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Affective competency of Filipino nurses working in the hospitals of Taif City Kingdom of Saudi Arabia

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This study aims to investigate the affective competency of Filipino nurses working in five hospitals of Taif City, Kingdom of Saudi Arabia. Transcultural Self-Efficacy Tool (TSET) Kit was used. The strength of self-efficacy perceptions of the nurses within the affective constructs shows that the five highest scores shows their own cultural heritage and belief systems, difference within their own cultural group, their own biases and limitations, role of family in providing health care and differences between cultural groups. The results indicate that the respondents are confident in giving care and are fully aware of the cultural background and culture specific health care that can affect nursing care. Respondents are confident in giving care to patient from a diverse culture. However, formal education seminars on transcultural nursing care in addition to training on Arabic Language will help them to communicate more effectively.

Key words: Nursing, Filipino workers, Saudi hospitals,

INTRODUCTION

In Saudi Arabia, nursing is a less desirable career choice for Saudi nationals in comparison to other professions. The poor image of nursing as a profession in the Middle East, the gender norms and the rapid population growth has contributed to the heavy reliance on expatriate nurses in health care organizations (Almutairi and McCarthy, 2012).

According to the Philippine Overseas Employment Administration (POEA 2007 to 2011 Statistics), Saudi Arabia is the top country of destination for new and re-

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hired Overseas Filipino Workers where nurses rank number two by professional categories. This is because,majority of nurses recruited by the Ministry of Health hospitals in Saudi Arabia are from India and the Philippines. However, these nurse professionals often come with limited knowledge about Saudi culture andIslam (Altamutairi and McCarthy, 2012). These expatriate Filipino nurses, therefore, may be providing care that is less culturally congruent. Culturally congruent health care refers to health care that is customized to fit with the client's cultural values, beliefs, traditions, practices and lifestyle (Jeffreys, 2010). By providing culturally and linguistically appropriate services, nurses may influence access to and utilization of care, quality of care, and patient outcomes, especially among racially and ethnically diverse patients (American Institutes for Research, 2004).

Nurses spend more time than any other professional with the patient. They have a unique opportunity to influence access to care, quality of care, and patient outcomes. As a consequence, the nurse's knowledge of the patient's culture, beliefs and health care practices will greatly influence nursing care. However, becoming culturally competent is a process that requires major changes in attitudes, beliefs, behaviors, and communication styles that each person develops throughout his or her lifetime (American Institutes for Research, 2004). The aim of this study was to determine the self -efficacy of Filipino nurses working in Saudi hospitals in affective construct as part of their transcultural competency.

MATERIALS AND METHODS

The present investigation is a descriptive-evaluative study aim to determine differences between the levels of affective competency among Filipino nurses. The study was conducted in five Ministry of Health hospitals located in Taif, Makkah Region, Kingdom of Saudi Arabia. A total of three hundred and seven respondent full time Filipino nurses were recruited using a simple random sampling fishbowl technique. The nurses were predominantly females (97.1%). The highest percentage of nurses was in the age group of 25 to 29 years old (30.6%). Almost half of the respondents were of Moro descent representing 43% of the entire group. Nurses, were recruited for the study from King Abdulaziz Specialist (n = 167) Hospital, King Faisal Hospital (n = 41), Taif Children's Hospital (n = 53), Chest Hospital (n = 24) and the Mental Health Hospital (n = 22). They were selected, regardless of their position as staff nurses, assistant head nurses, head nurses, nurse educators, nurse administrator/supervisor and assistant nursing director. All of the respondents were graduates of Bachelor of Science in Nursing, and the majority of them were working as staff nurses. None of them had prior Transcultural competency training.

The research questionnaire was prepared based on the Cultural Competence Education Resource (CCER) toolkit prepared by Jeffreys (2010). The following research instruments were used according to CCER:

1. Demographic Data Sheet for Nurses (DDSN). This provided demographic information on the nurses including educational level.
2. Transcultural Self-Efficacy Tool (TSET). This tool evaluated the nurse's confidence in performing general transcultural nursing skills among diverse client populations.

