Registered Nurses' Perspectives on Barriers and Enablers of Incorporating Ubuntu Principles in the Management of Childhood Illness in the Mahikeng Sub-District, North West Province

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Abstract

Introduction: There are several obstacles to applying Ubuntu principles in the treatment of childhood illness, including a lack of understanding of the concept, cultural disparities, and limitations of the healthcare system. Promoting respect for children's rights, family involvement, and integrating Ubuntu into Integrated Management of Childhood Illness (IMCI) by registered nurses can improve patient care and potentially increase treatment adherence and outcomes. Therefore, including Ubuntu in IMCI is crucial to a successful, culturally aware approach to paediatric healthcare.

Methods: The study employed an exploratory descriptive approach. The participants were selected using purposive sampling. Data collection was done through focus group interviews. A study was conducted in specific primary health care facilities, such as community health centres and clinics, located in the Mafikeng sub-district of the North West Province. The collected data were analysed using thematic analysis.

Results: The study revealed two themes and their sub-themes: registered nurses' views on barriers to incorporating Ubuntu principles into IMCI and registered nurses' views on facilitators of Ubuntu principles

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Conclusion: Registered nurses recognise a significant opportunity to improve holistic care by incorporating Ubuntu principles, which emphasise compassion, connectivity, and community solidarity in the management of childhood illness. In the end, nurses can be empowered to provide care that not only heals disease but also fosters the child's well-being within the larger human and communal context by strengthening these enablers and removing impediments.
Contribution: The study will contribute to more knowledge on incorporating Ubuntu principles into IMCI

Keywords: caregivers; IMCI; registered nurses; Ubuntu

Background

Integrated Management of Childhood Illness and Sustainable Development Goal 3 (SDG 3) are closely related as both aim to improve children's health outcomes and promote the overall well-being (Taylor and Kazembe 2024). In South Africa, while IMCI has contributed to enhancing child health, it has encountered several challenges. These include insufficient healthcare worker training, inadequate resources, and difficulties in reaching rural and underserved populations. Additionally, the rigid, one-size-fits-all approach of IMCI may not fully consider the cultural beliefs, practices, and values that influence healthcare decision-making in South Africa (Mokwena 2017).

Ubuntu, with its emphasis on community, interconnectedness, and respect for human dignity, could address these gaps by fostering a more culturally sensitive, holistic, and community-driven approach to managing childhood illness. Kamwangamalu (2015) highlights that the collaborative, inclusive spirit of Ubuntu may conflict with structured health systems in which authority is concentrated at the top and decision-making is centralised. Many healthcare systems' focus on control and efficiency often results in fragmented care, reducing the likelihood of joint decision-making and mutual support. Ubuntu encourages family and community involvement, which could enhance patient engagement and adherence to health interventions, making it a valuable addition to the IMCI strategy in South Africa (Ngubane 2016). Despite the potential benefits, various obstacles to the effective integration of Ubuntu principles within IMCI exist, including systemic, cultural, and resource-related issues. Manda (2010) states that IMCI is a strategy designed to improve child outcomes, although the cultural aspect is not included.

Ubuntu's emphasis on compassion, community, and shared humanity in healthcare aligns with holistic approaches to patient care (Mulaudzi and Gundo 2024). Ubuntu philosophy, with its focus on compassionate care, serves as the foundation for engaging with individuals who are protected yet vulnerable (Nyandeni, Raliphaswa, Musie, Maputle, Gundo, Mulaudzi, and Sepeng 2024). This perspective encourages empathy, respect, and a sense of shared responsibility among healthcare professionals by recognising patients as both individuals and members of a broader community.

Mugumbate et al. (2024) further state that Ubuntu is an indigenous African philosophy and way of life that has been used for centuries to shape, guide, and sustain positive human interactions, relationships, and well-being among African indigenous peoples and communities. Interconnectedness fosters a more inclusive approach to care, where patients' well-being is valued both individually and within the larger societal context (Molefe 2024). However, Pandya and colleagues indicated that barriers often include costly, time-consuming training and inadequate post-training support for healthcare workers in IMCI (Pandya, Slemming, and Saloojee 2018). Lastly, the perspectives of professionals enable a more comprehensive understanding of the conflicts between modern globalised behaviours and traditional Ubuntu practices. These perspectives can help clarify how Ubuntu can be adapted or preserved to enhance social cohesion and address the needs of a rapidly changing world (Mugumbate and Chereni 2019). Therefore, the study aimed to explore and describe registered nurses' perspectives on the barriers and facilitators to integrating Ubuntu principles into IMCI.

