

Nurses' Perception of Arab Women Needs in Intensive Care Units: Focus Group Study

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Abstract: Patients admitted to the intensive care unit are subjected to many stressful experiences. Identifying the needs of critically ill Arab women requires attention and considered of high importance. The aim of this study was to explore intensive care nurses' perceptions of the Arab women's needs in intensive care units by means of focus group interviews. This study used a qualitative design based on a thematic content analysis of focus group interviews with nurses working in intensive care units in Jordan. A total of 24 registered nurses shared their experience in four focus group discussions. A qualitative content analysis was used (Graneheim and Lundman, 2004) to analyze the participants' texts. The overall analysis of texts revealed that participants encountered many situations with critically ill patients enabled them to understand their needs in the intensive care units and suggested some practical solutions that may help in meeting those needs. Two main themes emerged from texts: the need to feel safe and secure and the need to preserve religious and cultural values. The study concluded that Arab women in intensive care units need to feel safe, and comfort. Gender specific needs such as covering the body and the avoidance of intimate contact with health care professional from opposite gender are important to be considered while providing health care for women in the intensive care unit. Efforts should be made to facilitate the women's compliance to cultural and religious issues in the critical care settings as well as in other health care settings.

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1. Introduction

Patients admitted to the intensive care unit (ICU) are subjected to many stressful experiences. Some of those patients are unconscious, or in critical condition, or might be in need for supportive special devices such as mechanical ventilation to keep them alive (Radtko, et al., 2011). Unfortunately, most of the patients in the ICU are in life-threatening conditions and mainly do not remember their stay in the ICU; make it hard for patients to give information of what had happened to them during their critical period of illness.

The patients are often describing their experience in the ICU as frightening and think that the health care professionals may harm them (Jones, et al. 2010). Patients' experiences and memories of critical care are vague and painful. Some patients remember and preserve painful emotions and fears related to their experience (Storli, et al., 2008). Nevertheless, most of critically ill patients are unable to speak because of the presence of endotracheal or tracheostomy tubes (Meriläinen et al., 2010). In addition, critically ill patients are often sedated to tolerate the invasive procedures required for treatment and to reduce anxiety (Sessler and Varney, 2008). This may stand as a problem to assess their needs by interviewing them.

The critical care unit is a continuously changing environment in which patients are helped through the crisis of critical illness. Patients' experiences and memories of critical care are blurry and ambiguous. Only few patients remember and retain these memories, however, they expressed strong emotions and anxiety related to their experience (Storli, et al., 2008). These intense feelings may be related to the critical care environment and to the treatment modalities; for instance, patients may recall being unable to communicate.

Meeting the needs of critically ill patients should be emphasized to gain their satisfaction and ensure high quality of care. (Aro, Pietila and Järvelin, 2012). Intensive care units are designed to meet the needs of most critically ill patients, resulting in an environment that is not always modified to the care needs of specific population. Usually, the environment in the ICU is designed to meet the physical needs of the patients; it may not sufficiently meet the other needs such as those related to gender issues with the consideration of cultural and religious components of care. Few studies conducted with the ICU patients in non-western culture (Alasad and Ahmed, 2005; Halligan, 2006; Zeilani and Seymour, 2010; Zeilani and Seymour, 2012). For example, Alasad and Ahmed (2005) interviewed 28 Jordanian ICU nurses to

explore their experiences in communicating with the unconscious patients in the ICU. The nurses revealed that verbal communication was essential; however, the nurses felt frustrated when they could not have a two-way talk with patients and thus rely on their experiences to identify patients' needs.

Identifying the needs of Arab women in the ICUs requires attention and considered of high importance. However, there is a lack of research regarding the Arab women experience in critical care units. Though, the majority of those women are suffering considerably, physically, socially, and spiritually (Zeilani and Seymour, 2012). Asking nurses about the ICU women needs is seen as a reasonable choice since nurses can convey information related to patients' experiences because they have a unique relationship with critically ill patients especially when the patients cannot communicate their needs verbally. Zeilani and Seymour (2012) emphasized the importance of studying Arab Muslim women's needs and preferences for health care in critical care settings and stressed the significance of assessing the cultural and spiritual aspects of this care. Therefore, our intent in this study is to improve the ability of healthcare providers to deliver culturally competent care while recognizing the individualized need for each critically ill patient. The aim of this study was to explore intensive care nurses' perceptions of the Arab women's needs in intensive care units by means of focus group interviews.

