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RESEARCH ARTICLE

Untangling Intimate Care Experiences for Patients Admitted to Public Hospitals in South Africa

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Abstract:

Background:

Hospital admission can be a traumatic and humiliating experience for patients due to the institutionalised attire they must wear. Intimate care may trigger experiences of helplessness and disrespect due to exposure to their body parts and having to be touched by nurses.

Objective:

This research aimed to explore and describe patients' perceptions of their bodies and their experiences of intimate care execution during their hospital stay.

Methods:

A qualitative explorative-descriptive design and Trauma-informed care framework were used to explore and describe the participants' perceptions and experiences of intimate care execution during admission to the two sampled hospitals. Twenty participants admitted to medical and surgical units were purposively recruited. Data was collected using semi-structured interviews, and thematic analysis was used to give meaning to the data.

Results:

Three overarching themes emerged from the data: the sacredness of the human body; Patients want their dignity to be respected during intimate care and touch; and creating the nurse-patient intimate care relationship. Patients wish the nurses to maintain their dignity and privacy. Intimate care and touch should be initiated in a safe environment where patients can make informed decisions.

Implications for Nursing:

Declothing of personal attire during admission violates patients' dignity and privacy and is dehumanising. During intimate care and touch, nurses should create a cultural, religious and gender safe environment, allowing inpatients to make informed decisions regarding the care provided to their bodies.

Conclusion:

Patients' beliefs system should be incorporated into autonomy and informed decisions about the care to be provided to naked bodies. Hospitalisation should not reinforce physical and psychological trauma. Respect and dignity are paramount when caring for the patient's body.

Keywords: Intimate care, Patient, Trauma-informed care, Touch, Culture, Religion.

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1. INTRODUCTION

Caring for the body is often provided in the safety of a home. However, visiting the hospital suggests that individuals and their families can no longer offer adequate physical or psychological care [1]. Cultural and religious beliefs, environmental barriers to privacy and inadequate decision-making involvement influence family involvement in physical care [2]. Therefore, clothing is central to the patient's sense of dignity. When admitted to hospital wards, they must change into hospital attire. Wearing a hospital gown is associated with

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losing dignity and reinforcing the patient's role of dependence on the health care providers [3]. Whilst adjusting to a hospital environment, the patients have to give access to their bodies to nurses, who are strangers and different from them.

Once a patient is admitted to the hospital ward, the nurses should provide fundamental care involving bodily care that fulfills physical, social, and psychological needs such as hygiene, elimination, and nutrition [4]. Intimate care is defined as task-oriented touch to areas of the patient's body that might produce feelings of discomfort, anxiety, and fear or might be misinterpreted as having a sexual purpose [5]. The provision of intimate care is hands-on work that invades acceptable personal and social space [6]. It transforms a private personal action into a social process shaped by a complex interplay of behaviours, recipient of care characteristics and physical care environment [6]. Therefore, a nurse who is a stranger and different from the patients based on age, culture, religion, gender and sexual orientation will often be required to see and touch patients' bodies to provide necessary nursing care.

The nurse ought to provide quality and non-discriminatory nursing care. South Africa's democratic constitution is committed to respecting individuals' cultural and religious choices. However, patient preferences differ from a cultural, religious, and linguistic point of view [7]. Society permits nurses to touch patients as part of their caring role [8]. This access to the body may violate the patient's autonomy, respect, and dignity. Patients admitted to the hospital wards are already traumatised, and their self-worth is tested. Therefore, nurses must provide intimate care and touch that is acceptable to the patients based on their culture, religion and sexual orientation. The study aimed to explore and describe patients' perceptions of the care of their bodies and experiences of intimate care execution during their hospital stay.

2. THEORETICAL GROUNDING

A patient may experience trauma at any point of time in their life. This trauma may destabilise and damage one's sense of safety, self and self-efficacy, as well as one's ability to moderate emotions and navigate interpersonal relationships [9]. Admission to the hospital can be a traumatic experience for a patient. It can be aggravated by the inability to make decisions about the exposure and touch of their bodies during intimate care. The Trauma-informed care (TIC) approach guided the study, as it advocates for patient-centeredness, which requires nurses to provide care that prevents re-traumatisation during admission and intimate care and touch [10]. It involves an empathetic, supportive recognition and awareness of trauma's impact on openness, including assessing for social connections, support systems and encouragement of family, spiritual and community resources [11]. It also guides the nurses in understanding that all patients have trauma and accepting and supporting patients through positive adaptation and healing [12]. It is built on an appreciation of, and responsiveness to, the consequences of the trauma, and it requires individuals and organisations to provide services and care that offer a sense of safety for patients and nurses [9].

