot accept tokenistic consultation or solutions that perpetuate biomedical hegemony under guise of integration. Meaningful integration requires recognising traditional knowledge as valid and valuable, creating space for traditional healers' expertise within healthcare systems, and structuring collaboration as partnership between equals rather than biomedicine grudgingly accommodating inferior alternatives.

- **Cross-cutting patterns and interpretative synthesis**

Having examined both individual and group-level patterns, this section now synthesises key cross-cutting insights that transcend particular stakeholder categories or specific issues, revealing underlying dynamics that shape cultural accommodation, healing system integration, and healthcare interactions in this Western Cape and South African context.

- **The structural production of concealment**

One of the most significant findings across both individual and group levels is the widespread practice of concealment - patients hiding traditional medicine use, avoiding disclosure of cultural practices, and strategically managing information shared with healthcare providers. This concealment is not randomly distributed but rather systematically produced by healthcare environments perceived as judgmental, inflexible, or hostile to practices outside biomedical frameworks.

The cycle operates as follows: Patients who disclose traditional medicine use or cultural practices experience (or witness others experiencing) negative responses - judgement, blame, dismissal, or attribution of health problems to non-biomedical practices. These experiences teach that disclosure carries risks without corresponding benefits. Rational response is selective disclosure or concealment. Healthcare providers, encountering patients who do not disclose, underestimate the prevalence and importance of traditional healing in patients' lives. This underestimation reinforces institutional perceptions that traditional medicine is not a significant issue requiring systematic attention, reducing the likelihood of developing supportive frameworks. The absence of supportive frameworks perpetuates judgmental responses when disclosure does occur, maintaining the cycle.

This cycle has profound implications for both patient safety and care quality. Undisclosed traditional medicine use prevents healthcare providers from screening for herb-drug interactions, adjusting dosages appropriately, providing informed guidance about sequencing treatments, or recognising when symptoms may be related to traditional remedies rather than disease progression. Additionally, concealment perpetuates power asymmetries: patients feel unable to

be fully honest with healthcare providers, undermining trust and therapeutic alliance fundamental to effective care.

Breaking this cycle requires demonstrating through consistent institutional action that disclosure is safe and beneficial. This cannot be achieved through exhortation alone - telling patients they should disclose without changing how disclosure is received merely adds moral pressure to existing practical barriers. Instead, healthcare systems must create conditions enabling disclosure: training providers to respond to disclosure with curiosity rather than judgement; developing protocols for collaborative discussion of how different treatments might be coordinated; providing evidence-based guidance about known interactions whilst acknowledging gaps in knowledge; incorporating traditional medicine assessment into routine intake without stigma; and visibly demonstrating respect for patients who use multiple healing systems.

➤ **Agency as navigation rather than compliance**

Traditional models of patient behaviour often frame agency in terms of compliance versus non-compliance with professional recommendations. This framing positions healthcare providers as authorities who issue directives and patients as actors who either obey (compliance/adherence) or disobey (non-compliance/resistance). However, the findings of this study amplify that patient agency operates in far more complex ways than this binary suggests.

Patients demonstrated sophisticated tactical agency: they strategically switched between healing systems depending on perceived appropriateness for particular conditions; they selectively disclosed information based on assessments of whether providers would respond supportively; they concealed practices they valued whilst appearing to comply with biomedical directives; they toggled between assertive advocacy and conflict avoidance depending on circumstances; they evaluated not only clinical efficacy but also relational quality and dignity when making care-seeking decisions.

This navigation is not non-compliance but rather active, intelligent management of complex healing landscapes in contexts where formal healthcare systems have not created space for open pluralism. Patients are not passively rejecting biomedical authority; they are pragmatically

accessing multiple healing resources, using informal strategies to achieve goals that formal systems could support but do not. Reconceptualising agency as navigation rather than compliance has several implications. First, it challenges deficit models that position patients who use traditional medicine as ignorant, non-compliant, or resistant to modern care. Instead, such patients emerge as sophisticated navigators making reasoned decisions about which healing resources to use when. Second, it suggests that improving care requires not convincing patients to stop using traditional healing but rather creating formal systems that support the navigation patients are already doing informally. Third, it positions patients as potential partners whose experiential knowledge about navigating multiple healing systems could inform policy and practice development rather than as problems to be managed.

➤ **Dignity as determinant, not decoration**

Throughout both individual and group-level analyses, dignity emerged not as an abstract ethical principle but as a practical determinant of care engagement, communication quality, and health outcomes. Patients explicitly linked experiences of respect or disrespect to decisions about continuing care, disclosing information, and returning for services. Community participants insisted on dignity and autonomy as rights rather than favours. Even nurses recognised that respectful communication improved cooperation and care quality.

This finding challenges healthcare systems that position dignity as supplementary to technical care quality - as desirable enhancement when time and resources permit but secondary to core biomedical functions. Instead, the data suggests dignity is constitutive of quality care, not decorative addition. When patients feel disrespected, judged, or reduced to bodies requiring technical repair rather than persons deserving understanding, they withdraw from care, conceal information, avoid services, or comply superficially whilst actually pursuing alternative healing pathways.

From patient perspectives, technically competent biomedical care that fails to respect dignity and cultural identity is not quality care regardless of positive clinical outcomes. Conversely, healing encounters that honour whole personhood - addressing emotional, spiritual, and cultural dimensions alongside physical symptoms - constitute quality care even if technical interventions

are less sophisticated. This suggests that healthcare quality metrics focused exclusively on biomedical outcomes (test results, symptom resolution, adherence rates) miss crucial dimensions of care quality that matter profoundly to patients.

Operationalising dignity as central to quality care requires multiple transformations. Clinical spaces must be designed to enable cultural practices rather than merely tolerate them when they do not interfere. Intake processes must incorporate routine, nonjudgemental assessment of traditional medicine use and cultural preferences. Healthcare provider training must emphasise relational skills, cultural humility, and communication approaches that convey respect for patients' knowledge and autonomy. Performance evaluation must include dignity-related indicators such as patient reports of feeling respected, healthcare providers' demonstrated cultural responsiveness, and institutional accommodation of diverse healing practices. Resource allocation must recognise that time spent on cultural assessment and relational care is not inefficiency but investment in quality.

➤ **The policy vacuum and its consequences**

Across all participant groups and areas of inquiry, absence of clear policy emerged as a fundamental problem. Nurses wanted policy guidance to reduce individual decision-making burden and ensure fairer treatment. Community participants identified policy absence as fomenting inconsistent behaviour depending on individual practitioners. Focus group participants consistently framed issues as requiring policy-level intervention. Even patients recognised that care quality depended on which staff member they encountered rather than being systematised.

This policy vacuum has multiple consequences. First, it creates discretionary accommodation: cultural responsiveness depends on individual practitioners' knowledge, attitudes, and willingness to make exceptions rather than being embedded in standard practice. Second, it leaves healthcare providers without guidance for navigating complex situations, forced to rely on personal judgement without institutional support. Third, it perpetuates inequity: patients receive different quality of care depending on which facility they attend and which practitioner they encounter rather than having consistent rights and accommodations. Fourth, it signals

institutional priorities: absence of policy communicates that cultural accommodation is not sufficiently important to warrant systematic attention.

However, policy development alone is insufficient. International literature demonstrates that policies not accompanied by training, resources, accountability mechanisms, and institutional culture change often remain aspirational rather than implemented. Effective policy implementation requires: adequate training so staff have knowledge and skills to enact policies; resource allocation so required accommodations are feasible rather than additional burdens on already stretched services; accountability mechanisms ensuring policies translate into practice; institutional culture change positioning cultural responsiveness as integral to quality rather than optional enhancement; and ongoing evaluation and refinement based on implementation experiences.

Additionally, policy development must involve genuine partnership with communities and traditional healers rather than top-down imposition. Community participants' assertiveness suggests they cannot accept tokenistic consultation or policies that perpetuate biomedical hegemony. Meaningful policy development requires recognising community members and traditional healers as co-creators with legitimate expertise rather than merely recipients of externally designed interventions.

➤ **Integration as necessity, not compromise**

The finding that all participant groups recognised limitations of single-system approaches and expressed support for integration challenges both biomedical dismissal of traditional healing as irrelevant or dangerous and traditionalist rejection of biomedicine as culturally foreign. Instead, participants demonstrated pragmatic recognition that different healing systems address different dimensions of health and illness, with integration necessary for comprehensive care rather than optional enhancement.

This finding aligns with substantial international evidence and WHO recommendations for integrating traditional medicine into national healthcare systems. However, South Africa's progress on integration has been limited despite constitutional recognition of traditional healers

and policy commitments to cultural diversity. The gap between principle and practice reflects multiple barriers: regulatory challenges around scope of practice, safety standards, and quality assurance; professional protectionism from biomedical practitioners concerned about legitimating competitors; epistemological hierarchies positioning biomedical knowledge as scientific and traditional knowledge as mere belief; resource constraints in healthcare systems already struggling to provide basic services; and absence of training programmes preparing practitioners for collaborative work.

Overcoming these barriers requires recognising integration not as luxury available only when resources are abundant but as necessity for delivering equitable, effective, culturally sensitive care. This reframing positions integration as quality improvement initiative deserving resource allocation comparable to other healthcare priorities. It also suggests that continuing to ignore traditional healing - pretending patients use only biomedical care when evidence demonstrates widespread traditional medicine use - is not neutral maintenance of biomedical standards but rather active choice that compromises patient safety and care quality.

Models for integration exist internationally and could be adapted to South African contexts. These include: formal referral networks linking biomedical and traditional practitioners; integrated clinics where both health systems work side by side; collaborative care planning in which patients, biomedical providers, and traditional healers jointly develop treatment approaches; shared documentation systems enabling coordination; training programmes preparing both biomedical and traditional practitioners for collaborative work; research programmes generating evidence about optimal integration models; and regulatory frameworks clarifying scope of practice whilst ensuring safety and quality standards.

➤ **Power, knowledge, and the politics of recognition**

Underlying many of the specific findings is the fundamental question of power, knowledge, and recognition: Whose knowledge counts as legitimate? Who has the authority to define appropriate healing? Whose practices require accommodation versus whose practices constitute the standard? These are not merely superficial questions about efficacy but deeply political

questions about whose ontologies, epistemologies, and cultural practices receive institutional recognition and support.

South Africa's history of colonialism and apartheid created selective epistemological hierarchies in which European knowledge systems (including biomedicine) were positioned as superior, scientific, and modern, whilst African knowledge systems (including traditional healing) were dismissed as primitive, superstitious, and backward. Post-apartheid constitutional commitments to cultural diversity, human dignity, and redressing historical injustices provide legal and ethical foundations for challenging these hierarchies. However, the translation of constitutional principles into healthcare practices remains incomplete.

Community participants' assertiveness - their insistence on rights rather than accommodation, their demand for recognition rather than mere tolerance - reflects both post-apartheid empowerment and frustration at continued marginalisation. When CP4 insisted "They must allow everybody to do what he or she feels is right," this was not just individual preference, but claim-making grounded in constitutional rights to cultural practice, human dignity, and equality. When traditional healers described their willingness to collaborate whilst noting the absence of formal mechanisms, this reflected their positioning as legitimate healing practitioners awaiting recognition rather than marginal practitioners seeking permission to exist.

Healthcare systems' responses to cultural diversity thus become sites where broader societal questions about decolonisation, recognition, and justice are negotiated. Developing genuinely culturally responsive, integrative healthcare requires not merely technical adjustments (adding cultural competency training, creating accommodation procedures) but epistemic transformation. This entails recognising traditional knowledge as valid rather than merely tolerating beliefs; positioning traditional healers as professional colleagues rather than competitors or curiosities; understanding cultural practices as integral to persons' identities rather than optional additions that can be discarded when inconvenient; and restructuring healthcare around genuine epistemological pluralism rather than biomedical hegemony with superficial multicultural accoutrements.

➤ **The limits of individual solutions to structural problems**

A final cross-cutting insight concerns the mismatch between structural problems and individualised responses. Many of the challenges identified - inconsistent accommodation, absence of integration frameworks, discretionary rather than systematised cultural responsiveness - are fundamentally structural issues arising from policy gaps, institutional cultures, resource allocation asymmetries, and regulatory frameworks. Yet responses to these challenges often focus on individual-level interventions: training healthcare providers in cultural competency, educating patients about seeking appropriate care, encouraging community members to trust biomedical services.

Whilst such individual-level interventions have value, they cannot resolve structural problems. Well-trained, culturally sensitive healthcare providers still work in institutions that lack policies, resources, space, or time for cultural accommodation. Educated patients who understand the importance of disclosure still encounter providers who respond judgmentally. Community members encouraged to trust biomedical services still experience inconsistent quality dependent on which practitioner they encounter.

This suggests that improving cultural responsiveness and enabling integration requires multi-level intervention: individual training to build knowledge and skills; institutional policy development to create frameworks and expectations; resource allocation to enable implementation; regulatory reform to facilitate collaboration whilst ensuring safety; accountability mechanisms to ensure policies translate into practice; and structural changes to institutional cultures, performance metrics, and resource allocation patterns.

Crucially, this multi-level approach must recognise that frontline healthcare providers are themselves constrained by structures within which they work. Nurses who lack training, policy guidance, resources, and institutional support cannot single-handedly create culturally responsive care through individual goodwill alone. Focusing solely on individual-level change risks blaming practitioners for failing to address problems beyond their control whilst avoiding more challenging but necessary work of institutional and policy transformation.

- **Implications and directions for the future**

The comparative analysis across individual and group levels reveals a complex landscape characterised by shared values coupled with divergent practices, widespread desire for integration alongside structural barriers preventing it, and sophisticated patient agency constrained by fear of judgment and institutional inflexibility. Three overarching insights synthesise these findings and point towards implications for policy, practice, and research.

First, the problem is not primarily ideological opposition between biomedical and traditional systems, but rather structural and relational barriers preventing openly pluralistic care. Most participants across all groups endorsed respect, recognised limitations of single-system approaches, and expressed support for integration. The challenge lies not in convincing people of these principles but in creating institutional conditions enabling their realisation. This suggests that interventions must target structural and systemic levels - policy development, regulatory reform, institutional culture change, resource allocation - rather than focusing solely on changing individual attitudes or beliefs.

Second, judgment and concealment form a mutually reinforcing cycle that undermines both patient safety and care quality. Patients anticipate judgment and therefore conceal traditional practices. Providers, unaware of this concealment, underestimate prevalence and importance of traditional healing. This lack of disclosure prevents providers from developing comfort and competence in addressing traditional practices openly. Absence of open dialogue perpetuates misunderstanding and missed opportunities for collaborative care. Breaking this cycle requires healthcare systems to demonstrate, through consistent action, that disclosure is safe and beneficial, met with curiosity and collaborative problem-solving rather than judgement and dismissal.

Third, patient agency is tactical rather than passive and operates largely invisibly within formal healthcare spaces. Patients strategically navigate between systems, selectively disclose information, and make sophisticated judgments about blending healing modalities. However, because this navigation occurs covertly, it remains unacknowledged by healthcare systems and

unsupported by health policy. Recognising and legitimising this agency could transform it from underground survival strategy into visible asset for collaborative care planning. Rather than positioning patients who use traditional medicine as non-compliant problems to be managed, healthcare systems might recognise them as sophisticated navigators whose experiential knowledge could inform more effective, culturally congruent care delivery.

5.4 CONCLUSION

These insights collectively suggest that meaningful progress towards culturally sensitive, integrative healthcare in South Africa requires moving beyond both biomedical dismissal of traditional healing and superficial multiculturalism that tolerates cultural practices as long as they do not interfere with biomedical protocols. Instead, genuine transformation requires epistemic pluralism that recognises multiple valid healing systems, structural changes creating space for integration, relational approaches positioning patients as partners, and policy frameworks establishing cultural responsiveness as standard care component rather than optional enhancement. The following chapter explores these implications in greater depth, outlining specific recommendations for policy, practice, education, and research alongside considering implementation challenges and strategies for meaningful, sustainable change.

CHAPTER 6

STRATEGIES DEVELOPMENT

6.1. INTRODUCTION

This chapter presents a systematic development of evidence-based nursing strategies designed to enhance culturally sensitive patient care in metropolitan healthcare settings within the Western Cape, South Africa. The strategies emerge organically from the empirical findings presented in Chapter 4, the interpretive analysis detailed in Chapter 5, and the comprehensive discussion that aligned these findings with existing literature in Chapter 5. Rather than imposing externally derived solutions, this developmental process respects the voices of nurses, patients, community members, and traditional healers who generously shared their lived experiences, whilst simultaneously drawing upon national and international scholarship to ensure these strategies reflect best practice.

The researcher developed and validated nursing strategies in alignment with the World Health Organisation (WHO) criteria (WHO, 2021:1). The research findings were subsequently presented to healthcare management for validation, as they were identified as key stakeholders in the implementation and oversight of healthcare practices. Their authority in healthcare operations was essential to ensure that the proposed nursing strategies for culturally sensitive patient care were practical, feasible, and aligned with institutional goals and policies.

The chapter employs a research-based building block approach, systematically translating thematic findings into actionable strategies through five distinct phases: identifying core components requiring address, clustering related components into strategic domains, converting identified needs into specific objectives, developing concrete interventions with clear implementation pathways, and establishing robust expert validation processes. This methodical approach ensures that the strategies developed here are not merely aspirational but practically feasible, culturally appropriate, theoretically sound, and likely to generate meaningful improvements in healthcare quality and equity.

The strategies address intervention requirements at multiple ecological levels simultaneously individual practitioner competence, interpersonal communication and relationships, institutional structures and resources, and broader policy environments. This multi-level approach acknowledges that sustainable cultural competence cannot be achieved through individual efforts alone but requires coordinated systemic transformation. As the World Health Organisation (2023:7) emphasises in its Traditional Medicine Strategy, meaningful integration demands comprehensive approaches addressing education, regulation, and practice transformation concurrently.