2. Materials and Methods

This study used a qualitative design, based on a thematic content analysis of focus group interviews with nurses working in intensive care units in Jordan. The purpose of the focus groups was to identify themes that could promote understanding the needs of critically ill Arab women through sharing the experiences and knowledge of ICU nurses. Morgan (1998) defines a focus group as "a research technique that collects data through group interaction on a topic determined by the researcher". This method is appropriate for the purpose of this study to stimulate the critical care nurses' interactions and communication that hopefully be reflected on improving nursing practice. Focus group method is a useful and effective mechanism in which the researcher is interested in processes whereby a group jointly constructs meaning about a topic (Shaha, Wenzel and Hill, 2011).

Data Collection

Data were collected by means of multistage focus group discussions; a method that is based on sharing experiences and thoughts about a specific topic through the group interactions. The focus group provides a mean of listening to the perspective of key

stakeholders and learning from their experiences of the phenomenon (Jayasekara and Edu., 2012). Accordingly, Data were collected from four focus groups. Each group consists of six registered nurses who met the following inclusion criteria:

- Registered nurses with minimum of two years experience in the ICU.
- Currently working in one of the intensive care units.
- Welling to share their knowledge and experiences.

All nurses were invited to participate in the study through ads posted on the nursing boards in each ICU of the seven selected hospitals in Jordan. The ad included information about the purpose of the study, the inclusion criteria, and information about the focus group process. Accordingly, a total of 24 registered nurses who responded to the ads contacted the researchers and expressed their willingness to share their knowledge and experiences. The three researchers then provided individual further explanation about the study, and informed consent were obtained from each participant. In addition, nurses who were involved in the focus discussions selected the time and place of the focus group meetings according to their convenience.

The focus groups were conducted and lead by the study researchers (M A and R Z). Two sessions were conducted with each focus group. The aim for the two sessions is to ensure that the discussions had reached a repetitive and in-depth level by the end of the second meeting. The first focus group discussion questions sought to elicit the participants' perspective of Arab women's needs in the ICU. In the first focus groups, two main open questions were raised to direct the discussion, these were

- From your experience in caring for women in the critical care units, what are the issues raised by Arab women that reflects their needs in the ICU?
- From your perspective, what do you suggest to meet the Arab women's needs in the ICU?

The key questions for the second interviews were developed from preliminary analysis of the first interview transcripts, and were structured to ascertain further women's needs and suggested solutions raised in the previous interviews. Each focus group discussion took between 45–60 minutes and was tape recorded in Arabic and immediately following each interview, the researcher made a verbatim transcription.

Data analysis

A qualitative content analysis in several steps was used (Graneheim and Lundman, 2004). After reading the transcribed text, its content was organized individually by each researcher into meaning units, condensed meaning units, subthemes and themes. The

analysis was done in three phases. In the first phase, each researcher read the texts as a whole, the meaning units were identified, and data were condensed forming a level of self understanding. In the next phase, texts were classified within the study purpose context and suggested codes were decided. In the third phase, the research team met on many instances where codes were compared and developed a consensus coding frame. To increase the study's credibility, participants' validation was performed (Bryman, 2008). This validation process was performed in the second focus group discussions.

3. Results

Description of the Participants

Twenty four Registered nurses were participated in the four focus group discussions (16 female, and 8 male), ages ranged from 25–53 years, with a mean of 36.7 years. The majority of the participants had obtained a bachelor's degree (54.2%), with a mean experience of 8 years in the intensive care units. Demographic and characteristics of the participants are presented in Table 1.