The TIC framework utilises the six principles which aim to understand and respond to the impact of trauma [12, 13]. These principles assisted the author in creating semi-structured questions relevant to the manuscript's objectives.

2.1. Safety

Refers to the physical and psychological safety of patients and family members that is created to prevent re-traumatisation [12]. A physical, psychological [13], and welcoming environment should be created to maintain safety support through the therapeutic milieu where every social interaction is an opportunity for healing and change [14]. Nurses should create a safe space to provide intimate care and touch, including engaging the patients about the proposed care and allowing them to make decisions about their bodies.

2.2. Trustworthiness and Transparency

Trustworthiness advocates for patient-centred care with an emphasis on diversity, equality and inclusion and promotes patients' understanding of care [12]. *Transparent* is about openness about patient care and encouraging the patient to participate in their care actively. This principle is related to the South African service delivery standards approach, Batho Pele (People First), which promises patients quality healthcare and openness to the standard of services that the patient will receive [15].

2.3. Peer Support

Peer support is rooted in helping people find their inner strength, by connecting them with peer-supportive services in communities that mirror their cultural and religious beliefs, practices, and experiences [12]. Though diverse patients are admitted daily in hospitals, the principle of Ubuntu "humanness" is of great importance for the patients to co-exist harmoniously with the nurses and other patients in the ward. Peer support allows the patients to connect with others for help [13].

2.4. Empowerment, Voice, and Choice

Nurses should develop intimate care and touch activities acceptable to diverse patients. Quality care begins by valuing the person seeking help; thus, patients should not be seen as victims but as recipients of intimate care. The nurse and patient create a relationship of trust [12].

2.5. Cultural, Historical and Gender Values

During intimate care and touch, the nurse encompasses all aspects of a person's identity, including race, ethnicity, sexual orientation, age, religion, gender identity and experiences. Cultural responsiveness requires nurses to be aware of different cultural beliefs and preferences and to address individual needs during intimate care and touch.

3. MATERIALS AND METHODS

3.1. Design

A qualitative approach focuses on making sense of the lived and observed phenomenon in a specific context with selected individuals [16]. A qualitative explorative-descriptive research design allowed the author to explore and describe the

behaviour's beliefs, values and motives [17]. The primary aim is to understand better the phenomenon under study through the experiences of those who have directly experienced it, recognising the value of participants' unique viewpoints that can only be fully understood within the context of their experiences and worldview [18]. The study participants were admitted to medical and surgical units and experienced intimate care and touch during their hospital stay.

3.2. Participant's Sampling

The study was conducted in two hospitals accredited by the South African Nursing Council for clinical placement for nursing students in the Gauteng province. Medical and surgical units were selected; male and female patients, who met the inclusion criteria, were purposively recruited. The inclusion criteria were that participants should be admitted to male/female surgical and medical units for five days or more. In addition, the participants should be willing to participate, not suffer from psychological illness, or be on sedative medication. The unit managers assisted in identifying the participants who met the inclusion criteria. The age bracket of 22 to 60 was acceptable. Participants admitted less than five days, less than 22 years and older than 60 were excluded. After recruiting the participants, they were informed about the purpose of the study, its objectives and how they will participate.

3.3. Data Collection

Data was collected by using semi-structured interviews. Semi-structured interviews are set of guiding questions, and the participants' responses give the interviewer the flexibility to pose more enhanced questions [19]. The interview guide was developed with open-ended questions for the topic related to the purpose and objectives of the study and guided by Trauma-Informed Care (TIC). Twenty [20] participants took part in the semi-structured interviews. The author is a nurse and specialist in Health Sciences Education working at a university. Two female data collectors working in quality assurance offices were recruited to collect data to avoid bias.