6.2. THE BUILDING BLOCK APPROACH: FROM FINDINGS TO STRATEGIES

The strategy development process employed a systematic five-phase approach transforming empirical findings and literature insights into actionable interventions. This building block methodology ensures strategies are evidence-based, comprehensive, and practically implementable. These strategies were developed in phases as shown below:

6.2.1 Phase One: Identifying core components from findings

The initial phase involved careful re-examination of all six themes from Chapter 4, systematically extracting fundamental elements requiring attention in any comprehensive strategy. This extraction process moved beyond merely identifying problems to recognising underlying needs, assets that could be leveraged, and opportunities for positive transformation. Through close reading of thematic summaries and participant quotations, 30 core components were identified, representing building blocks that the strategies must address. These components span the following process, which was developed from the themes in Chapter 4 as shown below. These themes were used in the development of the strategies as recommended by the WHO guidelines.

Theme 1: Pathways to cultural competence

- Values-based foundation (Component 1.1)
- Formal education gaps (Component 1.2)

- Experiential learning mechanisms (Component 1.3)
- Peer-based knowledge transfer (Component 1.4)
- Professional identity integration (Component 1.5)

Theme 2: Systemic barriers

- Structural discrimination (Component 2.1)
- Communication gaps and language barriers (Component 2.2)
- Resource constraints (Component 2.3)
- Professional boundary ambiguity (Component 2.4)
- Policy and regulatory voids (Component 2.5)

Theme 3: Knowledge system conflicts

- Epistemological differences (Component 3.1)
- Integration frameworks needed (Component 3.2)
- Sacred versus secular knowledge (Component 3.3)
- Holistic versus symptomatic approaches (Component 3.4)
- Belief-integrated treatment (Component 3.5)

Theme 4: Patient navigation and agency

- Medical pluralism recognition (Component 4.1)
- Safe disclosure environments (Component 4.2)
- Economic decision-making (Component 4.3)
- Autonomy and choice (Component 4.4)
- Condition-specific utilisation patterns (Component 4.5)

Theme 5: Dignity, respect, and human rights

- Interpersonal respect as practice (Component 5.1)
- Cultural identity preservation (Component 5.2)
- Non-discriminatory care standards (Component 5.3)
- Emotional safety (Component 5.4)
- Informed consent and autonomy (Component 5.5)

Theme 6: Professional identity and ethical navigation

- Scope of practice clarity (Component 6.1)
- Ethical dilemma navigation (Component 6.2)
- Personal-professional integration (Component 6.3)
- Institutional accountability (Component 6.4)
- Continuous professional development (Component 6.5)

Phase Two: Clustering components into strategic domains

The 30 components were examined for relationships, shared features, and natural connections, clustering them into seven strategic domains representing major intervention areas. Components were clustered based on shared content focus, similar implementation approaches, complementary functions, and natural thematic relationships.

This clustering process yielded the seven domains presented in Table 6.1, each encompassing multiple related components and representing a major pillar of comprehensive cultural competence. For example, Strategic Domain 1 (Education and Training Systems) clustered Components 1.2 (formal education gaps), 1.3 (experiential learning), 1.4 (peer knowledge transfer), 3.1 (epistemological understanding), 3.4 (holistic assessment), 5.1 (interpersonal respect), 5.3 (non-discriminatory care), and 6.5 (continuous development) because all address knowledge and skill development through educational interventions.

Phase Three: Translating components into strategic objectives

Each strategic domain was converted into specific objectives articulating desired outcomes. Following SMART criteria where applicable (Specific, Measurable, Achievable, Relevant, Time-bound), objectives specified what would be achieved rather than merely what would be done. For example, Strategic Domain 1 generated objectives including: "Integrate comprehensive cultural competence and IKS content into undergraduate nursing curricula within 24 months" and "Train 100 per cent of nursing staff in anti-bias awareness and culturally sensitive communication within 24 months." These objectives provide accountability mechanisms,

enabling assessment of whether strategies achieve intended outcomes and requiring course recalibration when progress falls short. They communicate clearly to stakeholders what success looks like, moving beyond vague aspirations toward concrete, palpable changes.

Phase Four: Developing actionable strategies

The core developmental work involved translating objectives into concrete strategies specifying exactly what actions shall be taken, by whom, with what resources, according to what timeline, and measured by which metrics. Each strategy was developed with careful attention to:

- **Implementation Actions:** Detailed steps breaking strategies into specific, sequential activities. For example, Strategy 1.1 (Curriculum Integration) includes actions for curriculum review with stakeholder involvement, experiential learning with structured reflection, and peer learning network establishment.
- **Responsible managers and senior nurse clinicians:** Clear identification of who leads implementation (facility management), supports implementation and provides resources and oversight.
- **Resource requirements:** Specification of financial resources (curriculum development, infrastructure, staffing), human resources (expertise, time allocation, training), technological resources (online platforms, telehealth systems), and physical resources (space, equipment, materials).
- **Implementation timelines:** Realistic timeframes acknowledging system capacity and changing management requirements, with phased approaches enabling progressive implementation and early wins building momentum.
- **Success indicators:** Measurable outcomes demonstrating progress including process indicators (policies adopted, training completed, services established) and outcome indicators (competence demonstrated, disparities reduced, patient satisfaction improved).
- **Evidence base:** Explicit linkage to specific findings (with participant quotations) and literature (with author citations), ensuring strategies are grounded in empirical evidence and scholarly best practice rather than appearing as researcher preferences.

Phase Five: Expert validation framework

The final phase establishes rigorous processes through which developed strategies undergo expert scrutiny before finalisation, explained in Section 6.4 below. This validation ensures that strategies receive endorsement from experts who assess feasibility, appropriateness, comprehensiveness, and impact, enhancing credibility and legitimacy whilst identifying implementation barriers that require mitigation.

6.3. OVERVIEW OF DEVELOPED STRATEGIES

Table 6.1 below provides a comprehensive overview of all developed strategies, organised across seven strategic domains. This table enables audiences to appreciate the scope and interconnected nature of the strategic framework before engaging with detailed developmental processes and validation procedures.

Table 6.1: Summary of Developed Strategies for Enhancing Culturally Sensitive Patient Care

Strategic Domain	Specific Strategies	Key Implementation Actions	Primary Outcomes Expected	Timeline	Responsible for Implementation
Domain 1: Education and Training Systems	Strategy 1.1: Curriculum Integration of Cultural Competence and IKS Strategy 1.2: Mandatory Continuing Professional Development	• Comprehensive curriculum review with IKS expert involvement • Experiential learning with structured reflection • Peer learning and mentorship networks • Multi-level CPD programmes • Anti-bias and cultural humility training	• All nursing graduates possess substantive cultural competence • Practising nurses complete mandatory cultural CPD • Implicit biases are recognised and addressed • Cultural assessment becomes routine practice	24 months	Nursing education institutions, Nurse managers, Clinical educators, Western Cape Department of Health
Domain 2: Policy and Regulatory Framework	Strategy 2.1: Comprehensive Cultural Care Policy Development Strategy 2.2: Scope of Practice Clarification Strategy 2.3: Anti-Discrimination Standards	• Facility, provincial, and national policy development • SANC regulatory guidance on cultural care and IKS • Explicit anti-discrimination policies with consequences • Accessible grievance mechanisms	• Cultural care policies exist at all levels • Nurses have clear professional boundaries guidance • Discrimination is prohibited with accountability • Cultural accommodation is systematic, not discretionary	12-24 months	Hospital management, Policy makers, South African Nursing Council, Department of Health

Domain 3: Resource Allocation and Infrastructure	Strategy 3.1: Time Allocation for Cultural Care Strategy 3.2: Physical Infrastructure Strategy 3.3: Economic Accessibility	• Workload calculation reform including cultural care time • Flexible care models enabling accommodation • Dedicated spaces for cultural/spiritual practices • Community-based service expansion • Transport support programmes	• Adequate time exists for cultural communication • Physical spaces enable cultural practices • Economic barriers to care are reduced • Resources match claims about cultural care importance	12-36 months	Hospital management, Facility administrators, Department of Health
Domain 4: Communication and Interpersonal Practice	Strategy 4.1: Comprehensive Interpreter Services Strategy 4.2: Safe Disclosure Environments Strategy 4.3: Cultural Mediation Services	• Professional interpreter service establishment • Cultural communication skills training • Non-judgmental communication protocols • Community health worker cultural liaison roles	• Language barriers are systematically addressed • Cross-cultural communication is effective • Patients feel safe disclosing traditional medicine use • Trust enables honest therapeutic relationships	12-24 months	Nurse managers, Clinical staff, Interpreter services, Community health workers
Domain 5: Knowledge Integration and Care Coordination	Strategy 5.1: Traditional Healer-Provider Collaboration Strategy 5.2: Herb-Drug Interaction Screening	• Formal referral and communication mechanisms • Collaborative care planning processes • Herb-drug interaction database and screening • Education in comparative epistemologies	• Traditional healers and healthcare providers collaborate • Care is coordinated between systems • Patient safety through interaction screening	18-24 months	Nurse managers, Traditional health practitioners, Multidisciplinary teams,

	Strategy 5.3: Epistemological Respect	• Recognition of traditional healing legitimacy	• Epistemological differences are respected • Medical pluralism is facilitated		Department of Health
Domain 6: Professional Support and Development	Strategy 6.1: Ethics Consultation and Support Strategy 6.2: Professional Identity Integration Strategy 6.3: Communities of Practice	• Clinical ethics consultation service • Moral distress recognition and support • Reflective practice structures • Identity integration support for culturally embedded nurses • Cultural competence communities of practice	• Nurses receive support navigating ethical dilemmas • Moral distress is addressed • Professional identity tensions receive support • Ongoing peer learning through communities • Competence develops throughout careers	12-18 months	Nurse managers, Clinical educators, Ethics committees
Domain 7: Patient Partnership and Empowerment	Strategy 7.1: Partnership Model Implementation Strategy 7.2: Culturally Appropriate Consent	• Shift from compliance to partnership paradigms • Patient expertise recognition • Consent process adaptation for cultural contexts • Right to refuse and choose alternatives	• Patient-provider relationships are collaborative • Patient autonomy including cultural choices is respected • Informed consent accommodates cultural decision-making • Partnership replaces paternalism	18-36 months	Nurses, Nurse managers, Patient liaison officers, Healthcare institutions

6.4. EXPERT VALIDATION FRAMEWORK: ENSURING RIGOUR AND CREDIBILITY

Expert validation serves as the critical final phase, subjecting proposed strategies to rigorous scrutiny before finalisation. This validation ensures strategies are not merely researcher constructions but receive endorsement from experts representing clinical practice.

The expert validation process involved five experts with experience in culturally diverse healthcare settings. These experts comprised senior nurse managers and clinical nurse specialists working within metropolitan healthcare facilities in the Western Cape. The experts were selected using purposive sampling, based on their leadership roles, experience in culturally sensitive patient care, and involvement in policy implementation within healthcare institutions. Purposive sampling ensured that only individuals with relevant expertise and decision-making authority participated in the validation of the strategies. A total of five experts participated in the validation process.

The validation methodology followed a structured expert review approach aligned with the Delphi technique principles. Experts independently reviewed the developed strategies using a structured evaluation tool based on predetermined criteria, including relevance, feasibility, appropriateness, comprehensiveness, clarity, evidence-base, and potential impact. Each expert rated the strategies using a five-point Likert scale and provided qualitative comments for improvement. The feedback obtained from the experts was analysed and incorporated to refine the strategies, thereby enhancing their credibility within the metropolitan healthcare context.

6.4.1 Purpose of expert validation

Expert validation serves crucial functions:

Clinical feasibility assessment: Expert nurses' ground-truth strategies against practice realities characterised by time pressures, resource constraints, and competing demands, identifying implementation barriers, unrealistic assumptions, or resource requirements exceeding what systems can reasonably provide.

Credibility and legitimacy enhancement: Expert nurses endorsement signals that strategies underwent rigorous review and represent consensus, carrying greater weight with decision-makers than researcher recommendations alone.

Clinical nursing expertise (4-5 members): Senior nurse clinicians with extensive experience in culturally diverse settings, nurse managers with responsibility for practice standards and quality improvement, nurses demonstrating cultural competence and IKS integration in practice, and representation across clinical specialties (primary care, hospital, community health).

Validation process

The validation process comprised five structured steps ensuring rigorous, transparent, comprehensive review:

Step 1: Strategy document distribution

Expert members receive comprehensive documentation, including executive summary of research and strategic framework, empirical findings summary with participant quotations, literature review synthesis, complete developed strategies with rationales and evidence base, and evaluation framework and criteria guiding assessment.

Step 2: Independent expert review

Expert independently evaluates strategies using structured evaluation forms assessing each strategy across seven criteria using five-point Likert scales with qualitative elaboration:

- **Relevance:** Does the strategy address identified needs from research findings?
- **Evidence-Base:** Is the strategy grounded in empirical findings and aligned with literature?
- **Feasibility:** Can the strategy be realistically implemented given resource, policy, and system constraints?
- **Appropriateness:** Is the strategy culturally appropriate, ethically sound, and respectful of professional boundaries?
- **Comprehensiveness:** Do strategies comprehensively address all major domains requiring intervention?

- **Clarity:** Is the strategy clearly articulated with specific, actionable implementation steps?
- **Potential impact:** Is the strategy likely to create meaningful improvement in cultural care quality?

6.4.2. Validation criteria detail

The six validation criteria provide systematic standards guiding expert assessment:

Evidence-based: Strategies address gaps identified in findings with clear linkage to participant statements, align with best practices documented in literature, incorporate participant voices and perspectives, and articulate clear rationale for strategy choice.

Feasible: Strategies can be implemented within realistic timelines, specify obtainable required resources, account for existing constraints rather than assuming ideal conditions, propose phased implementation with early wins, and demonstrate likelihood of institutional will supporting implementation.

Appropriate: Strategies demonstrate cultural sensitivity and respect for diverse perspectives, align with ethical principles (autonomy, beneficence, non-maleficence, justice), respect professional boundaries and scope of practice, prove acceptable to key stakeholders, and avoid unintended negative consequences.

Comprehensive: Strategies collectively address all major domains requiring intervention, target multiple levels (individual, interpersonal, institutional, policy), include both immediate needs and long-term transformation, incorporate sustainability mechanisms, and maintain balance between breadth and depth.

Clear and actionable: Strategies articulate specific, detailed implementation steps, identifying responsible parties unambiguously, define specific, measurable success indicators, specify realistic timelines with milestones, and provide sufficient detail to guide implementation.

Impactful: Strategies create meaningful improvement in cultural care quality, address root causes positioning strategies for sustained impact, benefit multiple stakeholder groups, contribute to broader healthcare transformation, and generate changes proportionate to resource investments.

6.5 ALIGNMENT WITH FINDINGS AND LITERATURE

The developed strategies demonstrate strong alignment with both empirical findings and scholarly literature, ensuring evidence-based approaches grounded in local realities whilst informed by best international practices.

6.5.1 Grounding in participant voices

Each strategy explicitly responds to specific participant statements. For example:

- **Strategy 1.1: Curriculum integration**

This strategy directly addresses PN2's call: "At nursing school, there should be a module that teaches different cultures" and PN10's recommendation for "formal training in traditional medical practices."

- **Strategy 2.1: Policy development**

This strategy responds to PN3's observation that "We do not have any policy on cultural care - it depends on the nurse" and CP3's assertion that "if there were policy... they would know."

- **Strategy 3.1: Time allocation**

The strategy addresses PN6's constraint: "With so many patients, we can't spend time on cultural rituals - we have to finish the ward round."

- **Strategy 4.1: Safe disclosure**

This strategy responds to PN3's statement that patients hide traditional medicine use "because they think we will shout at them."

- **Strategy 5.1: Collaboration frameworks**

Operationalises PN10's observation that "Sometimes patients want us to refer to traditional healers, but we cannot - there is no system for that." This grounding ensures strategies honour lived experiences rather than imposing solutions disconnected from practice realities.

6.5.2 Alignment with scholarly literature

The development of the strategies was also emphasised by the following literature as depicted below:

The WHO Traditional Medicine Strategy 2023-2032 emphasise education, regulation, and research as pillars of integration operationalised through Strategic Domains 1 (education), 2 (regulation/policy), and 5 (research-informed integration). This collaboration was also restated by one of the validators as a key component. In addition, Ngunyulu et al., (2020:3) advocate for curriculum decolonisation "integrating indigenous theories of knowledge and adopting curriculum that reflect African worldviews" operationalised through Strategy 1.1's curriculum transformation with IKS expert involvement. According to Makhene (2023:4-5), critiquing "Western-focused training" creating an "imbalance between formal nursing education and cultural realities" whilst calling for transformation addressing "colonial legacies in education" is addressed through Strategies 1.1 and 1.2. Furthermore, Daniels and Mtshali (2023:203) suggest that identifying institutional constraints, lack of culturally sensitive training and negative attitudes as barriers, is addressed through Strategic Domains 2 (institutional policy), 1 (training), and Strategy 1.2.2 (anti-bias training) in this study.

In addressing cultural sensitivity, Shakwane (2022:2) recommend that "culturally sensitive patient care should go beyond cosmetic acknowledgements of diversity and instead integrate cultural sensitive care into education, policy and service design" which is operationalised through comprehensive strategies addressing education (Domain 1), policy (Domain 2), and service design (Domains 3, 4, 5) in the current study. Molefe and Ramlall (2021:145) notes insufficient policy-driven integration between systems, resulting in disjointed service delivery. This is addressed through Strategy 5.1 on establishing formal collaboration frameworks. This alignment

ensures strategies reflect evidence-based best practices whilst extending scholarship by providing detailed implementation pathways grounded in local contexts.