Table 1. Demographic and Participants' Characteristics N=24 (100%)

Variable	N (%)	Range (Mean)
Gender		
Female	16 (66.7)	
Male	8 (33.3)	
Age (years)		25-53 (36.7)
25-29	6 (25)	
30-35	6 (25)	
36-39	2 (8.3)	
40-45	5 (20.8)	
46-50	3 (12.5)	
51 and above	2 (8.3)	
Education		
Diploma's degree	3 (12.5)	
Bachelor's degree	13 (54.2)	
Master's degree	8 (33.3)	
Experience as a Registered nurse (years)		2-30 (12.5)
2-5	2 (8.3)	
6-10	12 (50)	
11-15	3 (12.5)	
16-20	2 (8.3)	
21-25	2 (8.3)	
26-30	3 (12.5)	
Experience as a ICU nurse (years)		2-16 (8.1)
2-4	3 (12.5)	
5-7	10 (41.7)	
8-10	4 (16.7)	
11-13	4 (16.7)	
14-16	3 (12.5)	
Position		
Unit supervisor	4 (16.7)	
Head nurse	6 (25)	
Staff nurse	14 (58.3)	

Women's Needs and Suggestions

The overall analysis of texts revealed that participants encountered many situations with critically ill patients enabled them to understand their needs in the ICU and suggested some practical solutions that may help in meeting those needs. Nurses in the ICUs shared their expertise in relation to the care provided to Arab women in the critical care units in view of their care-giving position. Two main

themes emerged from texts of the participants' stories in the focus group discussions that reflected the Arab women's needs in the ICUs. The themes were: 1) the need to feel safe and secure; 2) the need to preserve religious and cultural values.

1. The Need to Feel Safe and Secure

This theme incorporates participants' accounts of the importance of feeling of security related to the

critical care unit's environment including bed surroundings, machines and equipment, and people.

Women in the ICU feel that they are in a strange place, and they always express that to nurses, as one of the patients told me once "It was awful!! I feel very strange; I am hearing many voices; the machines, the nurses, doctors and visitors. Another patient was so scared from the machines, she felt very lonely, and when I try to talk to here she said that she looked at the unit as an odd and weird place and she wanted to go home.

Another participant stressed effective communication with the patients upon their admission to enable women to be familiar with the surrounding and thus decreases their fears:

I think communication with patients is very important. Dealing with patients depends a lot on their personality. Some patients are unable to speak because they are intubated, other patients speak very little, and some of them avoid speaking at all. This is understandable, they need more care, and support, we have to be very kind to them. We must explain everything around them, mainly, the monitors and machines. Hopefully, in time, and with our support, women will feel more comfortable, and accept the ICU environment

Participants stressed the important aspects of the client feeling strange when entering a new environment. As the discussion proceeded, participants emphasised the importance of explaining nursing procedures. They mentioned that it's important to explain each nursing procedure every time encountering her patients

We should explain everything, every procedure; we must be available for help and have the ability to listen and give them enough time to respond; may be by a sign. Some women need to talk mainly after being extubated from the ventilator; we need to repeat the instructions over and over again without exhausting them.

2. the need to preserve religious and cultural values

This theme describes participants' discussion about the Arab women concerns regarding preserving the values originating from their religious and cultural background. Participants in the focus groups raised many issues related to the patients' cultural and religious needs that have been compromised by their presence in the critical care units. They discussed situations happened with their patients where they invade the patients' Islamic beliefs and their cultural values. The patients' presence in the critical care unit deprived them from practicing religious rituals and compiles them to be in conditions that they think it is against their cultural values. Nurses discussed three aspects related to this need: the need to cover the

body, gender segregation, the need to conduct religious rituals.

2.1 The Need to Cover the Body

Participants raised the issue of women's frequent complaints of exposing their bodies and the feeling of embarrassment and humiliation from wearing a thin short gown

Our female patients are annoyed from exposing their bodies, they feel sham wearing the unit's gowns, I could never forget one of our ICU young patients when she was expressing her anointment of the hospital gown; she exactly said in a very hash way ...

"How awful this gown, it is too short to cover my legs, I feel as naked, I have never dressed like this before. And another patient told me "my dear, we need to cover our bodies, I couldn't imagine that my children would look at me with this bad gown. I don't like taking off my scarf in front of strangers" then she asked me for a blanket to conceal her body.