Methodology

Design

The study employed an exploratory descriptive research approach, a method in nursing and healthcare research that provides broad insight into particular phenomena. An exploratory, descriptive research methodology actively engages people in the study process, aiming to produce knowledge that promotes empowerment and social change. It is unique in that people and researchers collaborate to identify issues, collect information, evaluate findings, and implement solutions.

Setting

The study was carried out in public primary healthcare (PHC) facilities, specifically two community health centres (CHC) and three clinics, located in the Mafikeng sub-district of the Ngaka Modiri Molema district in the North West Province. The study was conducted in the preferred setting of registered nurses, which is the facility boardroom, as they had indicated during the data collection planning that it would be advantageous for the researcher to collect data where they are working and whilst they are on duty.

Population and Sampling

The targeted population for this study consisted of IMCI-trained registered nurses who provided services to children under 5 years old and consulted in clinics and CHCs in the Mafikeng sub-district. Non-probability purposive sampling was used to select registered nurses eligible to participate in the study (Gill 2020). Purposive sampling helped to select participants who shared important and relevant information about the study. The focus groups consisted of eight to ten registered nurses each, and data saturation was reached by the fourth focus group, as no new information emerged.

Recruitment of Participants

The study received approval from the National Health Research Ethics (NHREC). It was submitted to the North West Provincial Department of Health for permission to conduct the study in the Mahikeng sub-district. The researcher first went into the field to negotiate entry by first having an appointment with the operational managers of health facilities, who are gatekeepers. The purpose of the study was explained to the participants. The researcher and participants then agreed that data must be collected in a group format, and therefore, a focus group. The researcher had an appointment with registered nurses, who are the participants in the study (Vaughn and Jacquez 2020). The registered nurses, together with the researcher, planned how the study would be conducted, which was conducted in the facility's boardroom.

Data Collection

The researcher conducted five focus group discussions (FGDs) with more than eight (8) registered nurses at each facility to gather data. The participants were registered nurses working in PHC facilities and were providing healthcare services to children under five in the Mafikeng sub-district. The researcher, together with participants, planned to use the clinic boardrooms to conduct the FGDs. The purpose of the study was explained to the participants in their preferred language, English. The researcher then explained the questions that would be asked of the participants. Informed consent was obtained from participants after the information sheet was written in English. The FGD was conducted in English with the moderator present, lasting 40 to 60 minutes in different facilities. The moderator guided participants during discussions, created a safe environment, elicited rich data, and ensured that research objectives were met. The researcher gave an introduction, stating that she is studying at the University of Pretoria. After discussing consent forms and confidentiality, the participants willingly decided to take part in the study (Kitzinger 1995, Singer and Ye 2013). The researcher posed the following question: What are registered nurses' perspectives on the barriers and facilitators to incorporating Ubuntu principles into IMCI? The researcher probed, paraphrased, and asked clarifying questions during the FGD. The co-researcher was informed during planning that the researcher had utilised an audio recorder and field notes taken. The audio recorder captured detailed, nuanced data, providing an accurate, unbiased record of interviews that note-taking often misses. The FGDs were held in a quiet clinic boardroom, which was planned with participants during the planning phase. The silent sign was placed outside the door so that others would not disturb during the process.

Data Analysis

Data was analysed using thematic data analysis methods. Placing thematic analysis in context with other qualitative analysis methods can help us understand its scope and purpose. Thematic analysis is a qualitative data analysis process that involves looking

for repeating patterns in data collection, assessing them, and reporting on them (Lochmiller 2021).

The researcher and an independent co-coder used six (6) steps of theme analysis for analysing the data. As a first step in acquainting ourselves with the material, we read and reread the transcripts independently (Maguire, Reynolds, and Delahunt 2020). The initial stage was to organise linked thoughts by finding and labelling places with similar units of meaning. The second part of the theme analysis was assigning codes to these units of meaning (Terry, Hayfield, Clarke, and Braun 2017). The data were carefully and thoroughly organised in a methodical, extensive manner before the researcher and co-coder began coding transcripts independently. Comparable and linked codes were organised into themes based on textual phrases. Themes were examined, compared, and improved with the co-coder to ensure they appropriately represented the data, and the procedure was repeated for all transcripts. The quotations from the interviews were used as citations in the findings section. The procedure was repeated to guarantee accuracy and meaning retention. The researcher and co-coder then read the information associated with each theme and determined whether it supported the theme.