Specifically answers to the following questions were requested in the questionnaire:

1. Demographic information: Age, gender employment status, work setting, department, current work position, preferred nursing position in the future, prior degree completed, prior transcultural competency training, prior seminars attended and ethnicity?
2. What is the strength of self-efficacy perceptions of the nurses within the: Affective construct?
3. Is there a significant difference among the strength of self-efficacy perception of the nurses on the affective construct when grouped according to: Age, gender, work setting, department, current work position, preferred nursing position in the future and ethnicity?

The study was approved by the Biomedical Research Ethics Committee, College of Medicine, Taif University, and permission from the targeted hospitals was obtained. Consent for participation was obtained from respondents after they were notified of the aims, methods, anticipated benefits and potential hazards of the research. They were informed that, they had the right to terminate their participation at any time and that confidentiality would be always maintained.

The data was analyzed using Analysis of Variance (ANOVA) for comparisons between the various groups on specific factors. This was used to determine the difference among the strength of self-efficacy perceptions of the nurses on the cognitive, practical and affective construct when grouped according to age, gender, work setting, department, current work position, preferred nursing position in the future and ethnicity. Differences between means were considered as significant at the level of $P < 0.05$.

RESULTS

The strength of self -efficacy perceptions of the nurses on the affective constructs are shown in Table 1. The highest obtained mean score of 9.11 dealt with "your own cultural heritage and belief systems". The second highest rank was about "Difference within your own cultural group" had a mean score of 9.07, while the third highest rank dealt with "Your own biases and limitations" had a mean score of 8.93. The fourth highest rank in the strength of self-efficacy of the respondents in their affective construct dealt with "Role of family in providing health care' with a mean score of 8.86. The fifth highest rank among the variables dealt with "Differences between cultural groups" with a mean score of 8.84.

The fifth lowest rank among the variables with a mean score 8.04, dealt with "Importance of home remedies and folk medicine" while, the second lowest rank dealt with "Need to prevent ethnocentric views" with a mean score of 8.15, the third and fourth lowest rank dealt with "need to prevent cultural imposition and need of cultural care repartterning or restructuring with a mean score of 8.18, and the fifth lowest rank among the variables dealt with "Inadequacies in the Government Health Care System" with a mean score of 8.19. These results show that, although these variables scored lowest in rank, the respondents are still confident that they were able to

Table 1. Mean score distribution on the strength of self-efficacy perceptions on the affective construct of the Filipino nurses (n =307) working in the hospitals of Taif City, Kingdom of Saudi Arabia.

Affective Scale	Mean ± SD	Rank
You are aware of		
Your own cultural heritage and belief systems	9.11 ± 1.282	1
Your own biases and limitations	8.93 ± 1.373	3
Difference within your own cultural group	9.07 ± 1.280	2
Insensitive and prejudicial treatment	8.49 ± 1.82	17
Differences in perceived role of the nurse	8.59 ± 1.384	13
Traditional caring behaviors	8.58 ± 1.397	15
Professional caring behaviors	8.79 ± 1.345	8
Comfort and discomfort felt when entering a culturally different world	8.52 ± 1.451	16
Interaction between nursing, folk, and professional systems	8.60 ± 1.345	12
You accept		
Differences between cultural groups	8.84 ± 1.374	5
Similarities between cultural groups	8.79 ± 1.408	9
Client's refusal of treatment based on beliefs	8.80 ± 1.375	7
You appreciate		
Interaction with people of different cultures	8.83 ± 1.327	6
Cultural sensitivity and awareness	8.79 ± 1.342	10
Culture-specific health care	8.73 ± 1.374	11
Role of family in providing health care	8.86 ± 1.379	4
Client's world view (philosophy of life)	8.59 ± 1.401	14
You recognize		
Inadequacies in the government health care system	8.19 ± 1.563	26
Importance of home remedies and folk medicine	8.04 ± 1.601	30
Impact of roles on health care practices	8.46 ± 1.358	21
Impact of values on health care practices	8.48 ± 1.334	20
Impact of socioeconomic factors on health care practices	8.35 ± 1.391	22
Impact of political factors on health care practices	8.21 ± 1.429	25
Need of cultural care preservation/maintenance	8.34 ± 1.444	23
Need of cultural care accommodation/negotiation	8.28 ± 1.407	24
Need of cultural care repatterning/restructuring	8.18 ± 1.443	27
Need to prevent ethnocentric views	8.15 ± 1.435	29
Need to prevent cultural imposition	8.18 ± 1.428	28
You advocate		
Client's decisions based on cultural beliefs	8.49 ± 1.474	18
Culture-specific care	8.49 ± 1.445	19