Four interviews (two from each research site) were conducted on two female and two male participants to pre-test the interview guide, observe the participant's understanding of the questions and ensure that the trained data collectors conducted the interviews correctly. The four pre-testing interviews were not included in the final data set. Five open-ended questions were asked to all participants (Table **1**).

Probing was also done for clarity, such as "can you please discuss what you mean by…?". Data were collected between February – May 2022. Since participants were admitted to the selected units, data was collected in the side passage/veranda to allow participants to walk a short distance from their beds. The study was also conducted during the level 3 COVID-19 pandemic. The data collectors and participants wore face masks, and 70% alcohol hand sanitiser was used to clean patients' hands before signing informed consent. The duration of the interviews was 20/30 minutes.

3.4. Data Analysis

Qualitative data analysis is mainly inductive, allowing meaning to emerge from data. Thematic analysis is used to identify, analyse and report themes within data [17]. The author and independent coder used a five-step thematic process for data analysis [17]. Audio-recorded semi-structured interviews were verbatim transcribed into useable form to find meaningful responses; the responses were organised systematically. Once data was organised, it was coded by identifying themes that had the same connection related to intimate care and touch during the hospital stay. The Trauma Informed Care principles were also identified in how patients experienced their bodies' safety, autonomy, openness and involvement in the care of their bodies. The themes were created by putting each concept's code into context by linking with the participant's codes. The analytic conclusions from the data are presented as themes and sub-themes under results (4.2). The decisions on the final themes were based on the purpose of the study. Finally, the author and coder met to discuss the findings, and both shared their independent themes and had to agree on the final themes.

3.5. Trustworthiness

The study assured credibility, dependability, confirmability and transferability. For *credibility,* during data collection, the author and data collectors became familiar with the hospitals' systems and when the patients were available for interviews. Prolonged engagement during semi-structured interviews was ensured, to get all the questions in the interview guide answered and together with the probing. Two data collectors were utilised to collect data from the two institutions. The author and coder analysed data independently. *Transferability* is the degree to which the results can be transferred to other content or settings with the participants [19]. The thick description of the participants' experiences of intimate care and touch during hospital admission is described. The research process was discussed to enable the reader to assess whether the findings are transferable to their setting. *Conformability* is the degree to which other researchers could confirm the research study's findings [18]. Audit trail through sharing the research process, samplings, research material, emergency of the findings and information about data management.

Table 1. Interview guide.

-	**Please share with me your perceptions of the human body**
1	What are the cultural/or religious values when caring for the human body?
2	Since you have been admitted to the ward, can you discuss your experiences receiving basic nursing care requiring nurses to touch your body?
3	What can assist nurses in providing intimate care and touch in a culturally or religiously acceptable manner?
4	What strategies can be used to develop a nurse-patient intimate relationship?

Table 2. Summary of participants' characteristics.

Participants	PO1	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20
Institution Hospital 1 Hospital 2	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Ward/unit Medical Surgical	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Gender Male Female	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Age 22-30 31-40 41-47 50-55	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Cultural Groups Zulu Ndebele Swati Tswana Northern Sotho (Pedi) Southern Sotho Shona (Zimbabwe origin)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Religious Affiliations Christianity African Ancestry	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
No. of Days Admitted 5-10 10-20 More than 20 days	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√

3.6. Ethical Considerations

The researcher obtained an ethical clearance certificate from the College of Human Sciences Ethics Community in South Africa (Certificate number CREC 904143557_CREC _CHS_2021). Approval to conduct the study was also received from the Gauteng Department of Health and relevant hospitals in the Gauteng Province. The researcher outlined the study's background, purpose, and objective to the purposively selected participants. Participants were informed of voluntary participation, and no incentives were to be given. Before the commencement of the interviews, the participants signed informed consent forms. The names of the hospitals and participants were not reflected in the study or this article. In addition, the two data collectors and an independent coder signed a confidentiality agreement to protect the participants' information.

