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ORIGINAL ARTICLE

Cultural Competency among Expatriate Nurses in Saudi Arabia

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ABSTRACT

Background: The culture of Saudi Arabia is dominated by the values and virtues of Islam. Its increasing multi-cultural population of health care workers poses a significant challenge in providing individualized and holistic care to their patients. This descriptive study served as a baseline assessment survey to determine the level of competence among expatriate nurses in providing culturally competent nursing care.

Methods: The Individual Assessment of Cultural Competence, with approval from the Institution Review Board (IRB), was administered to 584 expatriate nurses of a University Hospital in Kingdom of Saudi Arabia.

Results: The findings of the study showed that majority of the respondents were Indians and Filipinos, with a frequency percentage of 53% and 39%, respectively. They were culturally competent in providing nursing care and there was significant difference in their cultural competency when grouped according to their age, gender, educational status, nationality and length of service.

Conclusion: The university hospital, recognizes the importance of cultural competence in the caring professions with the presence of diverse workforce. Hence, professional development programs are continually conducted to provide the nursing staff with the needed information primarily about Saudi culture.

Keywords: *Assessment; Culture; Cultural Competence; Nursing Care; Saudi Arabia*

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Introduction

The uniqueness of Saudi culture and the large number of expatriate nurses who have a limited knowledge of Saudi culture exacerbate the problem of providing culturally competent care (Almutairi and McCarthy, 2012). While a limited number of studies have been conducted on this topic, there is no consensus regarding the best way to enhance the cultural competence of practicing nurses. Various research studies have indicated that providing culturally competent care is challenging and complex. The most frequent identified challenges were: insufficient cultural knowledge, attitudes and beliefs about health and sickness (Clark and Murphy 1993), language barrier (Cioffi, 2003), lack of availability of interpreters (Hultsjo and Hjelm, 2005), prejudices and ethnocentrism (McGee, 2001), and lack of institutional support (Rosemarie, 2005). These factors not only impact on the values, beliefs and behaviors of clients, they underpin ideas around the provision of care and influence the expectations that clients and practitioners have of each other.

Culture has been defined by Bjarnason et al, (2009) as the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Kersey-Matusiak (2012) defined cultural competency as having specific cognitive and affective skills that are essential for building culturally relevant relationships between providers and patients. To serve the unique and diverse needs of patients, it is imperative that nurses understand the importance of cultural differences by valuing, incorporating, and examining their own health-related values and beliefs and those of their health care organizations, for only then can they support the principle of respect for persons and the ideal of transcultural care.

Cross et al., (1989), listed five essential elements that contribute to an institution's or agency's ability to become more culturally competent. These include: valuing diversity; having the capacity for cultural self-assessment; being conscious of the dynamics inherent when cultures interact; having institutionalized cultural knowledge; and having developed adaptations of service delivery reflecting an understanding of cultural diversity. These five elements should be manifested at every level of an organization, including policy making, administration, and practice. Further, these elements should be reflected in the attitudes, structures, policies, and services of the organization.

A literature review done by Niroz and Semuhungu (2010), showed that cultural competence encompasses nurses abilities to do self-cultural assessment and point out those aspects of it that are at variance with the patient's values, beliefs and practices; having an ability and interest in understanding other cultures and the application of cultural knowledge when encountering people from other cultures at their best interests; the ability to use a holistic approach when caring for culturally different patients; the willingness to provide care that is based on respect, empathy, understanding and that takes into consideration the patients' cultural and religious needs; and having the willingness and the ability to put into use the previously gained cultural awareness, cultural knowledge, cultural sensitivity and nursing skills.

Luna (1998) explored a number of strategies aimed at educating expatriate non-Saudi health professionals in the provision of culturally competent and culturally congruent health care. He identified Leininger's transcultural health care theory as the framework for achieving this goal. Transcultural nursing is a major component of a professional nurse practice model which provides a visionary perspective for nursing care. Within the practice model, transcultural care principles are used to guide education, clinical practice and nursing research. Furthermore, Leininger's theory serves to grasp a comprehensive view of folk and professional health systems and to identify ethical issues confronted by nurses in the transcultural setting. Additionally, Luna (1994) stated that nursing decisions and actions using Leininger's three modes were identified to achieve culturally congruent nursing care as only through knowledge, respect and sensitivity can nurses be effective in meeting the goals of the theory which is culturally congruent care to all clients of diverse cultures. Meanwhile, Kavanagh (1993) proposed that the future of transcultural nursing should emphasize development of realistic nursing roles that include a confluence of advocacy and diversity/universality and negotiation of responsible social conceptualizations of cultural issues such as race and diversity.