recognize that such variables can affect the care they give to their client.

The results of the parameters used to assess the degree of self-efficacy of the nurse respondents in the affective constructs are presented in Table 2. The awareness of the respondents on cultural heritage, belief systems, biases, limitations and difference within cultural groups were found to be different in relation to work setting, preferred position and ethnicity. Furthermore, the level of acceptability of the respondents regarding differences and similarities between cultural groups, and client's refusal of treatment based on belief were found to be different with regards to work setting, and preferred position in the future. The appreciation of interaction with people of different cultures, cultural sensitivity, culture-specific health care, role of family in providing health care, and client's world view were further found to be different when grouped according to work setting, and preferred position in the future. In addition, the recognition of inadequacies in the health care system,importance of home remedies and folk medicine, impact of roles, values and socioeconomic factors on healthcare practices, impact of political factors, need of cultural care preservation, need of cultural care accommodation, need of cultural care repatterning, need to prevent ethnocentric views, and need to prevent cultural imposition have significant differences in terms of work setting, department and current work position.

More specifically, the impact of health care practices has been perceived differently in terms of work setting and current work position, and the need for cultural care repatterning was different among nurses from different departments. Wherein, the advocacy on client's decisions based on cultural beliefs and culture-specific care was found to be significantly different in the preferred nursing positions in the future. The observed results indicate that the respondents have varying level of confidence and assertiveness about their own culture, bias limitations and belief systems when grouped according to work settings, preferred position in the future and ethnicity. This can be attributed to individual work experiences, as new nurses spend a significant amount of time learning their place in the social structure.

DISCUSSION

In this study, the respondents were highly confident that they were aware of themselves and they knew their own cultural beliefs, cultural heritage, along with their own biases, limitations and the differences within their own cultural group, they were totally confident and appreciated the role of the family in providing care, and were totally confident that they can accept differences between cultural groups. According to a study by Smith (2011) that focused on the learning experiences of Filipino nurses in the United States, families play a much more active role in the care of their family members because of a sense of family responsibility and loyalty to the family. Care of family is an important value to the Filipino people. Respondents readily appreciated the role of family in providing care.

Previous reports have shown that, the affective learning dimension is concerned with attitudes, values and beliefs, and is considered to be the most important in developing professional values and attitudes, and that affective learning includes self-awareness, awareness of cultural differences, acceptance, appreciation, recognition and advocacy (Jeffreys, 2006). However, some factors such as communication pattern, cultural perception of care vary from one country to another. Hence when healthcare professionals and clients come from different cultural backgrounds, misunderstanding may occur, so applying cultural competency in health care practice is very essential to mitigate disparities among cultures (Iheneche, 2010).

Furthermore, it can be assumed that Filipino nurses have profound experiences in their country about nursing care, even though not at diverse population, and the basic skills of respecting patient is inherent in their training. One of the core values, which is a vital component in the development of a professional nurse, and is emphasized in the Bachelor of Science in Nursing (BSN) program, is Love of people: Respect for the dignity of each person regardless of creed, color, gender and political affiliation (CHED, 2009). Based on the assessment made by Carey (2011), on nursing students' cultural competency assessment, students with work experience scored higher than those without work experience in interpersonal communication, cultural consideration, knowledge of cultural factors and appropriateness when interacting with ethnic minority clients. This further explains why Filipino nurses have high level of self-efficacy on affective construct, because they are culturally diverse. Diversity awareness refers to active, on-going conscious process in which we recognize similarities and differences within and between various cultural groups (Jeffreys, 2008).