6.6. IMPLEMENTATION PRIORITIES AND SEQUENCING

Whilst all seven strategic domains require address for comprehensive transformation, expert validation informs priority sequencing based on feasibility, urgency, and interdependence. Accordingly, Tawse and Tabesh (2020) define strategy implementation effectiveness as the extent to which an organisation's implemented strategies correspond with its strategic intentions. This means that these developed strategies are communicated with the Western Cape Department of Health. Preliminary considerations suggest:

Immediate priorities (Months 1-12):

- Strategy 2.1: Facility-level cultural care policy development providing immediate guidance addressing current discretionary practices
- Strategy 2.3: Anti-discrimination policies establishing accountability for respectful treatment
- Strategy 4.1: Interpreter service expansion addressing critical communication barriers that compromise safety and quality
- Strategy 3.2: Interim solutions for cultural/spiritual spaces (portable screens, designated areas) enabling immediate accommodation

Short-term priorities (Months 12-24):

- Strategy 1.2: Mandatory CPD ensuring all practising nurses develop cultural competence
- Strategy 3.1: Workload calculation reform allocating time for cultural care
- Strategy 4.2: Safe disclosure protocols enabling honest communication about traditional medicine use
- Strategy 6.1: Ethics consultation services supporting nurses navigating dilemmas

Medium-term priorities (Months 24-36):

- Strategy 1.1: Undergraduate curriculum transformation (requiring Faculty development and institutional processes)

- Strategy 5.1: Traditional healer collaboration frameworks (requiring relationship building and systems development)
- Strategy 3.2: Major infrastructure development for cultural/spiritual spaces
- Strategy 7.1: Partnership model implementation (requiring substantial culture change)

Long-term priorities (Months 36+):

- Strategy 2.1: Provincial and national policy frameworks (requiring extended multi-stakeholder processes)
- Strategy 2.2: SANC regulatory guidance (requiring regulatory development timelines)
- Strategy 3.3: Community-based service expansion (requiring workforce and infrastructure development)
- Strategy 7.2: Culturally appropriate consent processes fully embedded in organisational culture

This sequencing enables early wins to build momentum whilst recognising that comprehensive transformation requires sustained commitment over multiple years.

6.7 COMMENTS FROM THE VALIDATORS REGARDING THE EVALUATION TOOL

All validators evaluated the tool as both valid and reliable. Reliability refers to the consistency, stability, and repeatability of measurements over time, across different items, and among various observers. It reflects how consistently an instrument produces the same results under similar conditions, reducing the impact of random errors. Similarly, validity refers to the degree to which an instrument accurately measures what it is intended to measure. It reflects the truthfulness, relevance, and meaningfulness of the inferences drawn from research findings (Hossan, Wolfs, Jesmin & Petkovic, 2025).

The evaluation of the used tool was conducted using a Likert scale ranging from 1 (least reliable) to 5 (most reliable). The following average scores were recorded for each criterion:

Criteria	Average Score
Relevance	4.5
Evidence-based	5
Feasibility	4
Appropriateness	5
Comprehensiveness	4.75
Clarity	4.5
Potential impact	5

The overall average score for the tool was 4.6, indicating a high level of reliability and validity.

Overall impression and comments from expert validators

Validators described the strategies developed as robust and strongly aligned with Leininger's Cultural Care Theory that informs this study:

- The majority cited that the study would strengthen intersectoral collaboration between the Department of Health, the South African Nursing Council, and traditional health practitioners.
- They also alluded to increasing awareness and training programmes for healthcare workers to enhance culturally sensitive care.

- They highlighted the adoption of a global transformation approach to support the implementation of the strategies.

The study was commended for being evidence-based, well-structured, and responsive to the needs identified in the Western Cape research setting. However, a shortage of staff was noted as a barrier to engaging in meaningful cultural discussions with patients.

6.8 CONCLUSION

This chapter covered the development of strategies based on the previous chapter's findings. These strategies were developed and validated in the next chapter by experts who are nursing managers. The tool used to evaluate the strategies was approved by the experts following the Delphi method. The experts gave a reliability score of 4.5 out of 5 as shown in previous paragraphs. The next chapter dwells on the recommendations, limitations as well as the significant original contributions made by this study.

CHAPTER 7

CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS

7.1. INTRODUCTION

This chapter presents the conclusions drawn from the research study. The research used an inductive thematic approach to uncover deep insights into how nurses navigate cultural diversity, professional ethics, and systemic challenges in their day-to-day practice. The findings illuminated the complexity of culturally sensitive patient care, distinguishing it as a dynamic and relational process shaped by personal values, institutional structures, and historical legacies. The chapter first synthesises the major conclusions derived from the thematic findings, followed by evidence-based recommendations for nursing practice, policy, education, and further research. It then discusses the study's limitations and concludes with the researcher's reflective commentary on the overall research journey. The objectives of this study were developed and achieved through a qualitative research methodology, as outlined in Chapter 1.

Phase 1: Qualitative (nurses)

- To explore and describe nurses' perspectives on different cultural belief systems, including consultation of indigenous healers by the healthcare users.

This objective was achieved when the nurses were interviewed and shared their perspectives, as shown in the Appendix U. These perspectives contributed to the development of the strategies outlined in Chapter 7, Table 7.1.

Phase 2: Qualitative (patients)

- To explore and describe the lived experiences of patients at the healthcare facilities following the consultation with indigenous healers prior to coming to the healthcare.

This objective was achieved when the patients were interviewed and shared their perspectives, as shown in the Appendix V. These perspectives contributed to the development of the strategies outlined in Chapter 7, Table 7.1.

Phase 3: Qualitative (community members)

- Explore and describe community views for consulting indigenous healers before visiting a clinic or hospital for healthcare.
- Explore and describe how the community would like to be treated in a culturally sensitive manner after consulting with indigenous healers by the nurses in healthcare facilities.
- Explore and describe the views of community members in a context where some may reject indigenous health practices while others may be rejecting the mainstream treatments.

This phase was the most important one, as the community, which consists of healthcare users, voiced their views. Phase 3 was achieved through interviews with the community (Appendix W). This phase played a crucial role in developing strategies for healthcare users.

Phase 4: Development and validation of the culturally sensitive strategies

Based on the findings from phases 1–3 of this study, the researcher proceeded to develop and validate nursing strategies to enhance culturally sensitive patient care. The strategies were developed in accordance with the WHO criteria (WHO, 2021:1). The research findings were then presented to healthcare management for validation as they are key stakeholders in implementing and managing healthcare practices and their authority in healthcare operations is central in ensuring that the proposed nursing strategies for culturally sensitive patient care are realistic and align with institutional goals and policies. The strategies developed are depicted in Chapter 6, Table 6.1. The validation and finalisation of these strategies is in Chapter 7, Table 7.1.

7.2. CONCLUSIONS DRAWN FROM THE STUDY

7.2.1. Review of the research findings

This study found that cultural sensitivity in patient care in the Western Cape is far more complex than the usual perspective of cultural competence implies. Instead of a fixed skill or checklist, it is a dynamic, context-dependent, and intensely relational practice. Nurses, patients, and community members agreed that meaningful cultural sensitivity requires empathy, respect, open communication, and institutional support to bridge the gap between diverse cultural belief systems and biomedical prescriptions.

Table 7.1: Cultural dimensions of research findings

Dimension	Participant Nurses (PN)	Participant Patients (PP)	Community Participants (CP)	Focus Group (FGPN)
Respect & Accommodation	Willing to respect if it does not interfere with care; rely on guidelines or personal discretion. "You must respect that... but still give the same care." (PN5)	Link respect directly to care-seeking and compliance; disrespect causes avoidance. "When nurses are not kind, it becomes difficult." (PP3)	Demand equal recognition and space for culture. "They must allow everybody to do what is right." (CP4)	Acknowledge respect as necessary but conditional. "If it doesn't interfere, I'd let them keep it." (FGPN)
Policy & Structure	See policy gaps as limiting cultural handling. "When there's policy, it makes things smoothly." (PN1)	Experience the effects of inconsistency. "Eventually, I went home... I haven't gone back." (PP3)	Emphasise absence of clear policies. "There are no policies that talk about that." (CP3)	Highlight systemic lack of framework. "We don't have a unified cultural approach." (FGPN)
Beliefs About Healing	Biomedical logic dominant but tolerate belief if safe. "If you believe, go for it." (PN5)	Mixed: some reject, others conceal, others combine. "I would bring it, maybe hide it." (PP11)	Strong pluralism; advocate for dual systems. "I'll say both." (CP1)	Diagnose structural disconnection. "No structured understanding of how systems can work together." (FGPN)
Integration & Collaboration	Conceptually open but lack referral channels, worried about risks. "I wouldn't know where to refer." (PN9)	Strategically combine but fear disclosure. "I didn't tell them." (PP11)	Advocate openly for integration. "Doctors and traditional must just combine." (CP1)	Argue integration needs policy-level support.
Communication & Judgment	Fear offending, sometimes avoid asking. "I didn't want to be rude and ask her." (PN9)	Experience judgment as blame or stigma. "They put that stamp on me... it's that medication you take." (PP1)	Demand respectful engagement. "It gives dignity to the person." (CP4)	Note systemic prioritisation of physical over cultural.

Professional Ethics & Identity	See ethics as balancing respect with professional duty; lack cultural training. “No module to refer.” (PN7)	Expect fairness and human dignity from professionals. “The ones who are lacking must step up.” (PP10)	Position nurses as moral agents who should adapt.	See gaps as institutional failures requiring reform.
Agency & Navigation	Encourage conditional navigation (try both but come back if no improvement).	Navigate tactically: conceal, resist, or comply. “I would hide it.” (PP11)	Exercise assertive autonomy — sometimes reject biomedicine. “I’ve never been to hospital in 15 years.” (CP2)	View navigation as unstructured due to absent framework.
Dignity & Autonomy	Tie dignity to professional boundaries: respect, but not if it disrupts care.	See dignity in empathy and being free from judgment. “When they are not kind, it becomes difficult.” (PP3)	Assert dignity as equal recognition of cultural identity.	Procedural recognition only — if harmless, allow.
Holistic vs Symptomatic Healing	Focus on clinical diagnosis, but some note emotional/spiritual dimension. “Heal not just physically but emotionally too.” (PN8)	Seek comfort, recognition, and wholeness in care.	Link healing to spiritual/community life. “God has healed me.” (CP6)	Recognise systemic bias towards physical outcomes.

Table 7.1 above illustrates the key healing dimensions as described by the participants and were verified during data analysis and confirmed by healthcare experts. Four healthcare experts independently validated the strategies. These dimensions show how healthcare providers and users coalesce if these can be implemented. These dimensions shall be communicated to the Western Cape Provincial Department of Health, as they have given permission to conduct the study. The inductive thematic analysis in Chapter 4, subsection 4.3.1, revealed six major themes and several subthemes, each reflecting a separate yet interconnected aspect of culturally sensitive patient care. These themes were strengthened and expanded by the rich insights gained from focus group discussions, which highlighted the collective professional reasoning of nurses in complex multicultural settings and contributed to the nine dimensions, as shown in Table 7.1 above.

7.2.2 Synthesis of key thematic conclusions

Theme 1: Pathways to cultural competence – The non-linear journey

Cultural competence evolves through multiple pathways rather than through structured training alone. Nurses developed cultural understanding through lived experiences, peer interactions, and reflective encounters with diverse patients. This finding challenges the notion that cultural sensitivity can be “taught” through standardised modules; rather, it develops over time through continuous learning, humility, and patient engagement. Participants such as PN6 exemplified that deep cultural understanding can emerge from empathy and experience rather than formal qualification.

Theme 2: Systemic barriers and institutional constraints

Despite individual nurses’ intentions to provide culturally sensitive patient care, systemic barriers such as workload pressures, time constraints, language differences, and inflexible institutional protocols often prevented them from practicing effectively. These findings point to the structural nature of cultural insensitivity, rooted in organisational cultures that prioritise efficiency and

biomedical conformity over person-centred care. This underscores the need for systemic transformation rather than relying solely on individual nurse responsibility.

Theme 3: Knowledge system conflicts – Traditional and biomedical paradigms

A recurring tension emerged between traditional healing practices and biomedical standards. Patients expressed profound trust in traditional healers and spiritual rituals, while many nurses, though personally respectful, felt professionally constrained from engaging with these beliefs. The study illuminated that this tension arises not from ignorance but from epistemological and ontological conflict: Western medicine demands transparency and evidence, whereas traditional healing values secrecy and the sacredness of knowledge. This finding emphasises the need for mutual respect between knowledge systems and structured channels for collaboration.

Theme 4: Dignity, respect, and human rights in care

Cultural sensitivity was repeatedly framed by participants as an issue of human dignity and social justice. Patients' narratives of disrespect, ridicule, or dismissal confirm how cultural insensitivity translates into systemic violence. Nurses recognised that ensuring respect and dignity must precede any effort to provide culturally tailored care. "Dignity before culture" thus emerged as a moral imperative, highlighting that cultural respect is inseparable from ethical nursing practice and human rights obligations.

Theme 5: Patient agency and navigation of dual healthcare systems

Patients demonstrated remarkable agency in navigating both biomedical and traditional healing systems, often concealing traditional medicine use due to fear of judgment. This concealment creates clinical risks and reflects a lack of psychological safety within healthcare interactions. Participants' accounts revealed that rather than competing, these systems could complement one another if healthcare institutions recognised patients' cultural autonomy and developed integrated care pathways.

Theme 6: Professional identity and ethical navigation

Nurses frequently expressed inner turmoil and conflicts between personal beliefs and professional duties. The data shows that professional identity in multicultural settings involves ongoing negotiation between respecting cultural practices and adhering to biomedical ethics. The courage to admit “not knowing” emerged as a mark of professional maturity rather than weakness, underscoring the need for reflection and ethical humility as core components of cultural competence.

Theme 7: The gender dimension in cultural sensitivity

Male nurses in particular described navigating gender-specific cultural boundaries that restrict physical care for female patients or influence perceptions of modesty. This highlights the intersection of gender and culture in shaping care dynamics, an often-overlooked aspect of cultural competence training.

Theme 8: Integrating dreams and systemic resistance

Across interviews and focus groups, there was an overwhelming desire among nurses and community members for more formal collaboration between traditional healers and biomedical professionals. However, participants also acknowledged deep systemic resistance, regulatory uncertainty, and fear of professional repercussions. The study concludes that integration remains an aspirational yet achievable goal requiring institutional support, policy reform, and professional education.

Theme 9: Learning from experience – “The university of the ward”

Practical, experience-based learning emerged as the dominant mode of cultural competence development. Informal mentorship, experiential reflection, and real-time patient encounters contributed more significantly to cultural learning than theoretical instruction. This finding

suggests that professional development should incorporate structured reflection and case-based learning from practice realities.

Theme 10: The quiet revolution – Gradual cultural transformation

Despite structural barriers, the study verified incremental progress towards more culturally inclusive healthcare. Small policy changes, such as accommodating dietary needs and spiritual practices, were perceived as significant steps forward. These quiet transformations reflect nurses' resilience and moral commitment to patient-centred care despite systemic constraints.

7.3 CONTRIBUTION OF THE STUDY TO PRACTICE, POLICY, NURSING EDUCATION, AND FURTHER RESEARCH

This study makes the following significant original contributions as described in the paragraphs that follow:

7.3.1 Nursing practice

This study recommends that everybody should be accommodated and respected irrespective of who they are as in Table 7.1 dimension 1. As defined by WHO (2021) nursing is autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled, and dying people.

7.3.1.1 *Embed cultural safety as a core nursing value:*

Cultural safety should be recognised as an integral component of patient safety and clinical effectiveness. Nursing practice must ensure that patients feel respected, valued, and free from cultural judgment. Nursing care must be holistic as it is depicted in the Leininger's sunrise model.

7.3.1.2 *Enhance communication skills for culturally diverse contexts:*

Nurses should be trained to use inclusive language, active listening, and empathetic questioning to uncover patients' cultural and spiritual needs safely.

7.3.1.3 *Promote reflective practice and peer dialogue:*

Structured reflection sessions should be incorporated into routine nursing practice to help nurses examine biases and learn from cultural encounters with their patients.

7.3.2. *Develop patient disclosure protocols:*

Creating safe, non-punitive spaces where patients can disclose the use of traditional medicines or practices without fear of ridicule or discrimination.

7.3.2.1 *Strengthening interprofessional collaboration:*

Encouraging structured dialogues and referral systems between nurses, doctors, and recognised traditional healers to promote coordinated, culturally respectful care.

7.3.3 *Recommendations for policy*

7.3.3.1 *Institutionalise cultural competence standards:*

The Western Cape Department of Health should integrate measurable cultural competence indicators into facility accreditation, supervision, and quality audits.

7.3.3.2 *Formal recognition of traditional healing systems:*

Policies should support safe collaboration between traditional healers and biomedical practitioners through referral frameworks, mutual training, and shared care protocols. This is based on the fact that over 80 percent of the population globally believes and uses traditional healing systems.

7.3.3.3 *Cultural safety accountability mechanisms:*

Establish reporting and redress systems for patients who experience cultural discrimination or disrespect within healthcare institutions.

7.3.3.4 *Equitable resource allocation:*

Allocate resources for interpreter services, language brokers, cultural liaison officers, and continuous professional development to promote equitable patient experiences.

7.3.4 *Recommendations for nursing education*

7.3.4.1 *Integrate Southern and cultural epistemologies in curricula:*

Nursing education should move beyond cultural awareness checklists to include deeper understanding of epistemological diversity between healing systems. Basic nursing degree

courses to incorporate decoloniality, Southern epistemologies and Africanism as part of the modules.

7.3.4.2 *Experiential and community-based learning:*

Curricula should embed clinical placements in diverse cultural settings to allow students to engage authentically with community practices. This should include engagement with indigenous leaders as well as healers so as to get a full understand about the culture of their clients.

7.3.4.3 *Gender and culture sensitisation training:*

Address gender-based cultural challenges explicitly within nursing education, preparing male and female nurses to navigate culturally gendered care expectations.

7.3.4.4 *Promote reflective pedagogies:*

Introduce journaling, mentorship, and dialogue circles where nursing students critically reflect on personal biases and cultural encounters. When placed in the community for experiential learning.

7.3.4.5 *Continuous professional development:*

Encourage lifelong learning through workshops, seminars, and peer-mentoring on cultural humility and inclusive care. These workshop and seminars should include indigenous leaders and healers.

7.3.5 Recommendations for further research

7.3.5.1 *Comparative studies across provinces in South Africa:*

Future studies could examine whether similar cultural dynamics exist in other provinces in South Africa, especially in rural sites compared to metropolitan settings.

7.3.5.2 *Evaluation of integration models:*

Research should assess pilot projects that establish collaboration between traditional healers and nurses to determine their feasibility and patient outcomes as stated by the WHO (2021).

7.3.5.3 *Longitudinal studies on cultural competence development:*

Investigate how cultural competence evolves across nurses' careers and what institutional factors best sustain it.

7.3.5.4 *Patient perspectives on cultural safety:*

Additional qualitative work should centre patients' voices to explore their perceptions of respect, safety, and inclusion in healthcare settings.

7.3.5.5 *Policy impact research studies:*

Examine how cultural competence training and policy reforms influence patient satisfaction, treatment adherence, and overall health equity.