The participants acknowledged the women's need to cover their bodies and suggested to change the patients' gown style

I completely agree with the female patients, the gowns are short, and expose the female patient's body, we are Arabs, and Arab women are used to cover themselves. I think we should recognise this need. We can ask the stores to supply the hospital with gowns that are long with long sleeves. We must keep the linen covering the patients, increase our awareness of the issue of privacy; this should be written in our hospital policy

One of the participants suggested her strategy for covering the women's body:

I used to give the women two gowns to wear, one with the opening in the back, and the other with the opening in the front, so they would feel covered

Although most of the participants in the four focus groups agreed upon using two gowns for the female patients admitted to the unit, some participants prefer not to change the hospital policy regarding the dress:

Actually, the hospital cannot afford to provide us with suitable gowns for women, and we can't let them wear their ordinary clothes. These gowns are more suitable for examination and procedures. I recommend that the staff make sure that the curtains are around the women while performing any procedure.

2.2 Gender segregation:

Participants in the focus groups frequently raised women's concerns being taking care by male health care providers mainly the nurses whose job requires intimate contacts with the patients and demands frequent touching while providing nursing care. For example, one male participant described one situation with a patient in the critical care unit

While trying to turn a female patient to her side, I recognized that the patient pushed me away from her and asked for female nurse to care for her. I complied with her request, and after half an hour I returned to the same patient to talk about this issue and she told me "my son, don't you know in Islam, women are not allowed to be touched by stranger men".

Participants described how their female patients were annoyed when waking up in a bed next a male patient's bed. They asked for separate rooms or for rooms that receive female patients only. The focus groups presented a solution for this issue as follows

We need to have separate ICUs for female patients, and if possible to have female nurses to care for them. It's not difficult; in Saudi Arabia, most of the hospitals provide this service as they try their best to preserve the religious and cultural issues of health care.

2.3 The need to conduct religious rituals

Another concern related to the women's need to preserve religious values was the need to perform Islamic rituals such as prayers "Salaat" and fasting, and to follow Islamic rules of conduct those associated with diet, healing, and death. Participants discussed how women in the ICU asked to Fast mainly in the month of Ramadan (The Hijri Calendar). Patients insisted not to eat or drink anything from sunup to sundown in the times they felt they became better. Participants also mentioned that some patients ask to fast two days per week (Monday and Thursday). This often brings many discussions and arguments among the health team providers as one of the participant stated:

We always have argument among us about letting our patients fast, we all agree that in the critical phase of their illness, fasting is not allowed and affects women's health, but if the patient became better, some of us even the physicians like to allow the patient to fast especially in winter time where the patient fast for few hours, but this should be under the control of the team.

Participants started to think about the patient's need to meet the Islamic rules of conduct those associated with diet, healing, and death. The participants discussed situations where women in the unit asked about the type of meat offered for them and if it is "Halal". One participant suggested:

Since type of food is important, we can provide information sheet for the patient about the menu and the component of food, I know in the Islamic countries are careful to eat food that are Halal but with the high rate of imported food from non-Muslim countries, many patient refuse to eat food that they don't trust its source, my patients always ask us for permission to bring food from home, and this is against the hospitals' rules.

In addition to the source of food, participants discussed how the preference of food affects the patients' compliance with therapy and promote healings. One participant said

Many women in the unit insist on eating certain types of food such as honey, dates, black seeds, olive and olive oil. They believe that eating seven dates per day will promote wellness, honey and black seeks will cure from every illness, and olive comes from a holly tree.

In the focus groups, there were extensive discussions about the women and their families' practices in relation to death and dying issues. Participants declared that Muslim women asked the family presence to read verses from the holly Qu'ran over their heads especially if they feel that they are dying. Participants mentioned that they observed many practices of the family when their beloved ones are dying or at the time of death. Muslim family encourages the dying patient to recite the shahadatan (testimony of faith) and asked for clean white garb to wrap the body after the patient's death.

When women die in the critical care unit, only close family members can attend, they close her eyes, cover her body, and then put her right hand over the left before wrapping her in white cloth.

