

REFLECTIONS OF SOUTH AFRICAN NURSES
MIGRATING TO THE KINGDOM OF SAUDI ARABIA:
A FRAMEWORK FOR SUPPORT

By

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ABSTRACT

The last decade has seen an exodus of South African nurses migrating to "greener pastures". As a result of this migration, the South African Healthcare Service has been drained of one of its most essential resources – nurses. Subsequently, the crippling flight of nurses has thrown the nursing profession into a state of crisis.

The Kingdom of Saudi Arabia is one of the more popular destinations for South African nurses, the main reason being the attractive financial rewards. One agency reports that they send an average of thirty nurses a month to various hospitals within the Kingdom of Saudi Arabia.

Saudi Arabia is an Islamic country. Due to the uniqueness of the enforcement of the Islamic faith and the Saudi culture, many restrictions are imposed, particularly on women. The challenges and problems facing the South African nurses were, therefore, unique compared to elsewhere in the world.

This research study had a primary and a secondary objective.

- The primary objective of this study was to explore and describe the lived experiences of South African nurses related to living and working in Saudi Arabia.
- The secondary objective of this study was to develop orientation guidelines to support South African nurses working and living in Saudi Arabia.

The researcher utilized a qualitative, explorative, descriptive and contextual design based on a phenomenological approach to inquiry, in an attempt to answer the question: *"What are the professional and personal experiences of the South African registered nurses working and living in Saudi Arabia?"*

Eleven registered nurses were selected to participate by means of purposive sampling. These nurses had been living in Saudi Arabia between three and six months. Consent was obtained from participants and the ethics committee of

both the Nelson Mandela Metropolitan University and King Faisal Specialist Hospital and Research Centre.

The central theme emanating from the study was recognized as being 'Cultural Diversity'. The sub-themes identified related to the registered nurses':

- Religious/spiritual adaptation
- Environmental adaptation
- Emotional/psychological adaptation
- Professional adaptation

Based on the identified themes, guidelines were formulated to assist South African registered nurses when migrating to Saudi Arabia. Utilization of these should assist the South African registered nurse in assimilating into both the cultural and working environment. However, in reality, the outcome showed that no one can be prepared fully for what awaits them in Saudi Arabia.

Key words: Adaptation, cultural diversity, lived experiences, migration, registered nurse.

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CHAPTER 1

OVERVIEW OF THE STUDY

A man is always a teller of tales, he lives surrounded by his stories and the stories of others, he sees everything that happens to him through them; and he tries to live his own life as if he were telling a story.

Jean-Paul Sartre

1.1 INTRODUCTION AND BACKGROUND

The focus of this research study is to explore and describe the lived experiences of South African nurses who have migrated to Saudi Arabia. Hancock (2001:19) states that: *Probably the greatest political challenge to nursing today is the shortage of nurses worldwide and the migration of nurses from one country to another.* The International Council of Nurses (ICN) recognizes the right of individual nurses to migrate, while acknowledging the possible adverse effect that international migration may have on healthcare quality in areas experiencing critical nursing shortages (ICN 2002:10).

International migration has always been in existence, but the 21st century has brought with it more mobilization opportunities than ever before for nurses all around the world. This migration is further facilitated by shortages of skilled labour in industrialized countries and through international trade agreements. The migration flow has therefore changed, in that “supplier” countries are increasingly among the less developed countries. Recruitment is no longer between relatively rich countries but includes places such as Asia and Africa (ICN 2002:8).

A study on international nurse mobilization, trends and policy implications, states that there are certain *push* and *pull* factors that drive nurse migration. These are evident in the destination countries that have failed to *grow their own* and *keep their own* nurses in sufficient numbers. They have, therefore, used the quick fix of international recruiting, exploiting the existence of *push* factors such

as low pay, poor working conditions, lack of resources to work effectively, limited career and educational opportunities, economic instability and unstable and dangerous work environments, by exerting the *pull* factors of better working conditions, salaries, career opportunities, resourced health systems, political stability and travel opportunities (ICN 2003, 137).

Consequently, this study confirms the general consensus that nurses throughout the world migrate in search of incentives that fall within three categories:

- Improved learning and practice opportunities.
- Better quality of life, pay and working conditions.
- Personal safety.

The consequences of international nurse migration are threefold. Firstly, it impacts negatively on the national health system of every 'exporting' country. There is a loss of national economic investment in human resource development, an increase in costs due to lost production and the export of human capital in the form of education, training and experience and an increase in price and wages for skilled and professional labour (Kaplan, Brown & Meyer, 1999:1).