During the final phase, the researcher and co-coder discussed whether they agreed on the study's themes and sub-themes. The co-coder was also assigned to the data analysis process, which included ensuring and conducting member verification or peer debriefing to confirm that the findings were reliable and accurately reflected the data (Maguire, Reynolds, and Delahunt 2020).

Trustworthiness

In this study, the researcher ensured trustworthiness by following four principles: credibility, dependability, transferability and conformability.

The trusting relationship was built by establishing rapport with the participants and spending more time in the field to gain their perspectives and ensure credibility. To gain insight into the participants' perspectives, the researchers engaged with them over an extended period. Conformability was achieved by making raw data available to other researchers for member checking (Polit and Beck 2012). An audit trail was created to provide transparency into how data were analysed, and conclusions were reached, allowing others to monitor and confirm the process (Ahmed 2024). The researcher in this study, together with the co-researcher, outlined each person’s role and responsibilities. This was to ensure that everyone knows what to expect and how to do it. The research setting, participants, and techniques were thoroughly described, resulting in a thick description. The researcher addressed transferability by ensuring and explaining that the study results cannot be generalised to other settings (Ahmed 2024).

The University of Pretoria's Faculty of Health Sciences Research Ethics Committee (REC) approved the start of the current study (Ethics Reference No.: 617/2022). The

North West Department of Health (NWDoH) provided written consent. An informed consent form was provided, and the purpose and nature of the study were explained to them, along with the fact that their participation was voluntary and that they could withdraw from the study at any time without being subjected to any form of punishment or discrimination. Participants were informed that no names would be used in the alphabet to maintain anonymity, privacy, and confidentiality. Participants received cards with letters of the alphabet instead of their names, demonstrating adherence to the anonymity principle.

Results

This study included 37 registered nurses from five different health care facilities who volunteered to participate. Both genders were represented, but the majority of the participants were females. See Table 1 above for more information.

Table 1: Demographic Information of Registered Nurses

Variable	Category	Number
Gender	Male	03
	Female	34
Age	20–29	05
	30–39	15
	40–49	17

A total of five focus group discussions with seven to ten participants were conducted face-to-face; see Table 2 for more information on the study's findings. The study identified two main themes and eight sub-themes. According to the researchers, this study appeared to be a new contribution to the body of knowledge. The study focused on registered nurses' views on the facilitators and barriers to the incorporation of Ubuntu principles in healthcare facilities.

Table 2: The Findings of the Study

Main themes	Sub-themes
1. Registered nurses' views on barriers to incorporate Ubuntu principles into IMCI	1.1 Healthcare user-related barriers
	1.2 Healthcare provider-related barriers
	1.3 Healthcare system-related barriers
	1.4 Cultural and social barriers
2. Registered nurses' views on facilitators of Ubuntu principles	Integrative and holistic care
	Interprofessional and stakeholder collaboration and referral
	Educational interventions
	2.4 Psychosocial interventions

Theme 1: Registered Nurses' views on barriers to incorporating Ubuntu principles into IMCI

The first theme identified was the barriers to incorporating Ubuntu principles into IMCI. Five sub-themes emerged from this theme, namely, healthcare user-related barriers, healthcare provider-related barriers, healthcare system-related barriers, and cultural and social barriers.

Sub-theme 1.1 Healthcare user-related barriers

The healthcare user-related barriers emerged as the first sub-theme. The participants highlighted that patients do not show Ubuntu to one another and even to registered nurses. They display an attitude that makes it difficult for them to assist the patients with kindness. This was expressed as follows:

> The parents also need to have Ubuntu remember …er, if I am being kind and the mother is not kind. If the mother is reluctant to provide the information, I am also going to be reluctant to ask because she is giving me an attitude. **Participant A FGD 1**

One of the participants reported that:

> Yes, you know when you are in that kind of a situation where the parent is panicking and the children tend to sense yes the child is sick the mother panics and things become worse, you find as a nurse trying their best as you were saying about attitude you end up snapping because the real person with an emergency is the child yes I understand is your child but as a nurse I am trying my best to stabilise the child. **Participant G, FGD 2**

Sub-theme 1.2 Healthcare provider-related barriers

The registered nurses indicated that there are barriers related to healthcare providers, as they observe caregivers' attitudes when they visit the facility, and further alluded that this does not reflect Ubuntu principles. This was evident by the quotation below:

> In addition to the question that was asked me personally, I don't think Ubuntu is practised, especially in our facilities. Remember, I added about a baby-friendly clinic. In most cases, when the mother brings the child, we check that the child is growing and doing well. But if the mother brings a sick baby the first thing that is done is to shout at the mother first mam why did you sit and not bring the baby to the clinic, because most of the babies who are sick is the ones who don't come to the clinic for the monthly check-ups they only bring the child when they are sick and first thing that we do is to shout why did you not bring the child for monthly check up we end up shouting the patients because they did not do what they wore supposed to do. **Participant C, FGD 3**

Another participant verbalised:

> It occasionally occurs when you see a patient who has had consultations with another medical professional and realises that they withheld some information, not knowing what the obstacle was. When they tell you something, you become aware that this did not start here. **Participant D, FGD 1**

Sub-theme 1.3 Healthcare system-related barriers

Often, facilities are short of human resources for months, which also impairs the quality of service provided to children under five, as nurses burn out. The shortage of registered nurses leads to many patients being seen and affects the flow of care, as some services are neglected. This was evident by the quotations below:

> Sometimes, when coming to this thing of nurse-to-patient ratio contributes to burnout syndrome, whereby one ends up being short-tempered when attending patients, no compassionate care. **Participant C, FGD 1**

The participants further alluded that:

> According to what was by participant A and E I think this is also caused by shortage of staff you find in most cases 1 nurse assisting 60 patients like co-researcher c mentioned that it is all about pushing the que we want to finish we there are lot of patients we don't give them enough time also shortage of staff, the ratio of nurses to patients does not balance so sometimes you wonder what you are going to do in such a short space of time. **Participant C, FGD 2**

Sub-theme 1.4 Cultural and social barriers

Nurses reported that caregivers perform certain rituals, such as putting things on their babies or even giving them traditional medicines, which then impairs what is given to the baby.

> They take children to traditional healers they cut them for example the child is sick due to being malnutrition and they take the baby to the traditional healer and the healer cuts the baby and after that they take the child home hoping the child become better, but the child get worse and when the baby get to the clinic there is nothing we can do or maybe the child is in a situation that whatever we are going to do is too late so I don't know how are we going to do it. Do we involve them in the people that we need to educate, or where do we take these people who believe in culture and have their own beliefs? **Participant A FGD 4**

Sub-theme 1.5 Compromised healthcare

The compromised healthcare emerged as a sub-theme; the participant indicated that the quality, accessibility, and effectiveness of healthcare services are deteriorating, resulting in poor patient outcomes. Patients from diverse backgrounds may have difficulty understanding health information or communicating their needs, leading to misdiagnoses and ineffective treatment and thereby affecting the incorporation of Ubuntu principles into IMCI. This is supported by the quotation below:

> Yes, because at 6 months it is where you start to introduce the child to solid foods, so most of them if you don't educate them they go and feed the child solid food before time not looking that if the child is this age they have to eat this so we have to teach them that this is the type of solid food the child has to eat when they are 6months old so that they child can grow well. **Participant C FGD 4**

Another Participant added

> They always take time to bring their children on time when they are sick. Hoping that maybe tomorrow will be better. This is what healthcare feels like for people like me. **Participant E FGD 3**

Aspects of healthcare systems compromise the health of children under the age of five. Cultural and social barriers contribute to nurses not incorporating the Ubuntu principles.

Theme 2: Registered Nurses' views on enhancement of Ubuntu principles.

The registered nurses highlighted ways to enhance the application of Ubuntu principles in IMCI. The following sub-themes were derived from the theme of integrative and holistic care: Interprofessional and stakeholder collaboration, referral, educational interventions, and Psychosocial interventions.

Sub-theme 2.1 Integrative and holistic care

The integrative and holistic care was highlighted as an enhancer for the incorporation of the Ubuntu principle. This is evident in the following direct comments from the participants:

> When the mother brings the baby, you don't just concentrate on that, you check if the baby is exposed or not, the birth weight, if the baby is gaining, if the baby is immunised to age, and if the baby is developing according to age. **Participant I FGD 2**

Another participant added:

> Quality care is just like mentioned by participant C, that you help the patient the way you must help them, maybe they come with a cough, you check if the child doesn't have chest in drawers, difficulty in breathing and other things. I think that is quality care, you don't focus on the cough only, you check other relevant signs. **Participant E FGD 1**

Sub-theme 2.2 Interprofessional and Stakeholder Collaboration and Referral

Interprofessional and stakeholder collaboration emerged as one of the sub-themes participants highlighted, as it is important in enhancing the incorporation of Ubuntu into IMCI.