4. RESULTS

4.1. Demographic Analysis

Twenty (20) inpatients participated in the semi-structured interviews; eleven were females, and nine were males. The participants were admitted to medical (n=6) and surgical (n=14) units, with the numbers of days admitted 5-10 (n=13), 10-20 (n=6) and one was admitted for more than 20 days. Their ages ranged from 22 to 55 years. In addition, six South African cultural groups were identified, with the classification Nguni (Zulu, Swati and Ndebele) and Sotho (Northern or Pedi), Southern Sotho and Tswana), and one participant was of Zimbabwe origin (Shona). The Republic of South Africa is a democratic state founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedom. Section 15 of the Constitution of the Republic of South Africa affords its citizens freedom of religion, belief and opinion; section 31 further articulates the cultural, religious and linguistic communities. Table **2** provides a summary of the participants' characteristics.

4.2. Semi-structured Interviews Results

Three overarching themes emerged from the interviews (1): the perception of the human body as sacred (2); a sense of dignity during intimate care and touch; and (3) the nurse-patient intimate care relationship. When intimate care is initiated, patients should be given choices regarding the care of their bodies and create a safe environment to make culturally informed decisions. Table **3** summarises the themes and sub-themes that emerged during data analysis.

4.2.1. Theme 1: Sacredness of the Body

The sacredness of the body is perceived within the Christian and African spirituality. Spirituality is defined as how individuals seek and express meaning and purpose and experience their connectedness to self, others, nature and the sacred [8]. Sub-theme 1.1 discusses the participants' reflections on the body's spirituality.

Table 3. Themes and sub-themes for semi-structured interviews.

Themes	Sub-themes
Theme 1: Sacredness of the body	- Spirituality of the body - Keep my body covered - Respect my nakedness
Theme 2: Patients want their dignity maintained during intimate care and touch	- Ask permission to access my naked body - Tell me how my body will be exposed and touched - Give me a preference for touching my body
Theme 3: Nurse-patient intimate care relationship	- Openness to cultural diversity - Creating a safe space for informed decision-making

4.2.1.1. Sub-theme 1.1: Spirituality of the Body

The participants discussed the body with African and Christian spirituality.

4.3. Christian Spirituality

In Christian spirituality, the body is viewed as the Holy Temple that needs to be loved and respected. Two participants shared their Christianity spirituality of the body as follows:

"My body is holy and sensitive, which I need to respect more than anything. I am not supposed to be confused. I don't have to be seen or touched by someone because my body is the temple of God" (FP08).

"My parents taught me that I must respect my body and keep it for God. I respect my body, and I always pray that God helps me to stay safe and clean all the time. I am also afraid to fail God" (FP20).

The perception of the body as sacred is well understood, as stated in the New Testament: *"Don't you know that your body is the Temple of the Holy Spirit, who lives in you and is given to you by God? You do not belong to yourself but God" 1 Corinthians 6:19-20.* Therefore, keeping the body safe for God is critical.

4.4. African Spirituality

Regarding African spirituality, the ancestors' spirits are considered the centre of one's life. The female participants viewed their bodies as the shelter for their ancestors; therefore, they needed to treat them with reverence.

"I have ancestors with me; I cannot be touched, be seen by all people naked. My body must remain pure – I must not carry the spirits of others. I must stay clear, physically and spiritually clean. I don't have to be seen or touched by someone when I am menstruating" (FP01).

"In my culture, you cover yourself as a woman, especially your private parts, so others cannot see them. Even though I go to church, I still respect my ancestors, and I have to take care of my body as they are protecting me" (FP17).

Comparing Christian and African spirituality, respecting the body is essential, and the purity of the body is paramount for female participants. However, the male participants did not articulate the body's spirituality. Instead, one participant focused on his family and social status.

"I am the head of my family; I need to be respected and heard when I speak. My wives have to take care of my body, whether sick or well, like washing my feet […]" (MP06)

It is not surprising that the female participants were free to discuss the issues related to their bodies. Their willingness to discuss issues related to their bodies may have been influenced by the gender of the interviewers who were females. In contrast, the males did not focus their discussion on bodily spirituality but on status in the home and society. In South Africa, women are expected to keep their bodies pure and respectful. This emphasises is not made for men.