It appears as if a ripple effect is set in motion as the 'brain and skills drain' leads to the closure of facilities due to nursing shortages. The nursing shortages subsequently increase the stress levels of the nurses practicing in the depleted areas and the heavier, if not unrealistic, workload decreases the motivation of these nurses. The decreased motivation ultimately affects the standard and quality of nursing care rendered, as well as placing patient safety under threat. A new Harvard – Vanderbilt study of thousands of hospital records confirms a direct link between a lack of nurses and potentially fatal patient complications. *Hospitals aren't run by physicians. Hospitals are only successful if the nurses are there. A physician can cut you up, he can put you back together, but if you don't have the nurse who's following up, then the hospital falls apart* (Thompson, 2003:1).

Secondly, it impacts on the families that are left behind. Many internationally recruited nurses report that they would prefer to remain in their home country with their family and friends in a familiar culture and environment (ICN, 2001:3). Nevertheless, for the majority there is no option. Thoko Mkhize testified that *she had no choice but to go because her husband was retrenched from his job* (Naidoo 2000:1). Ms Kumalo, a South African nurse and a single mother of two, states very clearly: *Basically it's the money, I can't make payments here* (Itano, 2002:1). With the departure of one of the key role players there is a danger of the family unit becoming fragmented and the daily routine disrupted. The remaining spouse is forced to assume the roles and responsibilities of both parents. As a result, stress levels are increased, which may strain marital relations. The children who are separated from their mother or father may not fully understand or may struggle with the rationale of the departure. This can lead to insecurity; which in turn has consequences, be they behavioural problems, difficulties at school, regression in milestones or disruption in the bonding process.

Thirdly, one must acknowledge the potential dangers and vulnerabilities that migration may hold for the individual nurse. Internationally recruited nurses may be:

- At risk of potential abusive recruitment; the difficulty of verifying the terms of employment being increased due to distance, language barriers and cost. The ICN (2002:10) denounces unethical recruitment processes that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience. Together with its member national nursing associations, the ICN has called for a regulated recruitment process based on ethical principles that guide informed decision-making and support fair and cost effective recruitment and retention practices (ICN 2002:10).
- Vulnerable, given the difficulty in verifying the basic terms of reference of the work contract and the actual employment situation.
- Vulnerable to the practices in another country (ICN 2002:5). This is heightened in the countries that do not have a nursing regulatory body and the individual organization stipulates the standards and scope of practice.

Most countries do have a nursing regulatory body. Through regulation, the nursing profession and its members are defined, the scope of practice determined, standards of ethical and competent practice are set and systems of accountability are established (Affara & Styles, 1997:34). Regulation is the key to professional practice brought about by the forms and processes in which the professional nursing body implements order, consistency and control over its members. Nurses implement regulation through the control of their professional-ethical legal decisions (Van der Merwe, 2003:3).

Accordingly, the scope of practice by definition communicates to others the competencies and professional accountability of the nurse. It includes the activities nurses are educated and authorized to perform. It also defines the limits of nursing practice (Van der Merwe, 2003:5). Due to nursing regulatory bodies not having common criteria for generic competencies, the scope of practice will differ from country to country. This scope of practice forms part of the ethical and legal framework within nursing practice. When a different scope of practice is encountered, vulnerability and value conflicts may arise, causing tension in the workplace environment. The nurse should, therefore, reflect on the differences between her own scope of practice and the new scope of practice.

Reflection constitutes a specific process that should take place on four levels:

- Empirical – means the situation is guided according to some rule or regulation.
- Personal – a nurse's own engagement in the practice setting.
- Ethical – concerned with managing value conflicts that require value judgments.
- Aesthetic – when the desired outcomes are envisioned and the achieved outcomes are reflected (Johns cited in Kember, 2001:23).

Regardless of where or how nurses choose to work, the workplace environment will play an important role in the nature of the practice and its outcomes on both the providers and recipients of care. It is every nurse's right to work in an optimal environment so as to ensure quality nursing. It is the work of every

nurse leader to transform the practice environment so that the essence, uniqueness and outcomes of professional practice will be realized (Van der Merwe, 2003:5).

1.2 PROBLEM STATEMENT

South Africa (SA) has seen the exodus of skilled professionals over the last decade. An estimated 24,196 professionals emigrated during the period 1994-1997, 56% more than during 1989-1994. The true extent cannot be ascertained from official data, but statistics from the five main recipient countries that account for three quarters of South Africa's emigration population suggest that 233,609 South Africans left SA between 1989 and 1997 (Kaplan *et al*, 1999:1). During the first half of 2002, 7,400 graduates and professionals 'hit the runways' and it is estimated that between an eighth and a fifth of South Africans with a tertiary education now reside abroad (Dickson, 2002:1).