7.4 LIMITATIONS OF THE STUDY

Limitations of the study are issues and challenges that researchers face during the study that may exert an impact on the results and interpretations of those results (Akanle, Ademuson & Shittu, 2020:105-114). While this study offers rich insights into culturally sensitive patient care, certain limitations must be acknowledged:

7.4.1 Sample and context:

The research was confined to a metropolitan community in the Western Cape. Although data saturation was achieved across participant groups, the findings may not fully represent rural or private healthcare contexts. To mitigate this limitation, further studies could be conducted in different parts of the country, across provinces in South Africa, and focusing on rural–urban dynamics and complexities.

7.4.2 Self-reporting bias:

Participants may have presented socially desirable responses, particularly when discussing professional ethics or cultural sensitivity. This could have happened even if participants were reassured of confidentiality of the information supplied.

7.4.3 Language and translation:

Although interviews were conducted in English, subtle cultural meanings might have been lost during transcription and translation. The researcher strove to understand the language used by the community with emphasis on fidelity.

7.4.4 Researcher positionality:

My positionality as an insider researcher with professional nursing experience, personal interpretations could have influenced thematic development despite rigorous reflexive practice. Despite these limitations, data triangulation through the inclusion of different participant groups, including individual interviews and focus group discussions - strengthened the credibility and depth of the findings.

7.5. FINAL REFLECTIONS

This research journey has been both professionally and personally transformative. As a nurse and researcher, engaging with the voices of fellow practitioners and patients deepened my understanding of the moral, emotional, and systemic dimensions of cultural sensitivity. The process of coding, analysing, and interpreting lived experiences signifies that cultural sensitivity cannot be reduced to knowledge acquisition, but a continuous ethical and relational practice requires humility, openness, and reflexivity.

The reflexive process revealed my own cultural assumptions and professional biases, prompting ongoing introspection of how these influence my interpretation of care. Each interview, whether filled with laughter, frustration, or silent reflection reminded me that cultural encounters are fundamentally about human connection. Furthermore, the findings reinforced that nurses in South Africa operate at the intersection of diverse cultural worlds, colonial histories, and modern health imperatives. Their resilience, adaptability, and compassion are the backbone of culturally sensitive healthcare. Yet, systemic barriers continue to constrain these efforts. For true transformation, institutional cultures must evolve alongside individual competencies.

This study convinced me that cultural sensitivity is not a destination but a lifelong journey, an evolving relationship between nurses, patients, and the broader society. It requires courage to confront uncomfortable truths, commitment to ethical care, and compassion that transcends cultural boundaries. The hope is that this research contributes not only to scholarly discourse but also to practical transformation within nursing practice and healthcare systems across South Africa.

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APPENDIXES

APPENDIX A: UNISA ETHICS APPROVAL LETTER

Appendix A: University of South Africa Ethics Approval Letter



College of Human Sciences_CREC

Date: 26/03/2025

Dear: Mr Zama Alfred Mfundisi

Decision: Ethics Approval from 25 March 2025 to 25 March 2026

NHREC Registration # : (Rec-240816-052)
Ref # : 6030
Name: Mr Zama Alfred Mfundisi
Student # : 22638458

Researcher: Mr Zama Alfred Mfundisi

Western Cape

Cape Town

22638458@mylife.unisa.ac.za 0732176444

Supervisor: Professor David Ditaba Mphuthi mphutdd@unisa.ac.za

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Qualification: PhD

Thank you for the application for research ethics clearance by the College of Human Sciences_CREC for the above-mentioned research study. Ethics approval is granted for one year.

The **medium-risk application** was **reviewed** by the College of Human Sciences_CREC on **26 March 2025** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College of Human Sciences_CREC.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after the expiry date (**25 March 2026**). Submission of a completed research ethics progress report will constitute an application for renewal, for Ethics Research Committee approval.

Additional Conditions

1. Disclosure of data to third parties is prohibited without explicit consent from Unisa.
2. De-identified data must be safely stored on password protected PCs.
3. Care should be taken by the researcher when publishing the results to protect the confidentiality and privacy of the university.
4. Adherence to the National Statement on Ethical Research and Publication practices, principle 7 referring to Social awareness, must be ensured: "Researchers and institutions must be sensitive to the potential impact of their research on society, marginal groups or individuals, and must consider these when weighing the benefits of the research against any harmful effects, with a view to minimising or avoiding the latter where possible." Unisa will not be liable for any failure to comply with this principle.
5. Kindly note that the College of Human Sciences_CRECE requires the submission of regular progress reports to be submitted {half-yearly}. In line with section 7.2 of the Unisa Policy on Research Ethics (2024).

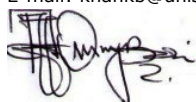
Note

The reference number 6030 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Kind regards,



Prof Khatija Khan
Chair of College of Human Sciences_CRECE
E-mail: khankb@unisa.ac.za



Professor Omwoyo Bosire Onyancha
Executive Dean / By delegation from the Executive Dean of College of Human Sciences_CRECE
E-mail: onyanob@unisa.ac.za

APPENDIX B: CITY OF CAPE TOWN-HEALTH ETHICS APPROVAL LETTER

Appendix B: City of Cape Town – City Health Ethics Approval Letter



CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Natacha Berkowitz
Epidemiologist: City Health

T: 021 400 6864

E: Natacha.Berkowitz@capetown.gov.za

Ref: 12205 2025-04-17

RE: Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Dear Mr Zama Alfred Mfundisi

Your research request has been approved as per your protocol. Please refer to the subsequent pages for the approval of any facilities or focus areas requested. Approval comments on any proposed impact on City Health resources are also provided.

Mitchells Plain & Southern:

Contact Person: Ms Jennifer Coetzee (Area South Manager)

Tel/Cell: 0824653339

Email: Jennifer.Coetzee@capetown.gov.za

Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to the clinic and its patients must be arranged with the relevant Manager such that normal activities are not disrupted.
3. A copy of the final report must be uploaded to <https://web1.capetown.gov.za/web1/mars/ProjectClosure/UploadReport/0/12205>, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (12205). Please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises
6. If this research gives rise to a publication, please submit a draft before publication for City Health comment and include a disclaimer in the publication that "the research findings and recommendations do not represent an official view of the City of Cape Town"
7. As the research is approved as per submitted protocol, any changes to the protocol need to be submitted and approved by City Health prior to implementation.

Thank you for your co-operation and please contact me if you require any further information or assistance.

Kind Regards

Dr Natacha Berkowitz Epidemiologist: City Health

Facilities

Area	Subdistrict	Facilities		
Area South	Mitchells Plain	Facility name	Interaction start date	Interaction end date
		Eastridge Clinic	2025-04-15	2025-07-15

Please note

- If a requested facility does not appear in the list above, its interaction request has been rejected and the reason for the rejection can be viewed in the link below
- Approval comments for facilities may exist. These comments can be viewed in the link below.

<https://web1.capetown.gov.za/web1/mars/ProjectFacility/Read/0/12205>

Impacted resources

Impacted resource	Decision	Comment
Space	Approved	Approved

APPENDIX C: WESTERN CAPE DEPARTMENT OF HEALTH ETHICS APPROVAL OF RESEARCH AT MITCHELLS PLAIN HOSPITAL

Appendix C: Western Cape Department of Health Ethics Approval of Research at Mitchells Plain Hospital



**Western Cape
Government**

Directorate: Health Intelligence

Health.Research@westerncape.gov.za

24th Floor, 4 Dorp Street

Cape Town, 8001 REFERENCE: WC_202503_055

ENQUIRIES: Dr Glynis Denicker

For attention: Mr Zama Alfred Mfundisi

Re: Approval of research at Mitchells Plain Hospital

Study Reference: **WC_202503_055**

Study Title: **Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries:

Mitchells Plain Hospital

Facility contact person: **Dr Jacek Marzalek**

Contact Details: **Email:**jacek.marszalek@westerncape.gov.za **Telephone:**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, provided that normal activities at requested facilities are not interrupted and staff are not put under pressure to comply with the research activities.
2. Researchers must provide the department with an electronic copy of a Final Report using the Annexure 9 template within six months of completion of research. This can be submitted to Health.Research@westerncape.gov.za. Future research will not be allowed on the health platform if a Final Report is not submitted.
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, or the final date of the ethics clearance letter, researchers are expected to complete and submit a progress report (Annexure 8) and an updated ethics clearance letter to Health.Research@westerncape.gov.za. Failure to do so will render this approval letter void.
4. Please note that if you are conducting a folder audit, and you do not have consent from individual study participants/subjects, you may not capture identifiable patient information in your database, as per the Protection of Personal Information Act 4 of 2013 (POPIA).
5. If you do have consent from individual participants in this study, and you are collecting identifiable patient data through your chosen research methodology, you should not keep the data for any longer than is required to complete this research, as per POPIA.
6. The reference number above should be quoted in all future correspondence.

Yours sincerely

A handwritten signature in black ink, appearing to be 'J. Marzalek'.

APPENDIX D: WESTERN CAPE DEPARTMENT OF HEALTH ETHICS APPROVAL OF RESEARCH AT MITCHELLS PLAIN CHC

Appendix D: Western Cape Department of Health Ethics Approval of Research at Mitchells Plain CHC



**Western Cape
Government**

Directorate: Health Intelligence
Health.Research@westerncape.gov.za
24th Floor, 4 Dorp Street
Cape Town,

8001 REFERENCE: WC_202503_055

ENQUIRIES: Dr Glynis Denicker

For attention: Mr Zama Alfred Mfundisi

Re: Approval of research at Mitchells Plain CHC

Study Reference: **WC_202503_055**

Study Title: **Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries:

Mitchells Plain CHC

Facility contact person: [facility Contact name]

Contact Details: [facility contact details]

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, provided that normal activities at requested facilities are not interrupted and staff are not put under pressure to comply with the research activities.
2. Researchers must provide the department with an electronic copy of a Final Report using the Annexure 9 template within six months of completion of research. This can be submitted to Health.Research@westerncape.gov.za. Future research will not be allowed on the health platform if a Final Report is not submitted.
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, or the final date of the ethics clearance letter, researchers are expected to complete and submit a progress report (Annexure 8) and an updated ethics clearance letter to Health.Research@westerncape.gov.za. Failure to do so will render this approval letter void.
4. Please note that if you are conducting a folder audit, and you do not have consent from individual study participants/subjects, you may not capture identifiable patient information in your database, as per the Protection of Personal Information Act 4 of 2013 (POPIA).
5. If you do have consent from individual participants in this study, and you are collecting identifiable patient data through your chosen research methodology, you should not keep the data for any longer than is required to complete this research, as per POPIA.
6. The reference number above should be quoted in all future correspondence.

Yours sincerely



Lesley Shand
Acting Director: Health Intelligence
Health
Western Cape Government

DATE: **30 June 2025**

<https://www.westerncape.gov.za/general-publication/health-research-approval-process>

APPENDIX E: WESTERN CAPE DEPARTMENT OF HEALTH COMBINED ETHICS APPROVAL OF RESEARCH AT BOTH MITCHELLS PLAIN HOSPITAL AND MITCHELLS PLAIN CHC

Appendix E: Western Cape Department of Health Combined Ethics Approval of Research at Both Mitchells Plain Hospital and Mitchells Plain CHC



Western Cape
Government

Directorate: Health Intelligence
Health.Research@westerncape.gov.za
24th Floor, 4 Dorp Street

Cape Town, 8001 REFERENCE:

ENQUIRIES: Dr Glynis Denicker

For attention: Mr Zama Alfred Mfundisi

Study Reference: **WC_202503_055**

Study Title: **Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries:

Facility Name	Approval Status	Facility Contact	Contact Details
Mitchells Plain CHC	Approved	Sr Yolando Samuels	Email:Yolando.Samuels@westerncape.gov.za
Mitchells Plain Hospital	Approved	Dr Jacek Marzalek	Email:jacek.marszalek@westerncape.gov.za

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, provided that normal activities at requested facilities are not interrupted and staff are not put under pressure to comply with the research activities.
2. Researchers must provide the department with an electronic copy of a Final Report using the Annexure 9 template within six months of completion of research. This can be submitted to Health.Research@westerncape.gov.za. Future research will not be allowed on the health platform if a Final Report is not submitted.
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, or the final date of the ethics clearance letter, researchers are expected to complete and submit a progress report (Annexure 8) and an updated ethics clearance letter to Health.Research@westerncape.gov.za. Failure to do so will render this approval letter void.
4. Please note that if you are conducting a folder audit, and you do not have consent from individual study participants/subjects, you may not capture identifiable patient information in your database, as per the Protection of Personal Information Act 4 of 2013 (POPIA).
5. If you do have consent from individual participants in this study, and you are collecting identifiable patient data through your chosen research methodology, you should not keep the data for any longer than is required to complete this research, as per POPIA.
6. The reference number above should be quoted in all future correspondence.

Yours sincerely

Lesley Shand

Acting Director: Health Intelligence

Health

Western Cape Government

<https://www.westerncape.gov.za/general-publication/health-research-approval-process>

APPENDIX F: ACKNOWLEDGEMENT LETTER FROM THE COMMUNITY LEADER

Councillor Norman Robert Adonis Ward 91

Tel: 02 444 9844 M: 078 376 2297

E: Norman.Adonis@capetown.gov.za

O: CNR BoKkeveld Ave & OlifantshoeK.Tafelsig, Mitchells Plain 7785



CITY OF CAPE TOWN
ISI XEKO SASE KAPA
STAD KA A PS7A D

de nq p y +g ac% p o as b1e . Tog othee.

06 May 2025

To whom it may concern

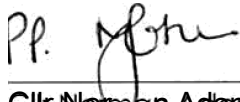
RE: confirmation of research done by Zama Mfundisi

'We greet you with the universal greetings of peace be upon you and hope that this letter reaches you in good health and community upliftment'

This letter serves as confirmation that Mr Zama Mfundisi has done some research in Ward 92 since May till July 2025 in our ward. Wishing you well in your future endeavours.

If there is any queries or information needed kindly contact us on the above numbers

Kind regards


Cllr Norman Adonis
Ward 92

APPENDIX G: INFORMATION SHEET FOR NURSES

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

(Zama Alfred Mfundisi)

Ethics clearance reference number:

Research permission reference number (if applicable):

May 2024

Title: Nursing Strategies to Enhance Culturally Sensitive Patient Care in a
Metropolitan Community: Western Cape, South Africa

Dear Prospective Participant (nurses)

My name is Zama Alfred Mfundisi, and I am doing research with David D Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa. I am self-funded, and I am inviting you to participate in a study entitled:
Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community:
Western Cape, South Africa

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to gain deeper understanding on the perspectives of nurses regarding patients who have sought consultation with Indigenous healers prior to hospital or

clinic visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop nursing strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. Your facility has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

WHY BEING AM I INVITED TO PARTICIPATE?

You are invited to participate in this study because your experience as nurses is essential to understanding the culturally sensitive patient care. Nurses play an important role in patient care and contribute direct experiences that influence healthcare procedures. Participants recruited based on their nursing backgrounds and experience with patient care. Contact information for potential participants will be obtained from professional networks, assuring compliance with the Protection of Personal Information (POPIA) Act, No. 4 of 2013. Strict protocols will be followed to protect the privacy and confidentiality of the participant's personal information. This study will include around 20 (twenty) nurses ensuring a diverse range of perspectives. Your participation will help to better understand culturally sensitive patient care and develop effective nursing strategies to improve patient care experiences.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The nature of your participation in this study will primarily involve engaging in semi-structured individual interviews and in a focus group in a quiet private room at the hospital or clinic. The researcher will set appointments with every participant as agreed on at a specific date and time to conduct the interviews or participate in focus group. During these interviews, you will be asked questions aimed at understanding your views and perspectives on culturally sensitive patient care. The questions will cover topics such as your experiences with patients from diverse cultural backgrounds, your understanding of cultural beliefs influencing patient care and your strategies for providing culturally sensitive patient care. Each interview is expected to last at least 45 (forty-five) minutes, depending on the depth of discussion. Each interview will be tape-recorded with your permission. The reason behind recording is to assist researchers to analyse interviewee's responses to gain insight, listen to the interview more than once and share the data with the supervisor only. The researcher will also take notes during the interview so that at the end of interview the researcher can reflect on the interview to identify gaps that might need to be

explored in a follow-up interview. Your participation will be essential in contributing first-hand insights to the research and your input will help inform the development of strategies for culturally sensitive patient care.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct benefits for participating in this study. But the participation is important to better understand the nurse's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop nursing strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to nurses who had experienced lack of sensitivity from fellow nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your information and identity will be kept confidential throughout the research process. Your name will not be recorded anywhere, and no one will be able to connect you to the answers you provide. Instead, your answers will be given a code number or pseudonym, and you will be

referred to in this way in the data, any publications or other research reporting methods. Only the researchers and identified members of the research team will have access to the data and they will ensure confidentiality by maintaining strict protocols. Your anonymous data may be used for other purposes, such as research reports, journal articles or conference proceedings. However, individual participants will not be identifiable in any publication or report of the study, ensuring your privacy is protected. Every effort will be made to maintain confidentiality and anonymity.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet at the University of South Africa for future research or academic purposes, electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

You will not pay anything, and you will not be paid by participating, the researcher is self-funding in this research study. However, any expenses incurred because of taking part in the study and transport costs will be paid back to you (reimbursed).

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study will receive written approval from the Research Ethics Review Committee of the University of South Africa (Appendix A). A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email:

mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, [Tel: 012429-8069](tel:012429-8069). Email: moodlj@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.



Zama Alfred Mfundisi

APPENDIX H: INFORMATION SHEET FOR PATIENTS

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

(Zama Alfred Mfundisi)

Ethics clearance reference number:

Research permission reference number (if applicable):

December 2024

Title: Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa

Dear Prospective Participant (patients)

My name is Zama Alfred Mfundisi and I am doing research with David D Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa. I am self-funded and I am inviting you to participate in a study entitled: Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to gain deeper understanding on the perspectives of patients regarding patients who have sought consultation with indigenous healers prior to hospital visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop

strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. This facility has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

WHY AM I BEING INVITED TO PARTICIPATE?