Chenowethm et al, (2006) concluded that nurses must pay attention to interpersonal relationships and develop respect for the health consumer's value systems and ways of being, in order to protect their rights and avoid the tendency to stereotype individuals from particular cultures. According to Williamson and Harrison (2010), there are two main approaches to culture; the first focuses on the cognitive aspects of culture, the values, beliefs and traditions of a particular group, identified by language or location, which views culture as static and unchanging, and fails to account for diversity within groups. The second approach incorporates culture within a wider, structural framework, focusing on social position to explain health status ra-

ther than on individual behaviors and beliefs, which includes perspectives on the impact of the colonial process on the ongoing relationships of Indigenous and non -Indigenous people and how this affects health and health care.

Calvillo et al (2009) suggested for developing and implementing curricula for cultural competency, teaching content, specific integrative learning strategies, methods for evaluating cultural competence and recommendations for effective implementation of the integrated curriculum.

Statement of the Problem

1. What was the profile of the respondents in terms of:
   i. Age;
   ii.Gender;
   iii.Education;
   iv.Nationality; and
   v.Length of service?
2. What was the level of the cultural competency of the expatriate nurses?

3. Was there a significant difference on the level of the cultural competency of the expatriate nurses when grouped according to profile?

Materials and Methods

Sampling

This descriptive survey served as a baseline assessment to determine the cultural competency among expatriate nurses in Saudi Arabia. It was conducted in a large tertiary University Hospital in the Kingdom. There were five hundred eighty-four (584) respondents of the study selected through random sampling from the total of one thousand nine hundred forty six (1,946) staff nurses of the university hospital. Saudi national staff nurses are excluded.

Instrumentation

The study utilized the Individual Assessment of Cultural Competence, developed by the AUCD Multicultural Council, adapted in part from Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist by Tawara D. Goode, Georgetown University Child Development Center. The tool was used with permission from Carolyn Richardson Leadership Training Coordinator, Robert Wood Johnson Center for Health Policy, University of New Mexico.

Statistical Analysis

The following statistical formula were used: Simple percentage to present the profile of the subjects; weighted mean was employed for the categorical responses of the respondents based upon the statements on individual assessment of cultural competence. The result was further subjected to different inferential statistics to determine the significant difference of the cultural competency of the respondents when grouped according to their profile including chi-square test for age, education and nationality, Mann- Whitney U test for gender, and Kruskal-Wallis H test for length of service.

Results

Profile of the Respondents

Table 1 displays the profile of the respondents in terms of age, gender, educational attainment, nationality and length of service. Majority of the respondents were in the age bracket of 26-30 years old with a frequency of two hundred thirty two (232) or thirty nine point seven percent (39.7%). One hundred two (102) or seventeen point five percent (17.5%) were in the age bracket of 36-40 years old. Eighty nine (89) or fifteen point two percent (15.5%) were aged 31-35 years old. Forty one (41) of them or seven percent (7%) were in the age bracket of 46-50 years old. Thirty (30) of them or five point one percent (5.1%) were aged 51-55 years old. Twenty eight (28) of them or four point eight percent were less than 25 years old and twenty four (24) of them of four point one percent (4.1%) were 56-60 years old.

In the aspect of gender, a greater portion were female with a frequency of five hundred fifty (550), representing ninety four point two percent (94.2%) of the total respondents. Meanwhile, only thirty four (34) were male staff nurses with a percentage of five point eight (5.8%).

Fifty four point five (54.5%) of the respondents were diploma in nursing with an aggregate number of three hundred eighteen (318). While Bachelor degree holder comprised of two hundred fifty six (256) or a total percentage of forty three point eight (43.8%). Only ten (10) of them or one point seven (1.7%) were master degree holder.