The past five years has seen an increase of health professionals (doctors and nurses) leaving South Africa for 'greener pastures'. Doctors exposed to conditions such as inadequate facilities and resources, poor working conditions, poor salaries and lack of treatment policies on diseases such as HIV/AIDS, are motivated to seek employment overseas. They are well trained and highly sought after and do not have to be actively recruited to pursue careers elsewhere (Peer, 2002:1). The South African Medical Association (SAMA) estimates that 3,500 of its 26,000 practicing doctors are presently living abroad (Itano, 2002:1).

The South African nursing arena is in crisis as the debilitating flight of nurses to various destinations overseas reaches alarming proportions. The registrar of the South African Nursing Council supports this view by stating that *South Africa's health system is stretched to breaking point* (Subedar cited in Stahl, 2003:2).

In addition, statistics indicate that 300 specialty nurses leave South Africa per month. According to the Democratic Nurses Association of South Africa (DENOSA), 25% of the 11,500 nurses with specialized qualifications left South

Africa in 1999 alone (Naidoo, 2000:1). South Africa is listed second on the list of the top 10 countries that provide the most nurses to the United Kingdom (BBC1, 2002:1), having supplied 6739 nurses over the past five (5) years (Smetherham & Lawrence, 2003:2). Unfortunately, it is not only the United Kingdom but also countries such as the United States of America, Canada, Australia, New Zealand and Saudi Arabia that are sapping the country of its nurses, thus rapidly diminishing the backbone and lifeblood of the South African healthcare system. The ripple effect of this nursing drain is that South Africa now has too few qualified nurses to cope, thus leaving crucial and sometimes life saving standards under threat (Broughton, Knowler & Leeman, 2002:1).

According to the WHO, this migration can be attributed to:

- Low pay.
- Poor working conditions.
- Failure to recognize the value of nurses and career prospects (Mafalo, 2003:39).
- Demand – furthermore, the South African nurses are highly trained and are renowned for their high standard of nursing skills (Hopkins as cited in Stahl 2003:2).

The Kingdom of Saudi Arabia is one of the more popular destinations for South African nurses, as the financial rewards are great. Nurses can earn an annual tax-free salary of approximately R228 000 to R360 000 (South African Rands) in Saudi Arabia, compared to an annual salary after four (4) years training of approximately R75 400 in South Africa (Annexure E to DPSA Circular 3 of 2005). There are many agencies that recruit nurses for Saudi Arabia, one of which reports that they send an average of thirty (30) nurses per month to various hospitals throughout Saudi Arabia (personal conversation Lee, December 2003). The recruiting officers of two of the largest hospitals in Riyadh, Saudi Arabia, where thirteen (13) nationalities are represented, stated that South African nurses make up 25% and 17% respectively of the total nursing staff. It is evident, therefore, that the South African nurses form a major part of the nursing backbone in Saudi Arabia.

It is a stressful experience for South African nurses to leave their homes and travel abroad for employment opportunities in Saudi Arabia. Even if it is something for which the nurses have planned and prepared, the culture shock is evident from the time they step off the plane, tired and jet lagged. "Culture shock" describes the impact of moving from a familiar culture to one that is unfamiliar (The Council for International Education (UKOSA), 2003:1). For the South African nurse it includes the shock of being separated from loved ones, support systems, familiar sights, sounds and smells. It also includes the shock of being in a fundamentalist Muslim country with an unfamiliar language; a country that is intolerant towards other religions; a country where women do not have the rights and equality that women in most other countries in the rest of the world are afforded, a country that has rigid and definite social roles, dress code and rules of behaviour; and a country that has an emerging nursing regulatory system.

The South African nurses not only have to contend with the aforementioned from a personal and professional perspective, but also have to face the challenges of an American-based nursing system in many of the hospitals. The North American system is unfamiliar to South African nurses since they follow a similar nursing approach to the United Kingdom. The shock is evident when they arrive in the units equipped with the knowledge of the South African scope of practice, thinking that they are prepared and ready to work. They are suddenly faced with a scope that allows practices not legally permissible in South Africa, for example transcribing of medications, taking narcotics out of the cupboard without a witness and free use of abbreviations.