4.4.1. Sub-theme 1.2: Keep my Body Covered

Hospital admission created inner conflict as the participants had to conform to the healthcare institution's requirements for admission, such as changing to hospital attire. In addition, they had to remove their clothing-having to wear a hospital gown that did not cover the whole body; with challenges of linen shortage, they could not change to clean attire daily. The participants shared their experience of switching from personal clothes to hospital attire as follows:

"Since I am admitted, sometimes gowns are torn, showing body parts; let us keep our panties. I am human, talk to me, allow the patient to decide what to wear – don't take all we have in our clothes. I wish they could allow us to keep some important clothing, not to say the relatives must take everything home" (FP13).

"I feel that being in a hospital, taking off my clothes, and having traditional attires – I feel like they take everything from me. I am forced to be naked, and a stranger has to look at my body. I feel my dignity taken from me" (FP20).

"I don't feel comfortable when they ask me to take off my clothes and put on hospital clothes because I am not used to being naked in front of strangers and not wearing my underwear. You are monitored like in prison, like that" (FP17).

The participants practising traditional African culture, found it hard to detach from their ancestry clothes and beads. As these beads and clothes symbolise the connection between the participant and the spirit of their ancestors:

"I have ancestors with me; […] I inform my ancestors and ask for permission. I have to take my ancestry cloth everywhere I go. […]. When I was admitted to the hospital, I was told that my family must take everything; the hospital could not risk bringing germs into the ward. This was hurtful as I did not think that my ancestors are dirty" (FP01).

"I am a traditional healer; […]. I connect with my ancestors with my beads. I had to take off my ancestors' beads when I was admitted. One nurse gave me bandages to cover my arms and ankles as I was unhappy to take them off. I could not be separated from my ancestor as they are my power" (FP07).

This sub-theme accentuates the importance of safe physical space for the patient's body. The participants expressed the desire to be informed about the hospital attire policy respectfully, and the attire should be clean and protect their bodies. In addition, the clothing needs to be appropriate to the gender and culture of the patient.

4.5. Theme 2: Patients want their Dignity Maintained during Intimate Care and Touch

When intimate care is executed, the nurse and patient are physically close. The patient's body is exposed and touched by a nurse, who is a stranger to them. For the participants, intimate care and touch dignity was related to nurses informing them about the exposure of their body and how they will be touched. They expected the nurses to give them preferences for care for their bodies and respect when their bodies are exposed. These findings are discussed in the three sub-themes below.

4.5.1. Sub-theme 2.1: Tell me how my Body will be Exposed and Touched

The participants emphasised the importance of communicating how their bodies will be exposed and touched. Admission to a hospital does not take away the patient's autonomy and ability to make an informed decision about their bodies:

"They don't tell you they will put something in your private parts. They say, "let me see" – you have to figure out when they put on gloves, and you are asked to open wider that something more will happen. It is also sad when a female nurse is standing and watching [a male doctor] saying "relax it so that it won't hurt" (FP20).

Exposing one's body to strangers is a frightening experience. Sometimes, the patients do not even know who is touching them, as multidisciplinary teams focus on a prescribed task. But, again, this may be unsettling for a vulnerable patient.

"[…] I don't feel free to show my body to a stranger. Feelings do not matter as they [nurses] have to do their work; you have to follow the procedure. I don't know who touches me, as they are many people who are dealing with my body" (FP17).

"One time, a male doctor checked me; I am not used to undressing for different men – […], I have been seen naked by more than three men. Every time I feel uncomfortable naked in their presence […]. Since in hospital, my body is no longer the same – everyone has access, I am just an object" (FP08).

The question "who is touching me" becomes critical when many healthcare practitioners have access to the patient's body. The patient's right to know who is touching them and how they will be touched is vital to stimulate active participation in the care or procedure, which is to be executed to provide for the needs of the given patient.

4.5.2. Sub-theme 2.2 Give me Preference before Touching my Body

Patient autonomy guarantees them decision-making on their bodies. Intimate care and touch require a private environment where patients feel physically and emotionally safe. The female participants focused on the nurse's gender choice.

"I respect my body, and when I care for it, I need privacy; I feel comfortable when a female nurse helps me as compared to a male; maybe they say I must show them certain parts of your body that are private, I become uncomfortable" (FP18).