The largest segments of the respondents were Indians and Filipinos, with a frequency of three hundred twelve (312) or fifty three point four percent (53.4%) and two hundred twenty eight (228) or thirty nine percent (39%), respectively. There were twenty seven (27) or four point six percent (4.6%) Jordanian. One point four percent (1.4%) or eight (8) of them were Pakistani and another one point four percent (1.4%) were Nigeri-

Table 1.Profile of the Respondents (n=584)

Profile	Frequency	Percentage (%)
Age		
<25 years old	28	4.8
26-30 years old	232	39.7
31-35 years old	89	15.2
36-40 years old	102	17.5
41-45 years old	38	6.5
46-50 years old	41	7.0
51-55 years old	30	5.1
56-60 years old	24	4.1
Gender		
Male	34	5.8
Female	550	94.2
Educational Attainment		
Diploma	318	54.5
BSN	256	43.8
Masters	10	1.7
Nationality		
Indian	312	53.4
Filipino	228	39.0
Pakistani	8	1.4
Sudanese	1	.2
Jordanian	27	4.6
Nigerian	8	1.4
Length of Service		
< 1 year	113	19.3
2-5 years	218	37.3
6-10 years	121	20.7
11- 15 years	68	11.6
> 15 years	64	11.0
Total	**584**	**100**

an. Only one (1) Sudanese took part of the study or a percentage of zero point two (0.2%).

Counting their length of service, two hundred eighteen (218) or thirty seven point three percent (37.3%) of them were employed in the hospital for 2 to 5 years. There were one hundred twenty one (121) or twenty point seven percent (20.7%) having 6 to 10 years of service. One hundred thirteen (113) or nineteen point three percent (19.3%) of them were less than 1 year. Sixty eight (68) or eleven point six percent (11.6%) were in the hospital for 11 to 15 years and sixty four (64) or eleven percent (11%) were more than 15 years of service.

Assessment of Cultural Competence of Expatriate Nurses

Table 2 reflects the cultural competency of the expatriate nurses in Saudi Arabia. The respondents obtained an overall grand mean of 3.15 and standard deviation of 0.321, interpreted as competent. They were culturally competent as they attempt to learn and use key words and colloquialisms of the languages used by the patients and families served (mean= 3.10 and σ= 0.881). They utilize methods of communication, including written, verbal, pictures, and diagrams, which will be most helpful to the patients, families, and other program participants (mean= 3.09 and σ= 0.978). They utilize interpreters for the assessment of patients and their families whose spoken language is one for which they are not fluent (mean= 3.02 and σ= 0.868). They reflect on and examine their own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence their behaviors (mean=2.97 and σ=1.03). They have developed skills to utilize an interpreter effectively (mean=2.83 and σ=0.926). They intervene, in an appropriate manner, when they observe other staff engaging in behaviors that appear culturally insensitive or reflect prejudice (mean=2.76 and σ=0.793).

They were highly competent, however, on some aspects as they are flexible, adaptive, and will initiate changes, which will better serve patients, families, and other program participants from diverse cultures (mean=3.66 and σ=0.549). They are mindful of cultural factors that may be influencing the behaviors of patients, families, and other program participants (mean=3.52 and σ=0.736). They recognize and accept that the patients and family members make the ultimate decisions even though they may be different compared to their personal and professional values and beliefs (mean=3.48 and σ=0.767). They continue to learn about the cultures of the patients and families served in the program, in particular attitudes towards disability; cultural beliefs and values; and health, spiritual, and religious practices (mean=3.41 and σ=0.731).

Table 2.Assessment of Cultural Competence of the Respondents (n=584)

Statements	Std. Deviation (σ)	Mean	Interpretation
1. I reflect on and examine my own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence my behaviors.	1.03	2.97	Competent
2. I continue to learn about the cultures of the patients and families served in the program, in particular attitudes towards disability; cultural beliefs and values; and health, spiritual, and religious practices.	.731	3.41	Highly competent
3. I recognize and accept that the patients and family members make the ultimate decisions even though they may be different compared to my personal and professional values and beliefs.	.767	3.48	Highly competent
4. I intervene, in an appropriate manner, when I observe other staff engaging in behaviors that appear culturally insensitive or reflect prejudice.	.793	2.76	Competent
5. I attempt to learn and use key words and colloquialisms of the languages used by the patients and families served.	.881	3.10	Competent
6. I utilize interpreters for the assessment of patients and their families whose spoken language is one for which I am not fluent.	.868	3.02	Competent
7. I have developed skills to utilize an interpreter effectively.	.926	2.83	Competent
8. I utilize methods of communication, including written, verbal, pictures, and diagrams, which will be most helpful to the patients, families, and other program participants.	.978	3.09	Competent
9. I write reports or any form of written communication, in a style and at a level which patients, families, and other program participants will understand.	1.08	2.77	Competent
10. I am flexible, adaptive, and will initiate changes, which will better serve patients, families, and other program participants from diverse cultures.	.549	3.66	Highly competent
11. I am mindful of cultural factors that may be influencing the behaviors of patients, families, and other program participants.	.736	3.52	Highly competent
Total	**.321**	**3.15**	**Competent**