4. Discussion

Several issues have emerged from the analysis of the focus group discussions. It was evident that the nurses understand women's needs in the ICU and are willing to accept changes in their place of work to meet these needs. The two main themes emerged from texts of the participants' stories reflected Arab women's needs in the ICUs mainly those that are related the religious and cultural values since most of the population (95%) in Jordan are Muslims. In this study all ICU nurses in the four focus group discussions had the opportunity to suggest ways to meet the patients' needs in the critical care units. By gaining nurses' input, we hoped to increase the possibility of successful practical solutions that may be implemented in any health care settings.

The Need to Feel Safe and Secure

Participants expressed very clearly that women in ICU were insecure and frightened from the unit's environment and from the connected machines and the strangeness of the place. Results of this study concur with a recent study by Zeilani and Seymour (2013) which indicated that women in the ICU were suffering from the ICU machines and expressed feelings of fear and discomfort. Machines attached to the body were perceived as a source of distress and suffering to ICU women (Zeilani and Seymour, 2012).

Generally, physical comfort and safety are the most important needs to all patients in critical care units (Aro, Pietila and Vehvila'inen-Julkunen, 2012). The

need for comfort and feeling safe is crucial for all patients in the ICU because feeling of insecurity cause remarkable stressors which hinder recovery and well-being and affects the quality of life. Fridh, Forsberg, and Bergbom (2009) explored nurses' experiences and perceptions of caring for dying patients in an ICU. They found that patients considered that the physical environment of the ICU has a major impact on their ability cope with their illness.

Participants in focus group discussions stressed the need to present information to women in the ICU regarding their illness, procedures, and interventions, with specific reference to the use of communication techniques such as active listening. The nature of the illness and of the planned treatments should be communicated. For example, it was considered important to understand the nature of the respiratory failure requiring mechanical ventilation to help the patients to breathe effectively (Nelson, Kinjo, Meier, Ahmad and Morriso, 2005). In qualitative study explored the lived experience of patients who were conscious during mechanical ventilation in an intensive care unit. The study suggested that effective communication is essential and to stand by the patients to fight for survival and regain independence (.Karlsson, Bergbom and Forsberg, 2012). Likewise, communicating effectively with patients dependent on ventilators is essential so that basic needs can be met. Several methods were suggested to communicate with non-verbal patients in the ICU including gestures, head nods, mouthing of words, the use of letter s, and the use of picture (Grossbach, Stranberg, and Chlan, 2011)

The Need to Preserve Religious and Cultural Values

Participants discussed Arab women trepidation concerning their religious and cultural values. They expressed the need to help the women in the ICU maintaining their cultural integrity and meeting the religious requirements.

Islam necessitates both men and women to dress modestly in the presence of the opposite gender. For Muslim women, only the face, hands and feet are uncovered. This rule may not be followed by all Muslims; some Muslim women adherence to Islamic dress to wear the "Hijab" or the "veil" that covers the head and body. Some of them apply face-covering "burqa" or the "khimar". It is also recommended in Islam that women wear non-transparent loose clothing that is not fitting to the body (Naik, 2006; Queensland Health and Islamic Council of Queensland, 2010).

Participants suggested to help Arab women in the ICU to cover their bodies by changing the gowns style to have long sleeves and closed from the back or, if this is not possible, to wear two gowns. They also suggested changing the hospital's policy regarding the

dress code. Recent literature discussing Islamic culture in relation to health care provided to patient in the hospital settings recommended: allowing female Muslim patients to wear sleeved long hospital gowns which are securely tied from the back, closing the curtains during physical examination and procedures, and to announce the presence of male professionals before entering the woman's room to allow her to cover her head (Boston healing landscape project, 2013; Zeilani and Seymour, 2012).

Participants in the focus groups discussed women's concerns being taking care by male health care providers and their annoyance by the frequent touching of male nurses while providing care. Women in the ICU were upset form sharing the unit with male patients and asked for separate rooms. The study results indicated that nurses understand women's needs regarding examination and care that require intimate contacts with male health care providers and acknowledge the belief to consider this in caring for women in the ICU because it is part of Arab culture and religious values. These findings were consistent with a study finding among Jordanian and Palestinian immigrant women living in the United States (Kawar, 2012).