Smith (2011) showed that in the Philippines a lot of things are recycled, because they don't have enough supplies and resources, forcing nurses to make do with what they have. Contrary to this, in Saudi Arabia, respondents perceived that inadequacies of the government health care system would not affect the care they provided because they were able to deal with any inadequacy. According to Almalki et al. (2011), a number of issues pose challenges to the health care system in Saudi Arabia, such as shortage of Saudi health professionals, limited financial resources and high demand resulting from free services. This means that, Filipino nurses can be affected by shortage of nurses, even limited financial resources, however they did not perceive that these inadequacies would affect the care they provide to the patient. Filipino nurses have a high

Table 2. Variation in the strength of self-efficacy on the affective construct grouped according to the demographic profiles of Filipino nurses working in Taif City Hospitals (n = 307) and, also participated in the study.

Affective scale (F Value)	Demographic Profile						
	Age	Gender	Work Setting	Department	Current Position	Preferred Position	Ethnicity
Your own cultural heritage and belief systems	0.78	0.07	11.33**	0.76	0.65	3.39**	1.32
Your own biases and limitations	0.84	0.01	9.92**	0.80	1.18	2.84*	2.66*
Difference within your own cultural group	1.02	0.20	5.00*	0.79	1.22	2.99*	2.87*
Insensitive and prejudicial treatment	0.81	0.02	4.31*	1.06	0.73	3.03*	0.80
Differences in perceived role of the nurse	0.46	0.11	4.89*	0.92	0.68	3.51**	0.97
Traditional caring behaviors	0.69	0.04	2.62	0.81	0.48	3.25**	1.75
Professional caring behaviors	0.57	0.05	5.10*	0.72	0.68	3.93**	1.35
Comfort and discomfort felt when entering a culturally different world	1.32	0.30	4.10*	0.92	0.79	3.48**	0.34
Interaction between nursing, folk, and professional systems	1.05	0.16	5.19*	0.75	1.12	3.60**	0.77
Differences between cultural groups	0.72	0.01	6.23**	1.34	2.39*	3.41**	0.99
Similarities between cultural groups	0.37	0.04	6.94**	1.26	2.16	3.92**	1.51
Client's refusal of treatment based on beliefs	0.47	0.47	7.38**	1.62	2.19	4.19**	1.20
Interaction with people of different cultures	0.33	0.02	6.57**	1.54	1.91	5.61**	1.07
Cultural sensitivity and awareness	0.50	0.05	4.96*	1.32	2.33*	5.08**	1.11
Culture-specific health care	0.61	0.35	4.36*	1.41	2.22	4.57**	0.99
Role of family in providing health care	0.75	0.32	5.36*	1.45	2.06	4.35**	1.77
Client's world view (philosophy of life)	0.73	0.43	4.72*	1.61	2.14	3.97**	2.00
Inadequacies in the SA. health care system	1.63	0.02	3.31*	1.51	1.15	0.84	1.96
Importance of home remedies and folk medicine	1.91	0.60	3.98*	2.58*	0.72	1.03	0.46
Impact of roles on health care practices	0.86	0.00	2.68	1.34	2.56*	0.98	0.82
Impact of values on health care practices	1.01	0.01	2.25	1.17	2.54*	1.51	1.11
Impact of socioeconomic factors on health care practices	0.75	0.48	3.15*	2.01	3.53**	1.06	1.37
Impact of political factors on health care practices	0.97	1.47	3.65*	1.84	1.85	1.74	0.73
Need of cultural care preservation/maintenance	1.16	0.49	2.78	4.38**	2.46*	1.50	0.56
Need of cultural care accommodation/negotiation	0.82	0.70	2.21	2.48*	1.20	1.08	0.83
Need of cultural care repatterning/restructuring	1.27	1.60	1.85	2.15*	1.30	0.69	0.84
Need to prevent ethnocentric views	0.84	0.75	2.51	1.90	0.94	1.72	0.30
Need to prevent cultural imposition	1.42	1.62	3.67*	2.73*	0.68	1.87	1.40
Client's decisions based on cultural beliefs	1.55	0.02	1.91	3.15**	1.00	3.46**	0.98
Culture-specific care	1.36	0.02	2.32	2.88*	1.44	3.33**	0.99