"I respect my body; I need privacy. I feel comfortable with most nurses, especially a woman like me, who help me, unlike when I am touched by a nurse who is a man, especially when seeing my naked body, I am not comfortable" (FP19).

Some male participants expected female nurses to care for their bodies and were comfortable with it and following the instructions given to them.

"I don't have a problem with a nurse; when they say "undress" I "undress" . I do whatever they want because I want help, and it is their job" (PM05).

"Since I have been to a hospital, the female nurses have assisted me in healing because at home there was no help. They are kind and gentle with me" (PM10).

Gender roles prescribe the duties of men and women. The participants being cared for by male nurses or doctors leads to discomfort. The patient must be naked for nurses to provide intimate care and touch, including elimination and hygiene. Unfortunately, the provision of this basic nursing care is often problematic, as most of the patient's private areas are exposed. Most female participants preferred to have same-gender caregivers.

"When the nurses have to bath me – I feel ashamed […]. I cry when they wash my private parts, […]. I wish to be given a chance to care for my naked body; I don't want it to be touched. If they [nurses] have time for me to wash my body slowly. But there is no time; they want to finish the job. I must lie there and allow them to complete their job on my naked body […]" (PF13).

Respect for the body is crucial when it is seen and touched by a stranger. This respect means that the patient is informed of what will be done to their body; touch and physical exposure must be for a reason or purpose.

"My body needs to be treated with respect, as I also treat the nurses with respect. I also expect to be respected. My body must be touched for a reason, not just to look at it, as I respect and love my body. Inform me what will be done to my body. If you are putting a drip, tell me what will happen, not just the doctor ordered a drip, give me the arm […], but a body with feelings." (FP09).

Being naked to a stranger makes one vulnerable, and a person's dignity is violated. Therefore, nurses are urged to respect the body of patients by exposing and touching the patients' bodies for a purpose. Even though male participants accepted the care of female nurses as caring and nurturing is a woman's duty, female participants were uncomfortable with their bodies being touched by male nurses.

4.6. Theme 3: Nurse-patient Intimate Care Relationship

The nurses and patients need to develop an intimate care relationship based on each member's trust, respect and integrity. The participants expected openness to cultural diversity and should be seen as partners in intimate care and touch, not victims. When creating the intimate care relationship, the nurses must allow the patients to make intimate care and make informed decisions. These sub-themes are discussed below:

4.6.1. Sub-theme 3.1: Openness to Cultural Diversity

The patients and nurses are diverse individuals. They need to communicate their diversity and find a way to share a safe space for the patient to heal. Nurses should take the time to discover the sociocultural needs of the patient. Respecting other peoples' cultures is closely knit with knowing them.

"Communication is essential to understand each other; it must not be one-sided. Give me [patient] a chance to say something about my culture and my body. Please explain what you are going to do with my body (PF20).

"We are people of different cultures, and our bodies mean different things – especially the issue of being touched and naked in front of a young male doctor – I don't know how it can be changed, but it isn't easy […]; you are just an object that needs to be touched and observed. I lost a baby and am now in the ward because some things did not come from the uterus, so I am still mourning for my baby. But no one seems to care about my loss except to tell me to open my legs, and the doctor put his fingers inside me. Can't someone take me as a human who needs to process everything?" (PF17).

The patients admitted to the hospital have different illnesses and are already traumatised. The onus is on nurses to avoid re-traumatisation of the patient. Allowing patients to share their culture, could assist the nurse and patient to find common ground and develop strategies to care for the patients' bodies in a culturally acceptable manner.

"Accept that people are different, and do not expect people to react the same way. Allow us to express ourselves without being shouted at. Let us respect each other – understanding that different patients have different needs" (PM02).

"Open communication, the nurses cannot know all our cultures, but if we can talk about it, as a patient, I will learn, and the nurse will be able to respect me as I am. Please do not treat me as weak. Let us listen to one another – so that we can understand each other" (PM10).

"We must tell them about our culture. Share our culture so that they can know. Nurses cannot know all cultures, listening from both sides is important […]" (PM04).

An open dialogue on what can and cannot be done on the patient's body needs to happen during the intimate care and touch implementation. The patients must participate actively in the care of their body and touch. Patients must be partners with nurses during the planning and execution of intimate care and eliminate the idea that patients are victims of their illness.