Intimate contact is acceptable between individuals of the same gender; conversely, it is considered unsuitable between the opposite genders. In most Muslim cultures, men and women are segregated by gender, except in the family settings (Guimond, and Salman, 2013). Although Islam does not forbid treatment by a doctor or a nurse of the opposite sex, Arab woman appreciate handling by another woman during her stay at a healthcare setting and she may feel more comfortable to be examined in the presence of another female or a family member while examined by a male nurse or a physician. The nurses suggested arranging for patients to be admitted to same-sex intensive care units when possible (Boston healing landscape project, 2013). Accordingly, the suggestion of the focus groups to have separate ICUs for female patients and to have female nurses to care for them is an appropriate solution to meet this need. However, this may raise a problem in some setting where nursing shortage is an issue.

The need to conduct religious rituals such as prayers "Salaat" and fasting and to follow Islamic rules of conduct associated with diet, healing, and death were discussed frequently by the focus groups in this study. Participants mentioned situations where women were concerned about the hospitals' food and how it might affects their compliance with the prescribed therapy. Muslims follow a "Halal" diet; consuming only foods that are prepared according to Islamic law. Eating pork, improperly slaughtered

meats, drinking alcohol, or taking other intoxicants are forbidden or "haram". Accordingly, it is important for health care providers to discuss with Muslim women in the ICU their dietary preference or allow family to bring food from home; however, this requires to be written in the hospital's policy. It is also of equal importance to check the ingredients of the drugs provided for patients that they are free from gelatin or alcohol.

Fasting during the month of Ramadan (from dawn until sunset) is obligatory for all adult Muslims. Patients who are very ill such as women in the critical care units are excused from fasting, instead, they may give charity for poor people. Another issue must be considered is that Muslim patients may be unwilling to take oral medications in Ramadan and prefer to take them at night (Abdalahim, et al., 2012). Accordingly, health care provider may think about changing medication schedules. However, healthcare providers must have critical judgment when allowing women in the ICU to fast to maintain their safety and recovery.

Muslims are obliged to recite prayers five times each day and they pray in the direction of Mecca. Before prayer, they must wear clean clothes that are free of blood, urine or feces, and engage in a cleansing process called ablution, washing the face, hands, arms, legs and feet (Naik, 2010). Health care providers should understand this issue and help women in the ICU to stay clean and facilitate their prayer. Nurses are supposed to provide women with clean well covered gown and head scarf and offer the patient a jug of water and a bowel to perform the ablution while there are in bed (Hammoud, White and Fetters). The patient may perform prayers while seated or even while lying down. It is important not to disturb the patient at prayer, unless it is an emergency.

Conclusion and Implication for Practice

The results offer valuable information for health care institutions mainly in critical care settings. From the nurses' point of views, Arab women in the ICU have needs that necessitate concentrate on. The need to feel safe and secure is a general need for all residents at different hospital settings. Patients need to feel comfort and have the right to communicate their fears with the health care providers. Gender specific needs such as covering the body and considering the avoidance of intimate contact with the opposite gender are important to be considered while providing health care for women in the ICU.

Efforts should be made to facilitate the women's compliance to cultural and religious requirements in the critical care settings as well as in other health care settings. Female patients should have the opportunity to perform the religious rituals as much as possible. We recommend that hospital administrators adopt a supportive system that are included in the policies and

regulations regarding meeting the unique needs of Muslim women such as changing the patients' dress, diet prescription, and gender segregation. Furthermore, the findings provide a basis for further studies including action research testing the application of new strategies in the hospital considering the cultural needs of critically ill patients.

Limitations of the study

The results of the study are important for understanding the needs of Arab women in intensive care units. However, the results are not generalizable internationally because of the different cultural contexts across the countries. This study was limited to a selection of nurses within one country in the Middle East, so may not be reflective of the nurses' perspective elsewhere. We believe, however, that the study themes are likely to have broad relevance and could be transferable to other contexts. In addition, using focus groups are usually not used to build consensus and there is a chance for domination of a group by some of the participants that may suppress the views of the other participants (Jayasekara and Edu, 2012).

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