*P is significant ≤ 0.05, **P is significant at ≤ 0.01

confidence level in their overall perception of the affective scale (average score of 9.7).

However, they felt low in “importance of home remedies and folk medicine”. Therefore, it can be assumed that they still do not know to what extent home remedies and folk medicine is important to their patients. According to Malone and Al Gannass (2012), many patients in Saudi Arabia still seek out alternative forms of therapy, such as the use of honey, black seeds, and other herbs, as this rich family tradition and culture is passed down from generation to generation. Filipino nurses already recognized their biases and limitations (mean score of 8.93), for they are culturally aware, however, because of language barriers, where most people in Saudi cannot speak English, especially those who do not have a tertiary education (Almutairi and McCarthy, 2012), the nurses cannot obtain deeper understanding of the patient desire to use traditional medicine or home remedies. The second, third and fourth lowest ranking variables, were: need to prevent ethnocentric views, need to prevent cultural imposition, need of cultural care repatterning/restructuring, showed that Filipino nurses know they should not influence the patient’s own beliefs regarding their culture, and they are not there to impose their values, and they should not do any restructuring/repartterning about patient world views.

Respondent nurses should restructure their own views based on the patient’s view. According to Ahmed and Bates (2010), associations were reported between higher levels of patients’ ethnocentric views and greater perceptions, and that physicians do not accommodate macro-cultural and linguistic differences, moreover, higher levels of ethnocentric views were also associated with greater perceptions that physicians provide patient-centered care. Therefore, in order for the patient to receive culturally congruent care, nurses need to deeply know their patient ethnocentric views. Campinha-Bacote (2002) stated that cultural assessment is a “systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served”. She further emphasized that, it is not enough for the health care providers to merely say they respect a client’s values, beliefs, and practices or to go through the motions of providing a culturally specific intervention. As they undergo positive experiences, they begin to feel more competent with skills and relationships, and become increasingly aware of discrepancies between their ideas of professional nursing and their actual experiences in the work setting (Hodges et al., 2008). Bandura’s (1977) self-efficacy theory claimed that expectations of personal efficacy are derived from four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states, hence the more dependable the experiential sources, the greater are the changes in perceived self-efficacy.

According to Wang et al. (2004), cultural construal of the self appears to play not just a role in the formation of culture-specific genres of autobiographical memory, but the determining role. This affirms the uniqueness of individual respondent nurses in their dealing with patients. A slight positive mood does not just make everyone feel a little better but also induces a different kind of thinking, characterized by a tendency toward greater creativity and flexibility in problem solving, as well as more efficiency and thoroughness in decision making (Picard et al., 2004). This means that Filipino nurses thinking and decision making is influence by their moods. While Beauregard (2009), concluded that mental processes significantly influence the various levels of brain functioning. However, Rushton and Ankney (1996) established that differences in cognitive abilities are correlated with differences in brain size, and both brain size and cognitive ability are correlated with age, sex, social class and race. Therefore, people from different cultures use their brains differently to solve the same visual perceptual tasks. Filipino nurses, as they are separated from home, are experiencing sadness, and even fear, decide on a situation depending on how they perceived it, but they are fully aware of their own culture, belief, biases and limitations. The majority of the nurses work in the acute care setting (79.8%) where they experienced caring for a patient in an emergency where sudden changed of emotion might occur (example, joy to fear), which influences their affective behaviour towards patient care, however their ambition of having a better position in the future and their own culture might somehow create a balance in their affect or emotions. Furthermore, Fernández-Berrocal et al. (2005) concluded that there is a connection between cultural norms and the individual’s ability to attend to, understand and regulate emotions.