> As we know, in the health system we work as multi-disciplinary teams, including doctors, nurses, social workers and others, to help the client, so we are going to have to involve the whole multi-disciplinary team to achieve the same goal. I think that is what we mean by involvement because we have to involve the whole team. **Participant E FDG 3**

This was supported by another participant:

> The outreach team leader is the registered nurse that leads the community health workers, the nurse is working with them if there is a problem the community health workers inform the OTL to assist and the OTL is the one who deals with referrals if they went to a house, and they see that the patient need to go the clinic the OTL refers them to the clinic but if it is something that they can assist wit they assist. **Participant D FGD 2**

Sub-theme 2.3 Educational Interventions

Educational interventions emerged as a sub-theme. The participant stated that they require health education on issues related to their children's health. They explained that this will significantly benefit them because they frequently leave the facility with questions that they are afraid to ask. Issues arise, particularly when deciding when to take their sick children to the clinic, as they first try home remedies due to a lack of knowledge. One of the participants expressed herself as follows:

> I think health-giving health education, like when is their day for children at the clinic, we can give health education, we must teach the mothers. Even though patients don't hold to the information, at least when you have taught them that if the child is in this condition at home, take them to the clinic immediately, don't sit with them until they are served. **Participant C, FGD 1**

This was further echoed by another participant:

> Other things we advise them is to apply, but don't give the baby Haramis to drink because it can cause kidney damage, and the age on it says 12 years, whereas your baby is 6 weeks old. Rather apply than give the babies to drink. **Participant A FGD 3**

Sub-theme 2.4 Psychosocial Interventions

The social background also affects caregivers psychologically. Stress, anxiety, and social isolation are common challenges that caregivers face, and they can hurt their children's health and effectiveness. In response to these challenges, psychosocial interventions have emerged as a critical area for caregiver support. This was alluded to by the following quotations:

> I feel like the mothers should be offered counselling because, as much as IMCI is about the children, it starts from the mother, because if the mother is not fine, they won't be able to take good care of the child. So, if we begin with offering them counselling if they need anything, we must offer counselling for the mothers. **Participant F FGD 1**

One of the caregivers supported the sentiment as follows:

> In addition to discrimination, we sometimes don't know the parents' background. So if a child is dirty and asks the mother in a nice way why the child is dirty, you can get a lot of information, maybe they don't have food, and they don't get grants. **Participant A FGD 2**

This theme focuses on registered nurses' views on barriers to incorporating Ubuntu principles into IMCI, on ways to enhance these principles, and on addressing caregivers' psychological aspects to improve their coping mechanisms and quality of life, while reflecting Ubuntu principles for care recipients under the age of five.

Discussion

The study aimed to explore the barriers and facilitators to incorporating Ubuntu principles in the management of childhood illnesses in children under five. The sub-themes emerged as healthcare user-related barriers, healthcare provider-related barriers, healthcare system barriers, compromised healthcare, and cultural and social barriers. Many healthcare users were related, and the caregivers' attitudes and behaviours made it difficult for professionals to provide services. Jibril et al. (2024) state that patients'

satisfaction has long been considered an important component when measuring health outcomes and quality of healthcare. Nurses reported that caregivers are often reluctant to provide information about their children's health and refuse referrals to other stakeholders. Furthermore, factors such as limited access to information, educational level, and socioeconomic support may impede free family participation.

The findings of the study are consistent with those of a study by Mathew et al. (2022), which found that healthcare recipients often fear being judged by healthcare providers. They further indicated that good communication between the caregivers and healthcare providers will facilitate a favourable decision towards their healthcare. The healthcare provider-related sub-theme emerged as participants indicated that caregivers complain that registered nurses, at times, shout at them when they bring their children under the age of five. Ubuntu encompasses principles and values; caring is one of them. Providing care is important for health and healing, and nurses play a key role (Nyandeni, Raliphaswa, Musie, Maputle, Gundo, Mulaudzi, and Sepeng, 2024). Therefore, registered nurses play an important role in caring for patients, including children under 5 years (Tolsma and Downing 2016).

Furthermore, nurses alluded that at times it becomes difficult for them to provide holistic care for the children, as other patients in the facility do not have patience when they are seeing the children, and the assessment takes longer when they explore the IMCI guideline. Nurses often encounter challenges when caring for children under the age of five, as other patients in the waiting area knock on the door and complain they have been waiting a long time. The study outlines barriers to health care delivery in the healthcare system, including poor infrastructure, distance, and poor coordination. This finding is consistent with Mangena-Netshikweta et al. (2019), who indicate that devastating workloads, unhealthy workplaces, poorly maintained infrastructure, and insufficient supplies and equipment all affect the quality of healthcare services provided at the PHC level.