You are being invited to participate in this study because your experience as patient is essential to understanding the culturally sensitive patient care. Nurses play an important role in patient care and contribute direct experiences that influence healthcare procedures. Contact information for potential participants will be obtained from professional networks, assuring compliance with the Protection of Personal Information (POPIA) Act, No. 4 of 2013. Strict protocols will be followed to protect the privacy and confidentiality of the participant's personal information. This study will include around 20 (thirty) patients ensuring a diverse range of perspectives. Your participation will help to better understand culturally sensitive patient care and develop effective nursing strategies to improve patient care experiences.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The nature of your participation in this study will primarily involve engaging in semi-structured individual interviews in a quiet private room at the hospital or clinic. The researcher will set appointments with every participant as agreed on at a specific date and time to conduct the interviews. During these interviews, you will be asked questions aimed at understanding your views and perspectives on culturally sensitive patient care. The questions will cover topics such as your experiences with diverse cultural backgrounds, your understanding of cultural beliefs influencing patient care and your strategies for providing culturally sensitive patient care. Each interview is expected to last at least 45 (forty-five) minutes, depending on the depth of discussion. Each interview will be tape-recorded with your permission. The reason behind recording is to assist researcher to analyse interviewee's responses to gain insight, listen to the interview more than once and share the data with the supervisor only. The researcher will also take notes during interview so that at the end of the interview the researcher can reflect on the interview to identify gaps that might need to be explored in a follow-up interview. Your participation will be essential in contributing first-hand insights to the research and your input will help inform the development of strategies for culturally sensitive patient care.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct benefits for participating in this study. But the participation is important to better understand the patient's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to patients who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your information and identity will be kept confidential throughout the research process. Your name will not be recorded anywhere, and no one will be able to connect you to the answers you provide. Instead, your answers will be given a code number or pseudonym, and you will be referred to in this way in the data, any publications or other research reporting methods. Only the researcher and identified members of the research team will have access to the data and they will ensure confidentiality by maintaining strict protocols. Your anonymous data may be

used for other purposes, such as research reports, journal articles or conference proceedings. However, individual participants will not be identifiable in any publication or report of the study, ensuring your privacy is protected. Every effort will be made to maintain confidentiality and anonymity.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet at the University of South Africa for future research or academic purposes, electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

You will not pay anything and you will not be paid by participating, the researcher is self-funding in this research study. However, any expenses incurred because of taking part in the study and transport costs will be paid back to you (reimbursed).

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study will receive written approval from the Research Ethics Review Committee of the University of South Africa (Appendix A). A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, Tel: [012429-8069](tel:012429-8069). Email: moodlijk@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

A handwritten signature in black ink, appearing to read 'Zama Alfred Mfundisi'.

Zama Alfred Mfundisi

APPENDIX I: INFORMATION SHEET FOR COMMUNITY MEMBERS

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

(Zama Alfred Mfundisi)

Ethics clearance reference number:

Research permission reference number (if applicable):

December 2024

Title: Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa

Dear Prospective Participant (community member)

My name is Zama Alfred Mfundisi and I am doing research with David D Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa. I am self-funded and I am inviting you to participate in a study entitled: Developing strategies for culturally sensitive patient care

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to gain deeper understanding on the perspectives of patients regarding patients who have sought consultation with indigenous healers prior to hospital visit,

with the aim of gaining insights into how these patients are perceived. The purpose is to develop strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. This community has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

WHY AM I BEING INVITED TO PARTICIPATE?

You are being invited to participate in this study because your experience as community member is essential to understanding the culturally sensitive patient care. Nurses play an important role in patient care and contribute direct experiences that influence healthcare procedures. Contact information for potential participants will be obtained from professional networks, assuring compliance with the Protection of Personal Information (POPIA) Act, No. 4 of 2013. Strict protocols will be followed to protect the privacy and confidentiality of the participants' personal information. This study will include around 20 (twenty) community members ensuring a diverse range of perspectives. Your participation will help to better understand culturally sensitive healthcare patient care and develop effective strategies to improve patient care experiences.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The nature of your participation in this study will primarily involve engaging in semi-structured individual interviews and focus group in a quiet private room in the community. The researcher will set appointments with every participant as agreed on at a specific date and time to conduct the interviews. During these interviews, you will be asked questions aimed at understanding your views and perspectives on culturally sensitive patient care. The questions will cover topics such as your experiences with diverse cultural backgrounds, your understanding of cultural beliefs influencing patient care and your strategies for providing culturally sensitive patient care. Each interview is expected to last at least 45 (forty-five) minutes, depending on the depth of discussion. Each interview will be tape-recorded with your permission. The reason behind recording is to assist researcher to analyse interviewee's responses to gain insight, listen to the interview more than once and share the data with the supervisor only. The researcher will also take notes during interview so that at the end of interview the researcher can reflect on the interview to identify gaps that might need to be explored in a follow-up interview. Your

participation will be essential in contributing first-hand insights to the research and your input will help inform the development of strategies for culturally sensitive patient care.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct benefits for participating in this study. But the participation is important to better understand the community's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to community members who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your information and identity will be kept confidential throughout the research process. Your name will not be recorded anywhere, and no one will be able to connect you to the answers you provide. Instead, your answers will be given a code number or pseudonym, and you will be

referred to in this way in the data, any publications or other research reporting methods. Only the researcher and identified members of the research team will have access to the data and they will ensure confidentiality by maintaining strict protocols. Your anonymous data may be used for other purposes, such as research reports, journal articles or conference proceedings. However, individual participants will not be identifiable in any publication or report of the study, ensuring your privacy is protected. Every effort will be made to maintain confidentiality and anonymity.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet at the University of South Africa for future research or academic purposes, electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

You will not pay anything, and you will not be paid by participating, the researcher is self-funding in this research study. However, any expenses incurred because of taking part in the study and transport costs will be paid back to you (reimbursed).

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study will receive written approval from the Research Ethics Review Committee of the University of South Africa (Appendix A). A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, Tel: 012429-8069. Email: moodljk@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.



Zama Alfred Mfundisi

APPENDIX J: PERMISSION LETTER TO WESTERN CAPE DEPARTMENT OF HEALTH TO CONDUCT RESEARCH AT MITCHELLS PLAIN HOSPITAL

PERMISSION LETTER

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

(Zama Alfred Mfundisi)

Request for permission to conduct research at Mitchells Plain Hospital

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community:
Western Cape, South Africa

November 2024

Prof C Househam

Head of Health

Department of Health

20th Floor, 4 Dorp Street

Cape Town

South Africa

8001

Tel: +27 21 483 3245

Dear Prof Househam

I, Zama Alfred Mfundisi am doing research with David Ditaba Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa.

I hereby request to conduct a research study at Mitchells Plain District Hospital and Eastridge Clinic. The study is titled:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

The aim of the study is to gain deeper understanding on the perspectives of nurses, and patients regarding patients who have sought consultation with indigenous healers prior to hospital visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop nursing strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. The facilities have been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

The study will entail semi-structured individual interviews and focus group with nurses and semi-structured interviews only with patients to explore about their experiences, views and perceptions of cultural sensitivity in patient care. To ensure that interviews with nurses do not disrupt their work, data collection will be scheduled during their breaks or at times convenient for them, in coordination with healthcare management. Flexibility in timing will be prioritized to minimize any interference with patient care. These interviews will provide flexibility in questions while ensuring that essential issues pertinent to the research objectives are covered.

There are no direct benefits in participating into this study. But the participation is important to better understand the nurses and patient's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop nursing strategies

for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to patients who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com/ 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, [Tel:012429-8069](tel:012429-8069). Email: moodlijk@unisa.ac.za

Yours sincerely



ZA Mfundisi

APPENDIX K: PERMISSION LETTER TO CONDUCT RESEARCH AT MITCHELLS PLAIN HOSPITAL

PERMISSION LETTER

Research title:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Researcher:

(Zama Alfred Mfundisi)

Request for permission to conduct research at Mitchells Plain Hospital

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community:
Western Cape, South Africa

November 2024

Dr Evan Swart

Chief Executive Officer

8 A Z Berman Drive

Lentegeur, 7787

Cape Town

South Africa

Tel: +27 21 377 4300

Dear Dr Swart

I, Zama Alfred Mfundisi am doing research with David Ditaba Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa.

I hereby request to conduct a research study at your facility. The study is entitled:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

The aim of the study is to gain deeper understanding on the perspectives of nurses, and patients regarding patients who have sought consultation with indigenous healers prior to hospital visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop nursing strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. Your facility has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

The study will entail semi-structured individual interviews and focus group with nurses and semi-structured individual interviews only with patients to explore about their experiences, views and perceptions of cultural sensitivity in patient care. The researcher and participants will agree upon a convenient time to conduct the interviews. These interviews will provide flexibility in questions while ensuring that essential issues pertinent to the research objectives are covered.

There are no direct benefits in participating into this study. But the participation is important to better understand the nurses and patient's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to patients who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional

counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, [Tel:012429-8069](tel:012429-8069). Email: moodlijk@unisa.ac.za

Yours sincerely



ZA Mfundisi

APPENDIX L: PERMISSION LETTER TO CONDUCT RESEARCH AT EASTRIDGE CLINIC

PERMISSION LETTER

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

(Zama Alfred Mfundisi)

Request for permission to conduct research at Eastridge Clinic

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community:
Western Cape, South Africa

November 2024

Dr Paul Nkurunziza

Director: City Health

First Avenue

Eastridge, 7785

Cape Town

South Africa

Tel: +27 21 444 6379

Dear Dr Swart

I, Zama Alfred Mfundisi am doing research with David Ditaba Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa.

I hereby request to conduct a research study at your facility. The study is entitled:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

The aim of the study is to gain deeper understanding on the perspectives of nurses, and patients regarding patients who have sought consultation with indigenous healers prior to clinic visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop nursing strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. Your facility has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

The study will entail semi-structured individual interviews and focus group with nurses and semi-structured interviews only with patients to explore about their experiences, views and perceptions of cultural sensitivity in patient care. The researcher and participants will agree upon a convenient time to conduct the interviews. These interviews will provide flexibility in questions while ensuring that essential issues pertinent to the research objectives are covered.

There are no direct benefits in participating into this study. But the participation is important to better understand the nurses and patient's experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop nursing strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to patients who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, [Tel:012429-8069](tel:012429-8069). Email: moodljk@unisa.ac.za

Yours sincerely



ZA Mfundisi

APPENDIX M: PERMISSION LETTER TO CONDUCT RESEARCH AT MITCHELLS PLAIN COMMUNITY

PERMISSION LETTER

Research title:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Researcher:

(Zama Alfred Mfundisi)

Request for permission to conduct research at Mitchells Plain Community

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community:
Western Cape, South Africa

November 2024

Mr Joanie Fredericks

Community Leader

Mitchells Plain

Cape Town

South Africa

Tel: +27 71 443 7643

Dear Mr Fredericks

I, Zama Alfred Mfundisi am doing research with David Ditaba Mphuthi, Professor in the Department of Health Studies towards a degree, Doctor of Philosophy at the University of South Africa.

I hereby request to conduct a research study at your community. The study is entitled:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

The aim of the study is to gain deeper understanding on the perspectives of members of community regarding patients who have sought consultation with indigenous healers prior to hospital or clinic visit, with the aim of gaining insights into how these patients are perceived. The purpose is to develop nursing strategies that enable nurses to interact sensitively with patients who hold diverse cultural belief systems. Your community has been selected strategically to allow for the inclusion of a wide range of individuals from various cultural backgrounds.

The study will entail semi-structured individual interviews with members of community to explore about their experiences, views and perceptions of cultural sensitivity in patient care. The researcher and participants will agree upon a convenient time to conduct the interviews. These interviews will provide flexibility in questions while ensuring that essential issues pertinent to the research objectives are covered.

There are no direct benefits in participating into this study. But the participation is important to better understand the communities' experiences, views and perceptions of cultural sensitivity in patient care. The information may help the researcher to develop strategies for culturally sensitive patient care aimed at improving cultural sensitivity patient care in healthcare settings to enhance patient care outcomes and experiences.

There will be no physical risk however, the possible discomfort involved may be an emotional reaction to patients who had experienced lack of sensitivity from nurses when dealing with patients who have interacted with indigenous healers before visiting a hospital for healthcare. In the unfortunate case that participants experience distress or discomfort, referral to professional counselling services will be provided and the researcher will ensure supportive environment throughout the study process. The researcher will arrange with a professional counsellor to be available in case participants experience emotional discomfort or psychological distress during the study.

If you would like to be informed of the final research findings, please contact Zama Alfred Mfundisi on 0732176444 or email: zama.mfundisi@gmail.com / 22638458@mylife.unisa.ac.za

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor, Prof David D. Mphuthi on Tel: 012 429 2058 or email: mphutdd@unisa.ac.za. The chairperson of the UNISA College Research Ethics Committee, Prof Janice Moodley, [Tel:012429-8069](tel:012429-8069). Email: moodlik@unisa.ac.za

Yours sincerely



ZA Mfundisi

APPENDIX N: CONSENT FORM

CONSENT TO PARTICIPATE IN THIS STUDY

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

Zama Alfred Mfundisi

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the semi-structured individual interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname :..... (Please print)

Participant Signature..... Date.....

Researcher's Name & Surname..... (please print)

Researcher's signature

APPENDIX O: INTERVIEW GUIDE (NURSES)

INTERVIEW GUIDE (NURSES)

Research title:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Researcher:

Zama Alfred Mfundisi

Introductions and greetings

Explanation of the study and request for consent for participation and the use of audio-recorder.

Signing of the consent for participation and recording.

Interview commences

BIOGRAPHICAL DATA SHEET				
Please complete the following biographical data sheet				
INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes with "X")				
Age Group				
18 - 30	31 - 40	41 - 40	51 - 60	60+
Gender				
Male	Female	Other (Specify):		

Highest Qualification Obtained						
Primary School (Specify Grade):	High School (Specify grade):	Certificate (Specify):	Diploma (Specify):	Degree (Specify):	Masters (Specify):	Other (Specify):
Number of years working as a PN						
1-5 years	6-10 years	11-15 years	15 and above			

Grand tour question:

1. Can you please share your views on culturally sensitive patient care in the context of nursing care?

Probing questions to explore and describe the views of nurses regarding cultural practices.

2. In your opinion, why is it important to respect other people's culture when giving nursing care for them?
3. Which items or things do you regard as cultural when you see them in patient at the hospital or clinic and why?
4. What has been your experience in caring for a patient who has a different cultural belief system to the one you believe in?
5. What views do you have in referring patient for indigenous consultations?
6. What strategies do you think can be developed to enhance culturally sensitive in patient care?
7. Any other information that you think is also significant that you would like to share?

Closing the interview

The researcher thanks the participant, and the recording is stopped.

APPENDIX P: INTERVIEW GUIDE (PATIENTS)

Research title:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Researcher:

Zama Alfred Mfundisi

Introductions and greetings

Explanation of the study and request for consent for participation and the use of audio-recorder.

Signing of the consent for participation and recording.

Interview commences

BIOGRAPHICAL DATA SHEET				
Please complete the following biographical data sheet				
INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes with "X")				
Age Group				
18 - 30	31 - 40	41 - 40	51 - 60	60+
Gender				
Male	Female	Other (Specify):		
Highest Qualification Obtained				

Primary School (Specify Grade):	High School (Specify grade):	Certificate (Specify):	Diploma (Specify):	Degree (Specify):	Masters (Specify):	Other (Specify):
Number of times admitted to the hospital/visited the clinic						
1-5 times	6-10 times	11-15 times	15 and above			

Grand tour question:

1. Can you please share your views on culturally sensitive patient care in the context of nursing care?

Probing questions to explore and describe the views of a patient regarding cultural practices.

2. In your opinion, why is it important to respect other people's culture when visiting hospital/clinic?
3. Which items or things do you regard as cultural when you see them in you as a patient and why?
4. What has your experience at the clinic/hospital been as a patient who has a different cultural belief system to the one who provides healthcare to you?
5. What views do you have in indigenous consultations?
6. What strategies do you think can be developed to enhance culturally sensitive patient care?
7. Any other information that you think is also significant that you would like to share?

Closing the interview

The researcher thanks the participant, and the recording is stopped.

APPENDIX Q: INTERVIEW GUIDE (COMMUNITY MEMBERS)

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

Zama Alfred Mfundisi

Introductions and greetings

Explanation of the study and request for consent for participation and the use of audio-recorder.

Signing of the consent for participation and recording.

Interview commences

BIOGRAPHICAL DATA SHEET				
Please complete the following biographical data sheet				
INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes with "X")				
Age Group				
18 - 30	31 - 40	41 - 40	51 - 60	60+
Gender				
Male	Female	Other (Specify):		
Highest Qualification Obtained				

Primary School (Specify Grade):	High School (Specify grade):	Certificate (Specify):	Diploma (Specify):	Degree (Specify):	Masters (Specify):	Other (Specify):
Number of times admitted to the hospital/visited the clinic						
1-5 times	6-10 times	11-15 times	15 and above			

Grand tour question:

1. Can you please share with me your views regarding culturally sensitive care?

Probing questions to explore and describe the views of a community member regarding cultural practices.

2. In your opinion, why is it important to respect other people's culture when visited hospital/clinic?
3. Which items or things do you regard as cultural when you see them in person and why?
4. What has your experience at the clinic/hospital been as a patient who has a different cultural belief system to the one who provides healthcare to you?
5. What views do you have in indigenous consultations?
6. What strategies do you think can be developed to enhance cultural sensitivity in patient care?
7. Any other information that you think is also significant that you would like to share?

Closing the interview

The researcher thanks the participant, and the recording is stopped.

APPENDIX R: OBSERVATION SCHEDULE

OBSERVATION SCHEDULE (NURSES AND PATIENTS)

Research title:

Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa

Researcher:

Zama Alfred Mfundisi

The following observation schedule will be used to observe interaction between nurses and patients at the selected facilities:

Date	Time	Location	Focus
Week 1, Day 1-2 (2 days a week for 1 months)	08:00 – 12:00	Clinic A - Waiting Area	Patient-staff communication during triage.
Week 1, Day 1-2 (2 days a week for 1 months)	10:00 – 14:00	Hospital B - Consultation Rooms	Nurse-patient interactions during consultations - casualty.