Although nursing throughout the world has a common practice language, the generic competencies differ. Competence is defined as *a level of performance demonstrating the effective application of knowledge, skill, values, attitude and judgment* (Van der Merwe, 2003:12). Competencies are determined by the individual organization because Saudi Arabia does not have a nursing regulatory body. Consequently, the added challenge that awaits the South African nurse is the expectation of competence with regard to certain clinical skills that were not necessarily required back home.

The researcher, having lived and worked in Saudi Arabia for the past three (3) years, has come to realize that alongside the culture shock and challenges that await the South African registered nurses is a set of associated problems that dovetail into the areas mentioned above. These identified problems are discussed from the researcher's personal experiences. The first of these relate to the biophysical factors. From a biophysical perspective, the South African nurses have to adjust to the geographical layout, the climate and the extremes of the desert. The extreme dryness and heat (reaching well over 50°C during many months of the year) take their toll. Most of them have never experienced such conditions and often suffer physically from heat exhaustion, dehydration and skin problems. Geographically, many hospitals are situated a distance away from the cities or towns, which leaves the nurses feeling isolated, frightened and lonely.

From a psychological perspective, a vicious cycle may arise. The separation from loved ones and the loss of a personal support system from home can cause worry and anxiety, which invariably lead to some degree of depression. This, in turn, affects sleep patterns, which can ultimately affect one's productivity at work, as well as functioning in the new environment. Another problem that most South African nurses encounter is sharing accommodation with one or two other persons who may or may not be of the same nationality. Sharing can be problematic as habits, idiosyncrasies and culture are vastly different and, therefore, interpersonal conflicts may arise, causing unhappiness and added stress. In addition, language barriers affect communication in all areas, be it with patients (interpreters are not always available), co-workers or the local shop assistants. This is a source of frustration with resultant increase in stress levels that can ultimately affect nursing care or lead to misunderstandings, which in turn may lead to an increase in interpersonal conflicts within the multi-cultural working context.

Socially, the South African nurses face another set of associated problems. Due to the stringent dress code in Saudi Arabia, South African nurses are unable to dress in the manner to which they are accustomed. They are advised to dress conservatively on the hospital premises and are forced to wear the cultural

dress, the “abaya” outside these premises. Nurses are often subjected to verbal abuse by the “Muttawaa” (religious police) when they do not cover their heads while shopping in town. This causes a sense of embarrassment and creates an element of fear, as well as leading to a diminished sense of identity. Some may experience a sense of resentment, both to the verbal abuse and the cultural practice itself.

In Saudi Arabia, communication with the opposite sex is not allowed unless one is married or in the company of one’s father or brother. For instance, a woman may not sit in the front seat of a car with a male or accompany a male to dinner in a restaurant, as this is against the law and, if caught, can lead to imprisonment. Such practices are completely foreign to South African nurses. This creates a pseudo-world with regard to socializing, since South African nurses are accustomed to freedom of choice in their own country. These restrictions could result in them either being enticed into taking risks and being punished if caught or in isolating themselves from socializing with the opposite sex.

Women are not allowed to drive in the Kingdom, which is yet another rule that robs the South African nurses of their sense of independence. Consequently, they are dependent on taxis for transport. This mode of transport is expensive, restrictive and enormously frustrating. It is also not possible to leave the Kingdom without an exit/re-entry visa, as the nurses are relieved of their passports by the sponsoring hospital for the purposes of safe keeping. They are issued with an “Iqama”, which they have to carry with them at all times when in the Kingdom. Consequently, nurses have to apply for a visa to permit them to exit the Kingdom, even for a week-end get away. Thus, spontaneous travelling is hampered, causing frustration.

Another associated problem experienced by South African nurses is the lack of opportunity to practise freedom of religion. The only religion recognized in Saudi Arabia is Islam and practise of any other religion is an offence punishable by law. Although the nurses know the situation before coming to the Kingdom, it still serves as a source of frustration, as the spiritual dimension is neglected and

jeopardized. South African nurses also have to adjust to the prayer call which sounds five times a day. As the mosques are often situated very near to the residences, sleep patterns can be disturbed initially. Since shops and restaurants close at prayer times, customers are not served during these times and, if shopping has not been completed, they are required to wait outside on the pavement until the prayer time is completed. These delays cause frustration.

The present political climate and terrorist activity in Saudi Arabia has impacted on the South African nurses' safety. The physical presence of armed guards, tanks and barbed wire at the entrances to all housing compounds reinforces the unstable situation. No longer is there the freedom to walk to the shopping centre or go for a run off the hospital premises. Social events have been curtailed and psychologically an element of uncertainty, fear and anxiety has become evident. Furthermore, the unstable situation has increased the anxiety levels of family and loved ones at home, and this has become an added stressor for the South African nurse.