In this study, the respondents were observed to have a strong understanding of their individual cultures as well as their awareness of their patients’ culture, each preferred position in the future, work setting and the kind of locality where they were raised. Filipino nurses are really known for their courtesy and respect for other people’s culture. They have the reputation of qualified and respected female workers with high work ethics, and are in high demand worldwide *(*Ivković, 2011). The level of acceptability of the respondents regarding differences and similarities between cultural groups, and client’s refusal of treatment based on belief were found to be significantly different in terms of work setting, andpreferred position in the future. This can be attributed to the nature of work demand in their own assigned positions and responsibility. Asian countries, tend towards collectivistic cultures value harmony and a deep respect for their elders and persons of authority (Ea, 2007). Filipino nurses might have difficulty imposing treatment on patients who refuse care, because of the

deep respect for the patient, since majority of them are staff nurses, however, preferred position in the future somehow affect the way they accept patient. Apparently, socioeconomic status had a strong, positive effect on ambitions, but not directly on self-concept (Young, 1998). In addition, migration seems to be prompted by the Filipino nurses' desire to earn more in order to be economically stable and have an affluent life (Yumol, 2009).

According to Bandura (1977), self-efficacy proved to be an accurate predictor of performance in the inactive mode of treatment because subjects were simply judging their future performance from their past behaviour. The same disintegration might be happening to respondent nurses, that is why department and preferred position as well as ethnicity significantly differs to some affective constructs. Caring for patient in acute care setting usually post an emergency where nurses give immediate care that they fail to interview client. Therefore, patient-nurse interaction happens later after the treatment, usually in patient relax mood and information about cultural beliefs and practices is already late to be incorporated in the treatment that can make nurses regret the situation (Jeffreys, 2006)**.** The beliefs and practices of patients who follow Islam, as perceived by expatriate nurses, may have an effect on the patient's health care, in ways that are not understandable to many health care professionals and policy makers internationally (Halligan, 2006).

Jeffreys (2006) stressed that "the affective learning dimension is concerned with attitudes, values and beliefs, and is considered to be the most important in developing professional values and attitudes. Affective learning includes self-awareness, awareness of cultural differences, acceptance, appreciation, recognition and advocacy. Moreover, respondent nurses have varying degree of self -confidence when it comes to cultural specific care especially since transcultural nursing is not a part of the nursing curriculum yet. Moreover, Jones et al. (2004), reported that cultural knowledge and educational preparation of the health worker may influence cultural skills. Workers who were most confident in their cultural skills in working with other cultural groups, were more confident in knowledge of cultural concepts and had higher education levels (Jones et al., 2004).

Conclusion

Filipino nurses affective construct as part of transcultural competency shows that even if they don't have formal education or attended seminars regarding transcultural nursing, they are confident in giving care to patients from diverse cultures. They still know the cultural specific factors that could influence the client behavior and how they will implement nursing care. Since nursing care is always an individualized process, nurses differ on how they execute or implement their care plan, and are not necessarily influenced by their own culture, belief and practices. However, caring for a client with diverse population need more formal education and up dated seminars on transcultural nursing care aside from formal language training on Arabic Language for them to easily comprehend what patient want and communicate effectively that nursing care is needed for their specific illness state or situation. Individuals with low confidence for transcultural nursing skills are at risk for decreased motivation, lack of commitment, and avoidance of cultural considerations when planning and implementing nursing care. Hence, Filipino nurses need formal education concerning transcultural nursing to address their weakness and limitations in caring for a patient with diverse culture and strengthen their competencies in transcultural nursing. In addition, although it is encouraging that Filipino nurses consider themselves as culturally competent, it will be wise to consider the possibility that differences may exist between nurse's perception and those of their patient. It would be valuable to measure the patient perception of their nurses' cultural competence as well and compare both ratings.

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Conflicts of interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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