Date	Time	Location	Focus
Week 1, Day 1-2 (2 days a week for 1 months)	09:00 – 13:00	CHC C - Communal Areas	Observing cultural norms in group settings.
Week 1, Day 1-2 (2 days a week for 1 months)	11:00 – 15:00	Hospital A - Waiting Area	Conflict resolution and cultural practices.

APPENDIX S: OBSERVATION GUIDE

OBSERVATION GUIDE (NURSES AND PATIENTS)

Research title:

**Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan
Community: Western Cape, South Africa**

Researcher:

Zama Alfred Mfundisi

The observation guide will include the following key aspects to be monitored by the researcher:
Verbal and non-verbal communication between healthcare professionals and patients.

- **Respect for cultural, ethnic, and religious differences.**
(Greetings and gestures, cultural practices during care, accommodation of dietary or treatment preferences based on cultural or religious beliefs).
- **Implementation of culturally sensitive care practices**
(Care plans to align with patient cultural needs, consideration of gender preferences in healthcare interactions, use of traditional or alternative healing practices in cooperation with medical treatments)
- **Responses to language barriers and use of interpreters**
(Availability of interpreters, ability to simplify language or use alternative communication methods).
- **Instances of conflict and their resolution methods**

(Common sources of cultural misunderstandings, strategies used by healthcare professionals to de-escalate conflicts).

The observations will be non-participatory to minimise disruptions and ensure authenticity.

APPENDIX T: FACILITY MANAGER/SENIOR NURSE CLINICIAN STRATEGY EVALUATION FORM

Developing Nursing Strategies to enhance Culturally Sensitive Patient Care in a Metropolitan Community in Cape Town, Western Cape

Evaluator: _____

Facility/Institution: _____

Date: _____

Instructions

Please evaluate each strategy independently using the 5-point Likert scale below.

Provide qualitative comments in the “Remarks/Comments” column to support your rating or elaborate on observations.

Scale:

1 – Strongly Disagree 2 – Disagree 3 – Neutral 4 – Agree 5 – Strongly Agree

Evaluation Table

Evaluation Criteria	Guiding Question	Rating (1–5)	Remarks / Comments
1. Relevance	Does the strategy address identified needs from the research findings?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
2. Evidence-Base	Is the strategy grounded in empirical findings and aligned with current literature?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
3. Feasibility	Can the strategy be realistically implemented given resource, policy, and system constraints?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
4. Appropriateness	Is the strategy culturally appropriate, ethically sound, and respectful of professional boundaries?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

Evaluation Criteria	Guiding Question	Rating (1–5)	Remarks / Comments
5.Comprehensiveness	Do the strategies collectively address all major domains requiring intervention?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
6.	Is the strategy clearly articulated with specific, actionable implementation steps?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
7. Potential Impact	Is the strategy likely to create meaningful improvement in the quality of culturally sensitive care?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

Overall Comments

(Please provide any general observations, strengths, concerns, or recommendations regarding the strategy.)

Evaluator Signature: _____

Date: _____

APPENDIX U: SAMPLE TRANSCRIPTS - NURSES

Transcript: PN1 (Participant Nurse 1)

Researcher:

Hello, sister.

PN1:

Hello.

Researcher:

Let me introduce myself. My name is Zama Mfundisi. I'm a PhD student at the University of South Africa. I'm doing my research towards my degree, a Doctor of Philosophy. I did explain my research to you, and I have given you the information letter, which you have read, and you have told me that you understood everything in the information letter. Is that okay?

PN1:

Yes.

Researcher:

Now we're about to start with our interview. It's a semi-structured interview. So I want to ask you to please remain calm, and share any information that you'd like to share. This is not a formal interview. It's a semi-structured interview. So I'm encouraging you to share all the views and ask any question that you would like to ask as we go with our interview. So I've got the information letter that you have already read, and I've got the consent form that you have read, and I'm going to ask you to sign if you are happy with everything that is in there, please, can we sign the consent form, put your name and surname, signature, and today's date.

PN1:

Okay, thank you.

Researcher:

So, are you ready now for us to commence with the interview?

PN1:

Yes, I am ready.

Researcher:

Alright, thank you. The first question that I would like to ask you is... I'm not sure if you are comfortable to tell me exactly how old you are. If you are comfortable, you can give me your age, or I can ask the age group that you belong - between 18 to 30, between 31 to 40, between 41 to 50, between

51 to 60, or 60 plus. Which one are you happy... are you happy with giving me exactly your age, or you want to tell me which age range?

PN1:

No, I don't have a problem. I can give you my age, I'm 34 years old.

Researcher:

Okay, thank you. And I just want to confirm your gender. I don't want to assume you're a male, a female or other.

PN1:

I'm female.

Researcher:

Okay, thank you. Just wanted to confirm, because I don't want to assume that people are females, people are males, while they are otherwise. *[Laughter]*

Researcher:

Okay, let's proceed, please. Can you tell me what is your highest qualification? You can tell me exactly your highest qualification, if you wish. Or you can tell me whether your qualification - is it primary, high school, certificate, diploma, degree, master's or you can just tell me your highest qualification that you have.

PN1:

My highest qualification is a postgraduate in primary health, and I have occupational health nursing.

Researcher:

Please tell me about the number of years of your working experience. How long have you been a nurse? Is it one to five years, six to ten years, eleven to fifteen years, fifteen years and above or do you want to tell me exactly what is your working experience?

PN1:

I have 8 years of working experience.

Researcher:

Okay, now let's get straight to the questions that we need to explore. Can you please share your views on culturally sensitive patient care in the context of nursing care?

PN1:

Can you please elaborate more on the question?

Researcher:

Okay, so let me first ask you, do you perhaps understand what a culturally sensitive patient care is?

PN1:

I think it's being considerate, especially on the cultures of patient. When you consult patient or taking care of patient, for an example, like Muslim patients, they in labour ward, you need to make sure that you ask them about their placenta if they want to take it, because most of the time they take it home to bury it. So, I think I understand it like that - where you have to be culturally sensitive with the patient.

Researcher:

Looks like you understand what cultural sensitivity is. Tell me then, what is your views in that? Do you hold any views when it comes to a different culture - different cultures of patient, or about the cultural sensitivity when it comes to patients?

PN1:

Yes, especially, I will talk more about the African ones because of I'm exposed more on it. The patient... sometimes come here sicker because of maybe the medication they used from their traditional healers, so we need to make sure even though they use traditional healer's medication which was not prescribed at the hospital... so we need to make sure that we don't judge them, and we treat them holistically, like other patients, even though we know you're not supposed to be using those. Especially with kids, most of the babies come here with diarrhoea and vomiting, and when you try to find out what happened, why the mom put the child to a traditional healer for colic, to be helped or to subside the colic, which then results in making the child sicker and end up at the hospital. So, I don't know if maybe I'm answering your question correctly. So yes, in that also we need to make sure that we still uphold the ethics, and make sure that we treat the patient the same and holistically, without any bias or judging of patient.

Researcher:

Okay, are you done?

PN1:

Yes.

Researcher:

Okay, tell me, you have mentioned that some of the patients, they use the medication that they are not supposed to be using. What do you mean by saying they are not supposed to be using?

PN1:

As I mentioned... let's say, for a pregnant mom when they come to the hospital. Because I'm working at the hospital, when they come at the hospital, we give them health education based on the experience that we have at the hospital and what we observe or see on every day. So, we give them health education, to not use traditional medication on the baby for colic, and that the colic it's a must for a child to have it. And if they think there's a problem with the child, they must take their child to the hospital. So, with that health education, still, we see more patients coming with the same problem, like the kids that are coming because of taking those traditional medication, ending up at the hospital. So that's why I'm saying they're taking medication that they were not supposed to take - which, according to the health education that we've given them, it states that they mustn't give the child any medication from a certain age. But then the child still ends up to the hospital due to the same medication that the mother was given health education on, for not to give the child.

Researcher:

Okay, tell me, is there any other medication except the one for the colic that you feel like the mothers do or the patient takes before they come to the hospital or at the clinic or in any department at the hospital?

PN1:

Yes, I will speak for the adults now. The adults, they will be sick at home for a long time without coming to the hospital. Firstly, they will go and consult the traditional healers before coming to the hospital, maybe thinking that the problem is spiritual, that needs traditional help. For some, they will get to the hospital being diagnosed of something, but then they will also go to the traditional healers, and they will be told maybe that it is spiritual or something. Then they will be given medication there by the traditional healers, and then they will be told to stop the medication that they were given at the hospital. Then they will take that medication from the traditional healers, which will make them worse. And then they end up coming back to the hospital worse than before. And they will confess that they stopped the treatment, they didn't use the treatment they were given at hospital. They went to a traditional healer and were taking that medication from the traditional healers, but now they think that they are worse than before they come.

Researcher:

Okay. Let's move forward to the next question that I want to ask you. So, tell me, in your opinion, why is it important to respect other people's culture when giving nursing care to them? You have mentioned earlier on that you are respecting every patient, irrespective of their culture, and you are treating them equally, and you're treating them ethically. So why do you think it is important to respect every patient's culture?

PN1:

I think it is important because each culture is important to each individual and showing respect to patient culture - you're making it easier for them to access the healthcare facilities. Because if they see that the professionals at the healthcare facilities, they don't respect their cultures or they don't consider it, they... they will be resistant to seek healthcare. Well, they know that they will be judged anyway. So, I think it's very important to respect it, to encourage them, or maybe to give them ability to be able to come to seek for help at the healthcare institution, knowing that they will not be judged.

Researcher:

Which items or things do you regard as cultural when you see them in a patient at the hospital or at the clinic?

PN1:

Can you repeat your question, please?

Researcher:

Okay, I'm going to try to rephrase this question. So, let's say the patient comes in, and you notice that the patient is having some items on their body. It could be in their head, their hands, their eyes, their legs. Are there any items that you regard them as culturally... when you see them?

PN1:

Yes, I will say a few. Okay, like for Muslim patients, we can see that - they wearing their doek, covering themselves and those that are covering the body, especially women, then you will know that this person is Muslim. And then for Africans, mostly you will see them wearing beads on their head, hands, and on their foot. So that's how you will pinpoint that these people are... which culture they belong to. So that's how I pinpoint, "Okay, this one is belonging from this culture."

Researcher:

Okay, you spoke about the child who they sometimes brought by the mother, and small baby comes to the clinic or to the hospital sick. Are there any items sometimes on a child that you think this is put on because of the culture?

PN1:

Yes, yeah, they are. They have things that they put, like beads on their neck and even on their waist. There are some other things in their neck - I don't know how to call now in English.

Researcher:

You can put it in Xhosa.

PN1:

But it's like a thread around their waist with something, a small thing that they call it **isipaji**. So, they say that it prevents bad spirit from taking or entering the child. So those, those are the things that I normally see.

Researcher:

Okay, don't worry. I know sometimes there are words in Xhosa that it's difficult or they are not interpreted into English. So, it's okay, let's move. Let's proceed.

Researcher:

What has been your experience in caring for a patient who has a different cultural belief system to the one you believe in?

Researcher:

Mmm, are you believing in any culture?

PN1:

Yes, I am a Christian. I just want to share a story. When I was working at the clinic, there was this patient. The patient was a traditional healer wearing all the attires of the traditional healers. I was never exposed in that kind of an environment, like traditional healers and what they do and all those things. So, this traditional healer came to the family planning site to get the injection. So apparently, she came in without queuing and said that she's a traditional healer. The traditional healer doesn't stand in the queue and demanded help immediately. So, then we had the quarrel because of that, because other patients were also now shouting that she can't just go in front and be helped. So, things like that happen when you are in the healthcare settings, especially when you don't understand that perspective part of their culture or their beliefs. So now it causes conflict sometimes, or maybe seem like you are biased.

So, this lady just came and said that she won't queue because, according to what she is, she won't be able to queue. So I just wanted to share that - those are the other things that we come across.

PN1:

As healthcare workers, but then you must work around and see how you will help or how you're going to take a situation.

Researcher:

So let me just ask about that experience, what do you think should have been done in that situation where the patient demanding to be seen without taking a queue?

PN1:

Now, what I did when that happened - luckily, inside, there was no patient. So, this lady, when she came, there was no patient. I was about to call a patient because there was a patient that just left, which I was consulting. Okay, so I tried to be calm and explain to the patient that according to the hospital policy, this is what is supposed to happen. Unless it's an emergency, medical emergency, then that person cannot wait. The person needs to be seen immediately. But in her case, now it's not an emergency. But according to the policy of the hospital, there's nothing urgent or - when I assess you - there's nothing urgent that needs you to be seen urgent. So, I asked the patient to stay on the line to avoid chaos. The patient did understand and apologised for just entering without even knocking.

Researcher:

So, so let me ask this... do you think if there was a policy, would the situation be handled better than it was handled? Because you mentioned that there is no policy that says the traditional healer can just go and do whatever. Do you think if there was a policy covering that part of the person, the situation would have been handled better than it was handled?

PN1:

I think it was going to be handled better, because when there's policy, it makes things smoothly. Because everything we do at healthcare facilities, we do it according to what the policy says or guidelines. So, I think it will be much easier. And it was going to be easy, because you know what to follow and what steps you need to take when certain things happen. So, I don't know. But then I think maybe the reason there's no policy is because things like these are hardly happening - maybe, I don't know. So, but if the policy was there, I think it was going to be much easier. And then you'll be able to even show the patient, and then they read themselves what the policy says.

Researcher:

Okay, okay. Tell me... What views do you have in referring patient for indigenous consultation?

PN1:

Can you repeat your question again?

Researcher:

Okay... What views do you have in referring patient for indigenous consultation? So, you as a nurse, you're working at the hospital, sometimes at the clinic - so what are your views in referring patient to traditional healers? We're calling them indigenous healers. What are your views in referring patient to a traditional healer or indigenous healers?

PN1:

I just want to be honest. Okay... referring them to indigenous healer? I won't - I wouldn't refer because of, during my postgrad and my undergrad, I was never taught those. So, I think it's something that should be added on the curriculum so we can know what to do. Is it even possible? But I think it's something that can be done, if it's there on the curriculum or a certain postgraduate that you are sent to, then you can refer the patient to a traditional healer. But currently, I'm not quite sure how to answer your question, but then because of we are not exposed or talked about traditional healers at the institutions that we are working at, and it's not something that is always promoted that you do. So, the only thing that we are told is to give Western medication. And yeah, so with the traditional healers, for me, I wouldn't refer until at least there is something written down that we can do it - so that I can be able to even cover myself, if maybe something might happen when the person went to a traditional healer.

Researcher:

Mmm, okay, I hear you. What strategies do you think can be developed to enhance culturally sensitive patient care? What strategies do you think can be developed to help cultural sensitivity in patient care? Do you understand the question?

PN1:

Yes.

Researcher:

Okay.

PN1:

I think I understand it, but then you will tell me if maybe I'm not answering correctly. So, I think - especially for the indigenous healing. I personally think if indigenous healing can be incorporated with

healthcare service, like the government or the Department of Health can employ a traditional healer that is certified to have a consultation room in the hospital. Then, when you come across a patient that is requesting or asking me if I can go to a traditional healer, then they can be transferred within the hospital to that traditional healer that is certified and trusted by the Department of Health. So, if maybe there can be a traditional healer that is certified and trusted - which is allocated in each hospital, or tertiary hospital or secondary hospital - but in a hospital setting, where all those kind of patients that enquire that kind of assistance, then they can be referred to that person. And that person will work as an employee of the Department of Health.

Researcher:

Okay. So, is there any other information that you think it's important to talk about or discuss, or maybe that you would like to share about the topic that we just discussed, the nursing strategies to enhance culturally sensitive patient care? Is there any other thing that maybe you would like to talk about, just to share?

PN1:

Not really, but it's just an interesting topic that we just spoke about. And it will be really nice if the healthcare professionals can be sent maybe to a workshop where they are taught about this on how to handle these kinds of patients. Because sometimes we lack knowledge in those things, and we tend to judge patients. Because we need to understand that some patients, they grew up doing these things. They think that these practices are normal. So I think if the department can take the healthcare or the employees to a workshop or a short course that will teach the healthcare professionals about these kind of things, on how to handle it and how to portray yourself when you deal with this kind of person, without making them feel uncomfortable or seem like they've done something wrong, I think it can... it can be much better. And promote trust between us and the patient. Because sometimes other patients, they even lie and not tell the truth, because they know that they will be judged by us as healthcare professionals. So sometimes we can lose, or I don't know how to explain it - but we can misdiagnose due to that, that the patient is not telling the truth. And if we are open and non-judgmental, the patient will be able to table what really happened before coming to hospital for healthcare, or the truth - that "I went to a traditional healer" and what happened there. Well, some they don't even say that they went to the traditional healer, they are scared that they will be shouted at by the healthcare workers or they will be judged.

Researcher:

We have come to the end of this interview. Thank you for your time, I really appreciate. This will absolutely assist us in understanding culturally sensitive patient care and how patients are perceived by the nurses when they visit healthcare settings.

PN1:

You are welcome.

APPENDIX V: SAMPLE TRANSCRIPT - PATIENTS

Transcript: PP1 (Participant Patient 1)

Researcher:

Good afternoon, ma'am.

PP1:

Good afternoon.

Researcher:

Let me first introduce myself. My name is Zama Mfundisi. I'm a doctoral student at the University of South Africa. I'm at the data collection stage, hence doing this interview with you. It's a semi-structured interview not a formal interview. I have given you the information sheet. You have read the information sheet, and you said you understood, and you have confirmed that you are happy to participate in this research. I've also given you the consent form, which you also went through and signed, indicating that you are happy to continue taking part in this research. Is that so?

PP1:

Yes.

Researcher:

Let's go straight to it. Before we start, I just want to tell you that please be relaxed. You can ask any question as we go along with the interview. You can also explain everything as much as you would like to, and you can also ask questions when you're not understanding the question, I will be explaining that to you. There is no rush, but I would, of course, stick to the times. Like I said, it's not going to be long. It's going to be up to 45 or less - 45 minutes or less, like it's explained in the information sheet. Let's get to it. The first question I'm going to ask you, it's about your age. You can tell me your age as it is, if you so wish, or you can choose between the age group: whether you are 18 to 30 years, 31 years to 40, 41 years to 50, 51 years to 60, or 60 plus.

PP1:

31 years to 40.

Researcher:

Now I just want to confirm your gender, please. Can you confirm your gender for me, whether you are a male, female, or other?

PP1:

I'm a female.