"...work together, respect each other and have the spirit of ubuntu. Not allow the power to take over, as when it happens, we as patients we must act submissive and become victims of care" (PM11).

"As patients, we must be allowed to talk about our culture and share our preferences before being touched. They must ask you what you like your body to be touched so that there can be an understanding between the nurse and patient" (FP08).

Nurses and patients are expected to work together as a team; sharing power in caring for the body is critical to creating cultural openness in healthcare. It is accepted that nurses have the scientific knowledge to provide quality care to patients. Yet, each patient is different; nurses and patients should have an open cultural and religious conversation about the expectations of caring for and touching another person's body.

4.6.2. Sub-theme 3.2: Creating a Safe Space for Intimate Care Informed Decision-making

The participants' experiences suggest that the hospital wards do not offer patients an opportunity to make an informed decision about the exposure and touch of their bodies. Patient autonomy guarantees that they will be informed about the procedure and have time to make informed decisions. Unfortunately, when admitted, the expected communication about intimate care and touch does not happen:

"The key is communication. Unfortunately, when you are admitted, they allocate you to the ward, and no one talks about it when someone dies. Life continues as normal. The wards are full, and there is no space and no privacy. I don't understand what is happening" (PM05).

"Communication, work in harmony. Not that a nurse must tell us what to do. Listen to me even if what I am saying is not important. A nurse must give me a chance to explain my side. Whatever is done on my body, a nurse must first talk to me, allow me to decide on my body" (PM01).

Patients can only make decisions if they are informed about what will be done to their bodies. An uncomfortable conversation must be started on specific parts of the body which will be touched and how they will be touched. Sharing intimate care knowledge and touch will allow patients to make informed decisions on how to be touched and who is touching their naked bodies.

5. DISCUSSION

The article aimed to explore patients' perceptions of their bodies and experiences of intimate care execution during their hospital stay.

5.1. The Sacredness of the Body

The patients' belief system is paramount in caring for their bodies. Some participants viewed their bodies in a spiritual sense as a sacred Temple of God (Christianity) and home for their ancestors (Africanity). Therefore, they expected their bodies to be respected and treated with reverence. Spirituality encompasses the aspects of being human and experiencing life, a sense of interconnectedness with all living creatures and an awareness of the meaning and purpose of life [19]. The human body extends beyond the biological and physiological boundaries to encompass social dimensions of cultural and social forces [20]. Understanding the patient's values and practices is critical in providing care that embraces Christian

and African beliefs about human life and the body. The South African indigenous belief system depends on the ancestors' role in maintaining the person's health and well-being [21]. Even though section 31 of the Constitution of the Republic of South Africa guarantees equal rights to cultural, religious and linguistic affiliation, patients cannot exercise this right in a hospital setting, as the legacy of suspicion and disapproval of African practices still exists [7].

Consenting to hospital admission is trauma on its own, as the patient has to separate from the known environment and people. Hospital admission forces patients to give away power and control over their bodies, as they must abide by institutional policies and procedures. When admitted to their respective ward/unit, the participants were expected to change into hospital attire. They had to give away the only thing they might have, or own, at that moment. Hospitalisation is stressful and unsettling. It socially isolates one from the known environment and, at times, loses autonomy and privacy over activities done on their bodies. The clothing protects and maintains bodily and mental efficiency, which brings about comfort and safety. The hospital attire contributes to patients' increased sense of physical exposure, discomfort, disempowerment and embarrassment. The study participants' greatest desire was for their bodies to be covered and treated with respect. Most female participants complained about the shortness and transparency of the hospital gown. They felt naked, as it provided a less dignified outlook and exposed their body parts. Literature supports the participants on the thinness of the fabric, open back of the hospital attire and lack of body coverage [22, 23]. The exposure of body parts adds to the depersonalisation [22] and dehumanising [24] experiences of admitted patients [25]. McDonald [3] advocates for patients to wear their clothing to maintain self-esteem and, as a conscious reminder to healthcare practitioners, to recognise them as human beings. The hospital attire forces an individual into a patient role of low status and lacks control and privacy [24] of their bodies. Understanding the patient's culture and the meaning of the attire they are wearing is essential in safe hospital care. Allowing patients to wear their clothing may improve their acceptance of hospital care and control over their bodies. At the same time, the hospitals and patients' relatives should make means to maintain the cleanliness of the clothing.