Registered nurses face constraints such as limited human resources, hostile attitudes, and knowledge (Bangura et al. 2020). They further stated that increased financial resources would enable countries to equip and upgrade existing health facilities and increase their numbers.

Social and cultural barriers in healthcare significantly affect nurses' ability to provide adequate care for children under age five. Taylor and Kazembe (2024) highlight that language is a barrier, as caregivers in some cases speak different languages and are unable to speak English. Schouten et al. (2019) concur that language hinders the provision of care. The caregiver uses certain traditional herbs on their children, especially on the umbilical cord. Another practice that was highlighted was that when a child is sick due to being malnutrition, and they take the baby to the traditional healer, the healer cuts the baby. Cultural misunderstandings can impede the implementation of

Ubuntu principles in healthcare settings. The facilitators for the incorporation of Ubuntu principles, with sub-themes of integrative and holistic care, interpersonal and stakeholder collaboration and referral, educational interventions, and psychosocial interventions. A study demonstrated that patients value the information provided; their level of satisfaction with it was closely linked to the quantity of information they received from their healthcare providers (Jibril et al. 2024).

Integrative and holistic care emerged as a theme, and this, in correlation with Ma Sisulu's acts of caring from the heart, occurred in an environment that encouraged caring and respect for the individual (Nolte and Downing 2018). Another finding of Mulaudzi and Gundo (2024) is that the Ubuntu model of nursing views an individual's environment holistically and integratively, recognising a deep, inseparable interconnectedness between human well-being and the natural world. Interpersonal collaboration between the stakeholders, including registered nurses and caregivers, emerged as a sub-theme. Fayemi et al. (2021) indicate that Ubuntu ethics can guide community collaboration and accountability, and involving communities can help them gain sufficient understanding. Furthermore, Ubuntu emphasises humanness, connectedness, cohesion and conscience, all of which Sisulu embraced, as well as respect, empathy, cooperation, harmony, sharing, and warmth. In Ubuntu, an action is right if it promotes cohesion and reciprocal value, emphasising “the right way of living”(Nolte and Downing, 2018). Moreover, active family participation in IMCI programmes strengthens the relationship between the community and health workers, fosters trust, and encourages the use of available health services (Pinto et al. 2024). Moreover, Solidarity and cohesion are two essential Ubuntu principles that significantly impact nursing ethics (Mulaudzi et al. 2021).

The study revealed the need for educational and psychosocial interventions. Many registered nurses reported that conducting health education to caregivers allows them to ask questions when they do not understand. In this regard, the study by Cao et al. (2022) found that health education, as a non-pharmacological management approach, is highly effective.

The study also revealed that Ubuntu principles are essential, as the IMCI strategy aims to reduce morbidity and mortality among children under five by taking a comprehensive approach to common childhood illnesses. Educational and psychosocial interventions are essential parts of the IMCI programme (Pinto et al. 2024). Implementing community outreach programmes to educate parents and caregivers about common childhood illnesses, prevention strategies, and the importance of seeking medical care on time.

Limitations

The research was conducted with a relatively small group of registered nurses from selected clinics in Mahikeng, which may limit the generalizability of the findings to

other healthcare contexts in South Africa. Despite these limitations, the study provides valuable information about the obstacles and facilitators of implementing Ubuntu in nursing practice and offers tactics for advancing culturally sensitive care.

Conclusions

The study identified several barriers to integrating Ubuntu principles into the management of childhood illness. The structural orientation limits nurses' opportunities to practice the Ubuntu ideal of “I am because we are” in their daily interactions with children and families, despite Ubuntu's emphasis on collective responsibility, compassion, mutual respect, and interconnectedness. Resource limitations, such as insufficient staffing, inadequate equipment, and heavy patient workloads, were identified as a significant obstacle. These difficulties make it difficult for nurses to give the individualised, caring care that Ubuntu promotes. The sense of shared humanity at the heart of Ubuntu is weakened by the drive to accomplish clinical targets, which frequently leaves little time for meaningful contact with patients and families.

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Author Contributions

F.O.M. conducted a study and drafted the manuscript. F.M.M. and N.V.S. supervised the project, provided support during the study and edited the article.

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Data Availability

The raw data used to support the findings of this study are included in this article.

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