Researcher:

Please tell me about the highest qualifications that you have. Have you gone up to primary school? Have you gone up to secondary? Have you got a certificate, diploma, degree, master's or other?

PP1:

I didn't finish. I didn't finish high school. I dropped out of high school from Standard Eight.

Researcher:

Oh, okay. Tell me the number of visits, the number of times that you have been admitted to the hospital, or the visits that you've ever had at the clinic. Is it one to five times, six to ten times, 11 to 15, or 15 and above?

PP1:

I would say it's 11, because I've grown up coming to this clinic, so I would say it's 11 and above. And then I take my medication here.

Researcher:

Can you tell me about your number of visits to the hospital? How many times have you been admitted?

PP1:

Not more than five times.

Researcher:

Let's go to the big questions now. Please tell me, can you share with me your views regarding culturally sensitive patient care?

PP1:

Okay, can you explain this question deeper, like, I don't understand it.

Researcher:

I want to hear your views when it comes to culturally sensitive care and the how responsive or considering they are of the culture when it comes to the care, considering the times that you have visited the clinic or the hospitals. How do they respect or recognise the culture when they're giving care to you as a patient? Tell me about your experience when it comes to that. What are your views?

PP1:

We as people... let me talk about me. I grew up in a home of traditional orientated. But at the same time, I grew up going to that clinic, and now I'm taking my chronic medication there. Most of the time, I don't feel comfortable to speak about the other treatment that I'm taking, which is the traditional

treatment, with the nurses. Because nurses always shout at you when you use something that they didn't give. I know this medication helps me so much because I grew up taking it, and I know it helps me also with the condition that I have now. But I'm also taking the treatment from the clinic. But I know... one time I was sick, then I told the sister that I felt sick and I went to the traditional healer, as I usually do. When I get this kind of sickness, I take this medication. Then the sister was so rude to me and told me that I'm not supposed to take the traditional medicine. It's not allowed when I'm taking the treatment they are giving me. I must not take that traditional medicine without educating or telling me in a proper manner. It's like when you use traditional medicine, it's like you're using an evil thing or something that will kill you, of which I've been using this thing for a long time. And now, you feel like you don't want to disclose to them what other medicine you are using because of the attitude they give when it comes to these kinds of things. Seemingly, they don't respect it, and they just don't want to even hear about it.

Researcher:

I'm not sure if I answered your question.

Researcher:

Oh, it's fine, it's fine. There's no right or wrong answer. It's all about sharing your experiences, your opinions, and your perspective. You have mentioned that you grew up using this traditional medicine. Tell me more about that. Was it the reason for you to use that medication, tell me more about it, when you grew up.

PP1:

I grew up with my grandmother, there are certain medications that you take that prevent you from being sick, which is the medication that you take from plants, from the ground - you make it, and you drink it. It started there, where my grandmother would prepare those medications and give them to us as kids. I grew up understanding all those traditional medicines, and we even do go to traditional healers and consult there when we have problems and when we are sick, and we get medication, and we heal. Then the clinic part, I go to the clinic because of the chronic condition that I'm having, but still using the traditional medicine, which I grew up using, knowing that it helps. And even my kids - I give it to my kids also, because I know how good it is and how important it is to take those medicines. When I say that I take those medications, I mean that I know I've been taking it since I was very young. It's something that I have learned from my grandmother.

Researcher:

You have also talked about the feeling that you get at the clinic or the hospital when you're meeting the professional employees - like the nurses you have said sometimes you feel like you have done a sin or something that is not accepted. Tell me more about that. What makes you feel like that?

PP1:

As I said, it's the way they respond or they act when you tell them that you are using this medication, also this traditional medicine. It's like - the way they respond to it and the way they act to it. And sometimes, when I'm very sick and come to the clinic, they will even say that it's because of that medication that you are taking. They put that stamp on me that I'm using something that is causing everything that is going wrong. Like, when I'm sick and I come here, they always say it's that medication you take. Of which I know it's not that medication. I'm just sick. They will always go back to this thing of traditional medication. That's why I'm saying they don't respect people's cultures. I think they're supposed to respect it, and if they don't want me, or they don't get along with what I'm using, they must say it in a respectful manner. The way they handle it's not a good way for a nurse or professional to address things like that.

Researcher:

Okay, let's move forward. Tell me, in your opinion, why is it important to respect other people's culture when visiting the hospital? Because you just mentioned that, sometimes you feel like they don't respect other people's cultures. Why do you think it is important to respect other people's culture?

PP1:

I think it is important because if you don't respect people's culture, that means you don't respect that person as well. And by not respecting that person's culture, you will prevent even that person from coming to the clinic. It's everyone's right to come to the clinic and be respected. Now, if I'm not respected here, I won't see the need for me to come here at the clinic, even though I know that it's important for me to come here and take my treatment. It is very important for the nurses and the doctors also to respect one's culture, so that we, as a community, can feel comfortable coming and disclosing everything to them.

Researcher:

Tell me, which items or things do you regard as culturally when you see them in a person?

PP1:

It is very difficult. The only thing that I can identify in person is something that is obvious. It's the attire, what they wear. You get sangomas, people that wear beads, where they wear certain clothes. And then

you get Muslims - we are diverse here in Mitchells Plain, you get Muslims where they wear their attires, where they must cover their faces and bodies and wear all those covering clothes. You also get all sorts of different cultures, but we identify them by what they wear mostly.

Researcher:

What has been your experience at the hospital or even at the clinic as a patient who has a different cultural belief than the one that you're getting from the healthcare worker?

PP1:

I don't know if I'm understanding your question.

Researcher:

Let me repeat the question. What is your experience at the hospital or at the clinic as a patient? You are here as a patient. What experience do you have as a patient who has a different cultural belief than the person who's giving you care?

PP1:

Sometimes it is very difficult, because I remember, there's this day when I came to the clinic, and I was seen by this nurse. I disclosed that I used this medication, and the nurse didn't take it well. And she was a bit harsh on me because she... firstly, she does not believe in this traditional medicine. She's a born-again Christian, not using this medication, and she was totally against it. I think she was not supposed to be like that, if I may say. She was supposed to at least address me in a good manner, but she was so harsh with me because she does not believe in this. And it was like it's a demon - that I'm using these things, which I'm not supposed to use with the medication that I'm given at the hospital. I'm wasting government resources and medication, because I'm going to use this medication and become sick and come and seek help at the clinic. So, I must stop using these things and all that. I didn't feel quite nice when she was addressing me in that manner.

Researcher:

Looks like the health worker was having a different belief, or do you think that was because of the understanding that she had or he had at the time? Do you think that the person who saw you understood your culture and welcomed your culture? Tell me about that.

PP1:

I would like to believe that the person understood my culture, because this person is the same colour as mine. This person understands very well this kind of traditional medicine that I'm using. It's just that the person now has a certain belief that is against what I'm using. She did understand my culture, because I

believe that her background also comes from that - because we are of the same culture, we speak the same language. She understood it very well. But then, because now she has this belief, that's why we could not understand each other.

Researcher:

Tell me, what are your views on indigenous consultation as a patient?

PP1:

What is indigenous consultation?

Researcher:

What views do you have on traditional consultation, being seen by the indigenous healers. What views do you have when it comes to that?

PP1:

Well, I do go to the traditional healers

Researcher:

Generally, what views do you have when it comes to indigenous consultation?

PP1:

I think indigenous consultations...

Researcher:

Remember you said you grew up using the indigenous medication. The traditional medication is the same as indigenous - it's just maybe that word, "indigenous." indigenous, it's a traditional way of healing. The question that I'm asking is: what views do you have when it comes to going there, as you said earlier on, that you grew up using that type of medication?

PP1:

For me, going there - it's just like a normal thing. And you heal. And when you go there, they don't judge you. The indigenous healers, they don't judge you. And even if you are using your medication from the hospital, they don't judge you. They just treat you as you are. They just solve what you're coming for. They don't question the treatment you are using from the hospital. I feel more relaxed and comfortable when I go there than when I go to the clinic. I would say it's more comfortable that side than here.

Researcher:

We are closer to the end. I think we just left in less than five minutes' time, we're almost there. Tell me, what strategies do you think can be developed to enhance culturally sensitive care in patient care?

PP1:

I think if government can take the employees or send the employees to trainings or workshops to be taught about how to handle this kind of things when they meet people who use indigenous medication. Or the government can maybe try and make use of and understand about this medication that the traditional healers use. And maybe they can work together and come to an understanding of what is mixed - when you use that medication of theirs - so that they can understand that it's not dangerous, it's not a danger to our health. So that the nurses and the doctors can also understand that when we use these medications, it's not going to cause harm or cause anything or maybe delay the medication they are giving us from doing what it's supposed to do. I think if the nurses and doctors can go for training or a workshop, it is something that will teach them how to deal with these kinds of cases. At least when we disclose to them about this kind of healing, they will know how to handle it without making me feel small or making me feel like I'm doing something wrong. Whereas I know I'm not doing anything wrong. I've been using these things since I was very small. I think if government maybe can work together with the traditional healers and get to understand what they are using or maybe even certify them for their medication to be used without being judged when using them.

Researcher:

You have mentioned that if you get here (the clinic) and you mention that you are also using the medication from the indigenous healers, sometimes you feel like they are shouting at you, as if you have done something wrong. Do you think they are reasonable? Or do you think they've got a point that they make - to say why they really discourage you from using traditional medicine? What makes them not to be happy for you to use the indigenous healing medication?

PP1:

On the other hand, I don't blame them because they don't know. I don't blame them. They don't know this thing. As I said, some of them they never used, and they don't believe in those things. I don't blame them, because they don't know how helpful it is. And they think maybe it's going to affect the treatment that I'm getting here not to work nicely. Because yes, most of the time I get sick and come here and ask for help, they will say it's the medication that I'm using from the traditional healer - which they believe that it's the medication that is causing me to be sick. Thinking that maybe this medication that I'm using from the traditional healer is interacting with this one they are giving me here. I don't really blame them. If also I was in their shoes, maybe I would also feel the same thing. But that's why I'm saying the

government should take them for training so that we don't have to experience what we are currently experiencing at the clinics.

Researcher:

Last one. Tell me, is there any other information that you think is also significant that you would like to share with me around this topic as a closing remark?

PP1:

No, there's nothing. It's just that, with this research you are doing, I'm just hoping that when it's done, you will tell the government that this is how we feel - and maybe by doing that there will be a change in how things are done now at the clinic. Otherwise, there's nothing else that I want to say, no.

Researcher:

Okay, thank you so much for your time. We're at the end. Thank you for participating in the research. The information that you have given will really be helpful when I'm doing my analysis and when I'm drawing up my conclusions. Thanks for your time. I appreciate it.

PP1:

Thank you, sir.

APPENDIX W: SAMPLE TRANSCRIPT - COMMUNITY MEMBERS

Transcript: CP1 (Community Participant 1)

Researcher:

Good afternoon. My name is Zama. I'm a PhD student at the University of South Africa. Today I came to meet you. I asked your willingness to participate in my research. And you said yes. I gave you the information sheet that you went through, and the consent form which you have signed to say you are happy to participate. Is that so?

CP1:

Yes

Okay, so we're going to go straight to the interview questions, but I'm going to ask a few questions first before we start the interview. The first one will be about your age. Tell me how old are you? You can maybe just tell me exactly your age, or I can give you the groups to choose from like 18 to 30, 31 to 40, 41 to 49, 51 to 60 or 60 plus.

CP1: 47.

Researcher:

Then the gender? I don't want to assume your gender. Can you please tell me whether you are a male or female?

CP1:

Female.

Researcher:

Please tell me what is your highest qualification you have obtained? Is it a primary, secondary, high school, certificate, diploma, degree, master's or other?

CP1:

High school.

Researcher:

As a community member, I want to ask you how many times have you been at the clinic or at the hospital? Is it one to five times, six to ten times, eleven to fifteen, fifteen and above?

CP1:

Fifteen and above.

Researcher:

Oh, you've been to the hospital a number of times. Okay. This is not a strict interview. It's a semi-structured interview. You can ask, clarification or you can explain as much as you want, as it is not a formal interview. The first question is, tell me, in your opinion, can you share your views regarding culturally sensitive care? Tell me if you understand. If you don't, then I can explain it further. You understand the question?

CP1:

I understand.

Researcher:

What is your view about the culture and insensitivity of culture in the context of patient care by nurses?

CP1:

I go to sangomas sometimes, when my child is sick, I go to them maybe when my child is sick from epilepsy?

CP1:

Yeah, when my daughter had epilepsy, and then I go to the sangoma, and then they gave me medicine.

Researcher:

Okay. So do you understand culture and nursing care?

CP1:

Yes, I understand culture.

Researcher:

And can you tell me more about culture? What you understand about culture, the cultural sensitivity in patient care?

CP1:

I think is about going to a traditional doctor.

CP1:

Yes, yes, and then another one. It's a - when you go to the doctors and the clinics. I use both, yeah.

Researcher:

Oh, okay. So in your opinion, why do you think it is important for people to respect other people's culture?

CP1:

It's because sometimes you go to the doctor, and then the doctor, they don't see what's wrong with you. And then sometimes, when you go to the sangomas, and then they...they going to heal you.

Researcher:

Okay, so you're saying the sangomas, they heal you?

CP1:

Yes.

Researcher:

Tell me more. What do you mean the sangomas, they will heal you? What do you mean by that?

CP1:

Sometimes they tell you what's wrong with you, and then sometimes, sometimes you dream about the thing that's going to happen to you, yeah. And then you go sick, and then you go to the doctors, and then the doctor, they don't see what's wrong with you. Then when you go to the healers, they told you what's wrong with you. Sometimes you must go back to where you're born, and then you do traditional things.

Researcher:

Okay. So, you're saying it's important to respect the culture of other people?

CP1:

Yes.

Researcher:

So why do you think it is important to respect the culture of other people?

CP1:

We must respect all cultures. Like, for instance, Heritage Day, on Heritage Day, everybody, wear his or her traditional clothes like you find Zulu people, Xhosa, whatever. So we must respect our culture and other people's culture.

Researcher:

So tell me, what are the items or things that you sometimes see on other people, and you think that these are the things that are telling you about their culture, that tells that they belong to certain culture. So which items or things do you regard as culturally, where you see them in a person?

CP1:

There's a lot of things. Sometimes it's food, like, for instance, in our culture, we don't eat same foods.

Researcher:

Talking about food. Are there any other things that you think represent culture in a person, like in their body, in their head, in their feet, in the body, if you see something in a person?

CP1:

Like some other people in their culture, if someone passed away, they must cut our hair. Other cultures, they don't do that, others must wear black clothes. Other people, they don't do that.

Researcher:

Tell me about your experience when you are at the hospital or at the clinic as a patient. Have you ever had a problem whereby you meet someone who has a different culture as you, and how was that experience?

CP1:

Yes, I am.

Researcher:

Have you ever had that kind of experience? Can you tell me about it?

CP1:

Yes, Sometimes I go to the clinic. I don't see the doctor. Sometimes I would see doctor coming from Ghana or coming from Zimbabwe. I experience a lot of different cultures.

Researcher:

If you see someone who's having a different culture as yours, do you think they do respect your culture, or they understand your culture? Can you tell me more about that one?

CP1:

Yes, sometimes they don't understand my culture, because the problem is the language. They don't know my culture; they don't know my language. I also don't know their language. So, they're different like that.

Researcher:

Oh, okay. what views do you have when it comes to indigenous consultation. What views do you have on that?

CP1:

I do go to the traditional healer. Sometimes the doctor wants me to take off my clothes. Let's say I'm wearing a dress. I must take off the dress, and then they put the thing in my chest. But the traditional healer, they don't do that. I'm sitting there, they just throw the bones, they see what's wrong with me. So, that is how I experience things.

Researcher:

In your opinion, would you go and consult with the traditional healers. Are you satisfied with them, or the way that they do things in healing people? Do you want to tell me something more about their healing and the things that they do?

CP1:

I respect that.

CP1:

I respect that, because sometimes when you go to the hospital, you can be in a coma for three months. The doctor, they don't know what's wrong with you. And then when your family consults the traditional healer, they see you, and you become better. It's what I have experienced.

Researcher:

Okay. So in your opinion, what is being done by the traditional healer - if it can be incorporated or put together with what is done at the hospital - do you think that would help the people to heal better, if they had to combine what is being done by the traditional healer and what is done by the doctors and nurses at the clinic?

CP1:

Ah, I can say both, because sometimes you get healed by the hospital. And then also the indigenous healers. You must remember your culture, where you came from. I'll say both.

Researcher:

What do you strongly believe in between the two? And tell me, why do you think the one that you believe in is better?

CP1: The hospital, because the traditional, they can't operate you. And then the hospital, they operate you.

Researcher: T

hey give you operations. Okay. But you still do go to the traditional healer?

CP1:

I believe in tradition.

Researcher:

Okay. So have you ever been at the clinic and then you just came out of the traditional healer, and what happened in that experience?

CP1:

No, no.

Researcher:

You never had encounter whereby you had just been with the traditional healer. Have you ever told the nurses at the clinic that you were just with a traditional healer, and then this is what has been given by the traditional healer? And what was the response?

CP1:

No, I didn't.

Researcher:

What do you think can be the response if you had to go to a traditional healer, and you go to the clinic?

CP1:

The clinic is very important.

CP1:

You go to the traditional healer, then you go to the clinic. Sometimes the traditional healer can help you with the disease you got.

Researcher:

But you still say that they are also important, the traditional healer?

CP1:

Yes.

Researcher:

Tell me a little bit more about why you think they are important.

CP1:

The problem I believe in traditional healers. I will say so. I believe in it.

Researcher:

You believe it?

CP1:

Because some people - one of my family members, they go to the clinic, and then they don't get help there, and then they go to the traditional healers, and then they get help.

Researcher:

Tell me about the traditional healer. If you had to go to them - so compare what you receive from the clinic and what you receive from the traditional healer in terms of respect. Which one do you think they respect you as a person?

CP1:

The clinic.

Researcher:

Tell me more about that. Why you think the clinic respect you?

CP1:

More the clinic. If I'm sick in the clinic, I went once or twice. The second, the third day, maybe they wrote me a letter and say I must go to the hospital. Sometimes in the hospital, the doctors, they're going to see what's wrong with me, they're going to keep me there maybe for a while, and then I come out healed.