5.2. Sense of Dignity during Intimate Care and Touch

Dignity is a human element that is essential for the individual healing process. It is inherent self-worth that is absolute and given to all human beings by their rationality and ability to act as moral beings [26]. Intimate care and touch may bring about unfamiliar feelings as it invades accepted personal, physical and social contact between a nurse and patient. Thompson [27] attests that intimate care transforms a private and personal activity into a social process, where a stranger (nurse) exposes and touches the patient's body. In African culture, physical care is influenced by cultural and religious beliefs. Care for the body is provided in a family-safe environment. Lack of autonomy and inadequate patient involvement in decision-making about their bodies creates a barrier to dignity and privacy [2]. Hospitalised patients are separated from their family support system, which may contribute to trauma [14].

Participants needed to know how their bodies would be touched and exposed during intimate care. These findings are affirmed by the studies that indicated that patients wanted to know in advance if they would be touched [28] and how they would be touched [5]. The participants also wanted to be given preferences on how and who would touch and expose their bodies. In Trauma Informed Care, providing a safe environment requires the nurse to inform the patient about the procedure and ask permission to touch their bodies. This communication gives them a choice and empowers them to have control over their body and physical space [12]. The patient's choice, control and collaboration should allow them to actively participate in their healing process by using informed decision-making [29]. Female participants preferred female nurses to provide intimate care, such as perineal and vaginal examinations, especially in surgical units. Gender-sensitive care is required, as some women had gender-based violence experiences. Creating a safe and respectful atmosphere is necessary to develop gender-friendly care [14]. Therefore, the patient's unique cultural, social, religious and gender needs must be considered during intimate care and touch. The nurse should maintain the privacy and dignity of the patient at all times [6].

5.3. Nurse-patient Intimate Care and Touch Relationship

Openness about cultural diversity is critical in creating a nurse-patient relationship based on trust, dignity, respect and integrity. In addition, understanding other people's cultures allow nurses to recognise a patient as a person with cultural ideas and values. [30] Being culturally and historically sensitive stress that patients' beliefs and core values extend to the public; when coming to the hospital, they bring their personal experiences, traumas, and historical narrative to the nurse-patient relationship [12].

A safe cultural environment prevents re-traumatisation of the patient during hospital admission [31 - 34]. Nurses should be committed to social and just practices that aim to honour the humanity, dignity and sociocultural context of each person hospitalised [14]. The Nurse's Pledge of Service urges nurses to provide care with respect and dignity; they publicly declare not to permit consideration of religion, nationality, race, or social standing to intervene between their duties to the provision of quality care.

CONCLUSION

The provision of intimate care and touch is a privilege for nurses, as they share the sacred space of the patients. The findings suggest that the nurses and patients should co-exist and create a respectful and dignified environment for caring for the body and making an informed decision in accepting care and touch from nurses. In addition, understanding patients' cultural and religious diversity is vital in embracing the democratic constitutional rights of each person and treating the body with dignity and reverence. It is not expected that nurses should know all patients' cultural and religious belief systems; however, open communication on cultural issues during admission and hospital stay will assist in understanding the patient's unique needs. Patients' clothing during admission and respect for sacred attires such as cloth and beads need to be discussed in patient health safety and quality assurance forums

to come out with culturally and religiously acceptable ways to deal with this challenge.

AUTHORS' CONTRIBUTION

This is a single-authored paper. SS designed and performed the research study. She analysed (with the assistance of an independent coder) and wrote the manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The researcher obtained an ethical clearance certificate from the College of Human Sciences Ethics Community in South Africa (certificate number CREC 904143557_ CREC_CHS_2021). Approval to conduct the study was also received from the Gauteng Department of Health and relevant hospitals in the Gauteng Province.

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committee and with the 1975 Declaration of Helsinki, as revised in 2013.

CONSENT FOR PUBLICATION

Informed consent was obtained from all participants.

STANDARDS OF REPORTING

COREQ guidelines were followed.

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