Significant difference on the cultural competency of the staff nurses when grouped according to Age

As shown in table 3, there was a significant difference in the cultural competency among the expatriate nurses in Saudi Arabia as they were group according to their age, chi-square of 282.195, degree of freedom of 7 and p-value of less than 0.05, with a mean rank of 111.18 for <25 years old, 418.01 for 26-30 years old, 265.96 for 31-35 years old, 286.00 for 36-40 years old, 147.17 for 41-45 years old, 156.21 for 46-50 years old, 119.83 for 51-55 years old and 95.60 for 56-60 years old. The result of this statistical test suggests that older expatriate staff nurses develop a better cultural understanding when rendering nursing care thus becoming more effective health care professionals.

Significant Difference between the Cultural Competency of the Male and Female Staff Nurses

A Mann- Whitney U test was conducted to evaluate the hypothesis on the significant difference between the male and female staff nurses in their cultural competency. As shown in table 4, the results of the test revealed that there was significant difference, U= 558.00 (Z = -9.223) and p-value=<.05, with male (mean rank= 33.91) had higher level of cultural competency than the female (mean rank= 308.49).

Significant difference on the cultural competency of the staff nurses when grouped according to Education

Table 3.Significant difference on the cultural competency of the staff nurses when grouped according to Age: (n=584)

Age	n	Mean Rank	Chi-square	df	p-value	Decision over Ho	Interpretation
<25 years old	28	111.18	282.195	7	.000	Reject Ho	Significant
26-30 years old	232	418.01					
31-35 years old	89	265.96					
36-40 years old	102	286.00					
41-45 years old	38	147.17					
46-50 years old	41	156.21					
51-55 years old	30	119.83					
56-60 years old	24	95.60					
Total	584						

Table 4. Significant Difference between the Cultural Competency of the Male and Female Staff Nurses: (n=584)

Gender	n	Mean Rank	Sum of Ranks	*p*-value	Decision over Ho	Interpretation
Male	34	33.91	1153.00	.000	Reject Ho	Significant
Female	550	308.49	169667.00			
Total	584					

Note: Significant at .05 level of significance

As shown in table 5, there was a significant difference in the cultural competency of the staff nurses when grouped according to their education, chi-square of 41.735, degree of freedom of 2 and a p-value <0.05, with a mean rank of 321.32 for diploma nurses, 267.49 for Bachelor degree holder and 16.30 for master degree holder. This suggests that the higher the educational attainment of the expatriate nurses, the more competent they become.

Significant difference on the cultural competency of the staff nurses when grouped according to Nationality

Table 6 displays the significant difference on the cultural competency among expatriate nurses when grouped according to their nationality. The decision was to reject the null hypothesis, chi square value of 129.635, degree of freedom of 5 and p-value <0.05, with a mean rank of 324.87 for Indians, 272.14 for Filipinos, 19.31 for Pakistani, 2.50 for Sudanese, 54.91 for Jordanian and 19.81 for Nigerian. This reflects the need to enhance further the cultural knowledge and skills among expatriate nurses, especially the Indians and Filipinos.