Researcher:

But are there other things that you think can be treated by the traditional healers, but cannot be treated by the doctors?

CP1:

Yes,

Researcher:

Can you tell me about those things? What are the things?

CP1:

You see, when you get diabetics, the healers, they're not going to treat you. If you got cancer, the healers, they're not going to treat. If you got HIV positive, the healers, they're not going to help you with it. You must go to the clinic.

Researcher:

Tell me about the things that are being helped by the traditional healers. That makes you to respect the traditional healers like you said you respect them.

CP1:

Some of the disease... You get mad, you... you see people at night, maybe you sleep, you hear voices, or you just get up on the bed, and then you go out, and then you just disappear. They help stuff like that. So, of which, the doctors, they don't know what's wrong with you, but the healers know.

Researcher:

So sometimes you go to a traditional healer instead of going to the hospital or to the clinic?

CP1:

Yes. I go to the traditional healers because of... there's a witchcraft, I go to the traditional... it's because of the witchcraft.

Researcher:

Tell me more about witchcraft. What do you mean by the witchcraft?

CP1:

The witchcraft, it's whereby... You see, more special now we got the kids, yes, and then they use our kids with the dirty stuff. It's where the witchcraft came. You stay with your kids, you think your kids are in the house, all is good. When the kid is outside, they start doing bad things out there. So, it's those witchcrafts.

Researcher:

It sounds like you are using both. You did say that you are using both?

CP1:

I'm using both. They are helping in different ways.

Researcher:

Do you think it would be better for two of them to combine and be a one thing? Since that you have been using both.

CP1:

You know, can I say something?

Researcher:

Yes.

CP1:

You know what, the reason I use both. It's because of sometimes you go to the doctors, let alone the clinics, you go to those doctors, like what you call it... yes. You go to those surgery, yes. Some of them,

they are traditional healers. Because before they check you, they going to tell you what brings you here as if they are traditional healers. That is why I believe, and I use both.

Researcher:

Do you think if there can be a chance for them to combine, that the hospital and the traditional healer, if they are working together? Do you think that would be a good thing?

CP1:

Yes.

Researcher:

Tell me about that. Why do you think it would be a good thing?

CP1:

There's a medicine that the traditional healers, they got, they give people. And the doctors or nurses don't allow the medicine from the healers to come to the person who is in hospital, of which the same medicine is going to help this person. That's why I think it can combine.

Researcher:

Do you think it can work if it combines?

CP1:

Yes.

Researcher:

Okay, we are almost finished with the interview. Tell me, if anything that needs to be done, what do you think can be done to help people to heal better now that we having the traditional healers, and then we've got the formal medicine of helping people? What do you think, it can be done, it can help people get better?

CP1:

I think they can work together.

Researcher:

How can that be done?

CP1:

Ay, yo yo... *(unable to answer the question looked down)*.

Researcher:

No, it's fine. Okay, let me ask you the last question. Tell me, is there anything that maybe you want to tell me about the discussion that we just had now, anything that you think is important to talk about?

CP1:

I think the doctors must let the...traditional doctors...to help the peoples in the hospital. Because you see, when you go to the hospital, like your person is there and then the nurse is there, you can't keep the medicine you got from outside to give that person. Once the nurse sees you, they do not allow you. I think nurses must allow people to give their people the medicine even if it comes from outside. That is my opinion.

Researcher:

What are you saying that they won't allow you to bring the medicine from outside? what do you think is causing that?

CP1:

Because they said... they say is not accepted in the hospitals.

Researcher:

Do you think of the reason maybe that is why it is not accepted in the hospital? What do you think the reason why? What is behind that?

CP1:

They don't believe in traditional ways. They don't, because sometimes it's a coloured nurse, so they don't allow you and they don't understand. Even if it's a Xhosa, they will say no, you know the protocol of the hospital. They don't allow you. Don't allow to bring anything from outside...

Researcher:

Oh, okay. Do you think is anything what need to be done? Is anything that you think needs to be done for them to allow people to bring their medicine from outside, if they wish?

CP1:

I think the doctors and the traditional must just combine, and then we discuss work together. For instance, in 2020, there was a COVID, everyone was encouraged to get uhlonyane. And even if you go to the traditional doctors, I mean to the formal doctor. They say you must go buy umhlonyane, those chemists, come from the traditional doctor, so they must just work together, so they must work together.

Researcher:

Okay, thank you so much for your time. We are at the end of the interview. Thanks for your time.

CP1:

Thank you.

APPENDIX X: SAMPLE TRANSCRIPT - FOCUS GROUP NURSES

Transcript: FGPN (Focus Group Participant Nurse)

Researcher:

Good afternoon, everyone.

All Participants:

Good afternoon.

Researcher:

Today, we're going to conduct our focus group interview. We have seven participants here. Let me first introduce myself. My name is Zama Mfundisi. I am a PhD student at the University of South Africa. You've all received the information sheet and consent form. You've signed and agreed to participate - thank you for that. Please remember that this is not a formal interview, this is a semi-structured focus group. Feel free to speak freely, even laugh where appropriate. Just keep focused on the questions being asked.

Let's start with some demographics. I'll ask about your age groups. You can state your exact age or the range you fall under.

FGPN1: 31 to 40., **FGPN2:** 41 to 50., **FGPN3:** 31 to 40., **FGPN4:** 40 to 50., **FGPN5:** 41 to 50., **FGPN6:** 30 to 40., **FGPN7:** 30 to 40.

Researcher:

Thank you. Now, can we confirm your gender?

FGPN1: Female., **FGPN2:** Female., **FGPN3:** Male., **FGPN4:** Female., **FGPN5:** Female., **FGPN6:** Male., **FGPN7:** Female.

Researcher:

Next question is your highest qualifications, please share whether you hold a certificate, diploma, degree, master's, or other.

FGPN1: Master's. **FGPN2:** Diploma. **FGPN3:** Diploma. **FGPN4:** Master's. **FGPN5:** Master's. **FGPN6:** Diploma. **FGPN7:** Diploma.

Researcher:

Thank you. Are all qualifications within nursing, correct?

All Participants:

Yes.

Researcher:

Now let's talk about experience in nursing practice. Please share how many years you've been practicing: 1 - 5 years, 6 -10 years, 11 -15 years, or 15+ years.

FGPN1:1 to 10 years., **FGPN2:** 5 to 10 years., **FGPN3:**1 to 5 years., **FGPN4:** 11 to 15 years., **FGPN5:** 11 to 15 years., **FGPN6:**11 to 15 years., **FGPN7:** 15 years and above.

Researcher:

Let's get into the main discussion. There are no right or wrong answers, just your perspectives. The first question is: Can you please share your views on culturally sensitive patient care in the context of nursing?

FGPN1:

Patients are very sensitive when it comes to their culture. If we don't respect their culture or religion, it becomes a problem.

FGPN4:

I believe cultural sensitivity is important because patients are very attached to their cultures. We must respect their religion and cultural beliefs when we care for them.

FGPN2:

From my point of view, cultural sensitivity requires a lot of training. You need to understand, respect, and respond to different cultures. This includes things like how they dress, their language, even dietary requirements. For instance, some patients can't be touched without permission or by someone of a different gender. But we often lack that knowledge.

Researcher:

You mentioned a lack of knowledge. Can you tell me more on that?

FGPN2:

Yes, we tend to focus on physical care and recovery. We don't always consider patient's cultural preferences. It's not prioritised.

Researcher:

You also spoke about a lack of knowledge can you explain more about that lack in knowledge?

FGPN2:

As nurses, we move between provinces. Say I'm from the Western Cape and now work in the Eastern Cape - I'm dealing with people from different cultural backgrounds. If there was cultural orientation

training for healthcare workers entering new regions, we would be more prepared. But also, due to workload, we often don't have time to consider cultural issues even if we want to.

FGPN1:

But how would that work practically? There are so many cultures - how can the government teach every single one?

FGPN2:

It should be part of induction. When someone starts working in a new place, part of the orientation should include training on the dominant cultures of that region. For example, in the Eastern Cape, where cultural practices are more deeply rooted, staff should be made aware during induction.

Researcher:

So, in your view, some areas like the Eastern Cape might require deeper cultural sensitivity due to stronger traditional practices?

FGPN2:

Exactly.

Researcher:

What items or signs do you consider cultural when you see them on a patient - whether in hospital or clinic?

FGPN2:

When patients come in, you notice nonverbal communication - like avoiding eye contact. For instance, a male patient may not make direct eye contact with a female nurse. You can't just touch them either - you need to ask first. It's all part of their culture.

Researcher:

Let me clarify. When a patient arrives, what physical things - like clothing or items - do you recognise as cultural?

FGPN1:

Things like animal skin clothing, beads around the waist, or head coverings. These are signs of cultural beliefs or rituals.

FGPN3:

Yes, like the group (scarf) a married woman wears, or strings around the waist from traditional healers.

Researcher:

So, if a patient arrives with those items, would you allow them to keep them on in the ward, or ask them to remove them?

FGPN3:

If it doesn't interfere with medical procedures or hygiene, I'd let them keep them.

FGPN4:

I'd try to explain why they might need to remove them, especially for safety reasons, but always respectfully.

Researcher:

Have you ever cared for a patient from a culture different from your own? What was that experience like?

FGPN6:

Yes. Once, I was about to draw blood from a female patient. But because I'm male, I was not allowed to touch her. She said only a female nurse could do it. At first, it was confusing, but I respected that and asked a female colleague to assist.

Researcher:

How did that make you feel? Do you think it's fair, or do you think something should be done about it - like assigning genders to certain areas?

FGPN6:

At first, it was confusing, especially because her husband was present and seemed okay with it. But I respected the patient's wishes. I think facilities need to consider gender when assigning nurses in culturally sensitive situations.

Researcher:

What is your view on that situation where you couldn't touch the patient because of your gender? Do you think it was appropriate for the patient to make that request, or do you believe there should be protocols in place to handle such scenarios in the future?

FGPN3:

I believe it's important to respect the patient's cultural beliefs. However, it would be beneficial if healthcare facilities had protocols or guidelines to manage such situations. For instance, having staff of both genders available to accommodate patient's preferences without compromising care.

Researcher:

Having clear protocols can help in providing culturally sensitive care while ensuring that patient care is not delayed.

FGPN4:

I agree. In my experience, there have been times when patients refused care from certain staff members due to cultural or religious reasons. It's important to have a system in place to address these concerns promptly.

Researcher:

Thank you for sharing. Now, let's discuss any challenges you've faced when providing care for patients from different cultural backgrounds. Can anyone share an experience?

FGPN5:

Yes, I once cared for a patient who had specific dietary restrictions due to religious beliefs. At first, there was a misunderstanding, and the patient was given food that didn't align with their dietary needs. It caused distress, and we had to involve a dietitian to manage the situation.

Researcher:

That highlights the importance of understanding patient's cultural and religious needs.

FGPN6:

Adding to that, language barriers can also pose challenges. I've encountered situations where patients couldn't communicate their needs effectively, leading to confusion.

Researcher:

Do you think that patient was being unreasonable, or was she simply expressing her culture? And do you believe you had a duty to respect her culture when she said, "I don't want to be touched by a man"? Was she within her rights to do that? And do you feel, in any way, that you violated her cultural beliefs?

FGPN1:

I think she was just respecting her culture, and my duty was to respect that as well.

Researcher:

Okay. What's your view on not being able to touch a patient because of your gender? Was it acceptable for the patient to refuse care from a male nurse? Or do you think something should be done in the future so that staffing considers gender in culturally sensitive cases? What was your conclusion about the whole situation?

FGPN2:

It becomes uncomfortable when there's no alternative available. What if there wasn't another staff member present? That could create a problem. I think the government should look at ways to address this issue. You can't always assign staff based on gender. It should depend on skills and experience. But still, if a patient expresses a preference, it should be considered if possible.

FGPN6:

Yes, and institutions need to find a balance. If a patient comes in with cultural expectations, we should consider them, but patients should also understand the limitations within the facility. We can't always accommodate every preference due to resource constraints. Communities should be made aware of that. If you come to a clinic or hospital, you need to understand that not all cultural expectations can be fulfilled. Our role is to provide care within our means.

Researcher:

So regarding that patient who didn't want to be touched by a male - was it truly about culture, or could it have been something else?

FGPN4:

Honestly, I don't think it was about culture. Sometimes people use culture as a reason, but it's not always genuine. I've seen patients who claim cultural restrictions in one context but accept male nurses or doctors in other situations, like receiving an injection or wound care. So, I think it can be selective.

FGPN1:

When I approach a patient, I don't go in thinking about gender - I go in as a healthcare provider, neutral, and focus on giving care. But if a patient expresses a specific cultural preference, I try to respect that, as long as it's reasonable and feasible.

Researcher:

Okay, but again, do you feel that patient had the right to insist on not being touched by a man? Were you violating her rights or identity by attempting to treat her?

FGPN6:

She had the right, and I respected that. I tried to find someone else to assist her. It's like a patient who's fasting - you advise them medically, but ultimately you respect their beliefs. The same applies to patients coming from traditional settings, like after circumcision. When they come to the hospital, we still need to treat them, even if it contradicts certain customs.

Researcher:

That's an important point. When patients come from initiation schools or traditional ceremonies and end up in hospital - say, after circumcision - who takes care of them? What happens then?

FGPN4:

Medical staff treat them regardless. They came seeking help. That shows that they've already compromised their cultural rules to some extent by choosing care.

Researcher:

So are we violating their cultural norms by treating them, especially if we're women? Or does the fact that they're seeking help override that?

FGPN4:

I think when they come to hospital, they've already accepted that help may come in ways that aren't aligned with tradition. It becomes a matter of urgency over belief. Their condition forces them to compromise. It's not about nurses violating culture, it's about the patient choosing survival.

Researcher:

But then, in those cases, is it really their choice? Or is it the situation - like life or death - that forces their hand? What does that say about how we handle cultural issues in healthcare?

FGPN7:

I think that's where compromise comes in. Patients, nurses, and even community must understand that hospitals can't meet every cultural expectation. If a patient refuses blood tests from a certain gender, but no alternative is available, they might have to compromise. As much as we try to respect culture, we work in a system with limits.

Researcher:

So in cases where patients don't get everything they want, who is to blame? The nurses? The government? The policies? Or is it just a limitation of the system?

FGPN2:

Honestly, no one is really to blame. Especially in public hospitals, the resources are limited. Even in private hospitals, you can't guarantee a gender-specific provider. It's more complicated in public settings where patient numbers are high. We try to be culturally sensitive, but we also need to be realistic. It's everyone's responsibility, not just the nurse or the system.

Researcher:

We're talking in the South African context, where the population is extremely diverse. Different cultures

have different beliefs - even within the same population as this one of Mitchells Plain. Would you say our policies address this?

FGPN1:

Not effective. Other countries, like Saudi Arabia, structure healthcare around cultural practices. In South Africa, we don't have a unified cultural approach. It's very diverse, so our policies need to be flexible but also practical.

Researcher:

That's true. In Saudi Arabia, for example, you respect the host culture - even if your own differs. But in South Africa, it's more separated. Let's shift a bit. What are your views on referring patients for indigenous consultation or traditional healing?

FGPN2:

If a patient asks for it, I wouldn't ignore the request. I may not formally refer to them. it's not in our scope - I wouldn't support them in that choice and maybe speak with their family or note it in the file.

FGPN1:

Sometimes patients need that cultural or spiritual step to heal. Ignoring that can delay their recovery. I guess holistic nursing means including cultural needs too.

Researcher:

Would you ever bring it up with the patient - ask if they'd like to explore traditional healing?

FGPN1:

I might, even though I know it is not allowed. Sometimes patients need that. I'd assess the background and situation first. I wouldn't dismiss it because, as nurses, we need to treat the whole person.

FGPN1:

Our policies need to acknowledge that too. Right now, our system is very Western. There's no proper space or protocol for traditional healing.

Researcher:

So what should be done to improve culturally sensitive care?

FGPN4:

First, training. Nurses must be taught to understand culture, not just tolerate it.

FGPN5:

I agree with you. Cultural sensitivity should be part of our continuing education even at the nursing school.

FGPN5:

And we need system-level change. Policies must formally recognize traditional healing so that nurses don't feel like they're doing something wrong by supporting it.

FGPN3:

Exactly. Patients should feel safe to express their beliefs. Even though we understand we should not support that part of healing.

Researcher:

Thank you all so much. This has been a great discussion. Any final thoughts? As a closing remark.

FGPN7:

Just that culture is part of holistic nursing. It's not extra - it's important, that's my view.

FGPN7:

And we need systems that let us practice without feeling like we're crossing the line.

FGPN1:

Patients should never feel ashamed of their culture in healthcare settings.

Researcher:

Thank you again. I really appreciate your time and input. We are at the end. I'll stop recording now.

APPENDIX Y: LANGUAGE EDITING CERTIFICATE



Office: 0183892451

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Date: 1st December November, 2025

CERTIFICATE OF EDITING

I, **Muchativugwa Liberty Hove**, confirm and certify that I have read and edited the entire thesis, **Nursing Strategies to Enhance Culturally Sensitive Patient Care in a Metropolitan Community: Western Cape, South Africa** submitted by **Zama Alfred Mfundisi** in accordance with the requirements for the degree of **DOCTOR OF PHILOSOPHY (Nursing)** at the UNIVERSITY OF SOUTH AFRICA

Zama Alfred Mfundisi was promoted by Professor DAVID DITABA MPHUTHI.

I hold a PhD in Literature and Language Education and am competent to edit and advise on research practices, specifically coherence, cohesion and grammatical concord. Yours sincerely

Professor M.L. Hove (PhD, MA, PGDE, PGCE, BA Dual Honours; C2 NRF Rated Researcher; 2024 Visiting Scholar-University of London, SOAS)



APPENDIX Z: TECHNICAL EDITING CONFIRMATION LETTER



To Whom It May Concern

Re: Technical Editing

This letter serves to inform you that the **Doctor of Philosophy (Nursing)** thesis for **Zama Alfred Mfundisi**, title: **Nursing strategies to enhance culturally sensitive patient care in a metropolitan community: Western Cape, South Africa**, was technically edited and formatted.

Regards

Rinnie Matlou

A handwritten signature in dark ink, appearing to read "Rinnie", is placed below the printed name.