Significant difference on the cultural competency of the staff nurses when grouped according to Length of Service

A Kruskal-Wallis H (non-parametric for ANO-

Table 5.Significant difference on the cultural competency of the staff nurses when grouped according to Education (n=584)

Education	n	Mean Rank	Chi-square	df	p-value	Decision over Ho	Interpretation
Diploma	318	321.32	41.735	2	.000	Reject Ho	Significant
BSN	256	267.49					
Masters	10	16.30					
Total	584						

Table 6.Significant difference on the cultural competency of the expatriate nurses when grouped according to Nationality: (n=584)

Nationality	n	Mean Rank	Chi-square	df	p-value	Decision over Ho	Interpretation
Indian	312	342.87	129.635	5	.000	Reject Ho	Significant
Filipino	228	272.14					
Pakistani	8	19.31					
Sudanese	1	2.50					
Jordanian	27	54.91					
Nigerian	8	19.81					
Total	584						

VA) test showed that there was a statistical significant difference in the cultural competence among staff nurses in terms of their length of service in the hospital, $\chi 2(4) = 154.540$, df=4, p-value less than 0.05, with a mean rank of 262.58 staff with less than one year of service, 392.23 for 2-5 years of service, 278.36 for 6-10 years of service, 171.74 for 11-15 years of service and 160.66 for those with more than 15 years of service. The result indicates that expatriate nurses becomes more accustomed in the Saudi culture as they stayed longer years in the hospital thus enabling them to provide a culturally congruent care.

Discussion

differences in healthcare values, beliefs, and customs, as reinforced by Maeir-Lorentz (2008). Further, expatriate nurses must develop the culture of safety, as asserted by Williamson and Harrison (2004), to identify the needs of the individual receiving care. Further noting the idea of Pesquera (2008), delivering culturally sensitive care gives health professionals an opportunity to help reduce racial and ethnic disparities attributable to patient-provider interactions in the diverse settings across the continuum of care, with the patient as the primary focus. In fact according to the Institute of Medicine (2002) health care providers who lack cultural competence may be putting patients at risk for delays in treatment, inappropriate diagnoses, noncompliance with health care regimens, and even death. The results of this study re-

Table 7. Significant difference on the cultural competency of staff nurses when grouped according to Length of Service: (n=584)

Length of Service	n	Mean Rank	Chi-square	df	p-value	Decision over Ho	Interpretation
< 1 year	113	262.58	154.540	4	.000	Reject Ho	Significant
2-5 years	218	392.23					
6-10 years	121	278.36					
11- 15 years	68	171.74					
> 15 years	64	160.66					
Total	584						

The mainstream of health workers in the hospital who were Filipinos and Indians showed competence in providing culturally congruent nursing care. The findings of the study contribute important understanding to the area of patient and nurse safety in a multicultural environment and theoretical development to the field of cultural competence. Culturally competent nursing care helps ensure patient satisfaction and positive outcomes, as affirmed by Almutairi et al (2014). This requires nurses to recognize and appreciate cultural

vealed that the majority of expatriate nurses in this sample did not indeed rate themselves to be highly competent. It was encouraging that they indicated recognition of their own limitations in dealing with clients from cultures other than their own.

The study found a significant difference in the cultural competency among the expatriate nurses when they are grouped according to their profile such as age, gender, educational attainment, nationality and length of

service. The gap of their individual assessment on cultural competence suggests that some sort of disconnect often occurs in clinical setting because of cultural mismatch between them and patients. This was explained by Anderson (1998) that background and experience really do affect the interaction processes. Research to date demonstrates that training is an effective means of improving provider knowledge of cultural and behavioral aspects of health care (IOM, 2002). Coffman et al (2004) suggested that the repeated opportunity to work with people of other cultures and continuing education and training contributed to cultural competence. This has implications for curriculum development in enhancing culturally competent nursing care.

Conclusion

The Kingdom of Saudi Arabia hosts a diversity of cultures. Cultural diversity is encountered in all aspects of the nurses' lives while living and working in Saudi Arabia. Nurses within this culturally diverse environment struggled with the notion of cultural competence in terms of each other's cultural expectations and those of the dominant Saudi culture. The findings of the study contribute to better understanding that could help expatriate health care providers to recognize Saudi culture and enhance cultural competence. The importance of cultural competence in the caring professions should never be neglected as more diverse nursing professionals are joining in the university hospital. As health services designed to cater the needs of the patients admitted in the institution increases, it is required to review the ability of staff nurses to meet the needs of different ethnic groups with cultural considerations, which includes both culture-specific and culture-generic knowledge, attitudes, and skills. It is increasingly imperative that expatriate nurses have and continually develop a cultural competence that enables them to connect with, respond to, and interact effectively with their patients. The end result of the provision of culturally competent care by culturally competent nurses and healthcare organizations can be significant improvements in the health and well-being of patients.

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