The deduction can, therefore, be made that South African nurses arriving in Saudi Arabia have to deal not only with the culture shock and challenges that await them, but, undoubtedly, have to work through associated difficulties such as biophysical, geographical, psychological, social, spiritual and political problems in order to survive living and working in this complex country. Being a stranger in a strange land may lead to very specific professional and personal experiences outside the experiential world or expectations of South African nurses. Currently, it is not known how nurses experience working in foreign countries. In light of the above, the following research question has been formulated:

What are the professional and personal experiences of the South African registered nurses working and living in Saudi Arabia?

1.3 RESEARCH OBJECTIVES

This research study has a primary and a secondary objective.

- The primary objective of this study is to explore and describe the lived experiences of South African nurses related to living and working in Saudi Arabia.
- The secondary objective of this study is to develop orientation guidelines to support South African nurses working and living in Saudi Arabia.

1.4 TERMINOLOGY

The following terminology will be clarified for the purposes of this study:

- **Adaptation:** Adaptation is the adjustment of a person to change in internal and/or external conditions or circumstances. (Taber's Cyclopedic Medical Dictionary 1993:37).
- **Competence:** Competence reflects knowledge, skills, attitudes, values and judgment. In addition, nursing competence should evaluate the nurse's own beliefs, ethical values, attitudes, accountability and knowledge, matching the expected outcome (Van der Merwe, 2003:12).
- **Cultural diversity:** Cultural Diversity pertains to the diverseness of culture experienced by the South African participants working in Saudi Arabia who have been exposed to the realities of this country, which has a different culture to that of their own (Collins Gem English Dictionary, 2003:169).
- **Culture shock:** Culture shock describes the impact on a person/s moving from one familiar culture to one which is unfamiliar (UKOSA, 2003:1).
- **Experience:** Experience is what happens to a person; what is seen, done, felt or lived through (World Book Millennium: volume A-K, 2000: 749).
- **Immigration:** Immigration is to come to a place or country of which one is not a native in order to settle there (McLeod, 1986:422).
- **Migration:** Migration is to move from one place of abode to another, especially another country (Oxford Dictionary, 1990:751). This study looks at the movement/migration of SA nurses from South Africa to Saudi Arabia. The intent is not to settle but to merely work on contract for a certain period of time.

- **Nurse:** Known as a Staff Nurse in Saudi Arabia and a Registered Nurse in South Africa. For the purpose of this study, the definition given by the SA Nursing Act will be used: *A nurse is an individual authorized and capable of practising nursing or midwifery in his/her own right by virtue of registration in terms of section 16 of the South African Nursing Act, 1978 (Act 50 of 1978).* South African nurses working in Saudi Arabia work under their registration from South Africa, as the regulatory body in Saudi Arabia is in its infancy and not as yet fully established.
- **Reflection:** Reflection refers to the act, or an instance of, reflecting; the process of being reflected; an idea arising in the mind (Oxford Dictionary, 1990:1008). A multi faceted definition is more apt for this research study. Reflection operates through a careful re-examination and evaluation of experience, beliefs and knowledge. Reflection most commonly involves looking back or reviewing past actions. Reflection leads to new perspectives (Kember, 2001:28).
- **Support:** Give practical or emotional help to; take an active interest in (Collins Gem English Dictionary, 2003:577).

1.5 PARADIGMATIC PERSPECTIVE

This research is based on the nursing theory of WJ Kotzé, An Anthropological Nursing Science: Nursing Accompaniment Theory (Kotzé, 1998:3).

1.5.1 Metaparadigms

Kotzé (1998:4) states the following:

1.5.1.1 Man/Human Being/Person

Man is a unique multidimensional total being, invisibly body-psyche-spirit, continuously becoming within an inseparable dynamic relationship with world, time, fellow-beings and God (Kotzé, 1998:4). The researcher believes in Judeo-Christian values. All humans are creations of God and have individual needs, namely personal, interpersonal, social and environmental needs. In order to meet these needs, an individual should be approached in a holistic manner. In

the context of this study, man would refer to the registered nurse living in Saudi Arabia.

1.5.1.2 World

World refers to the world in which man exists, consisting of:

- **Objective or external world:** This world includes the world of science and technology, nature, ecology, astronomy and micro-organisms. In this study, the “external world” for the South African registered nurses living in Saudi Arabia will include both the physical and clinical environment and the challenges they may encounter within each.
- **Subjective or life-world:** The subjective world includes the personal world, the interpersonal world of co-existence and the dimension of time in which man exists (Kotzé, 1998:4). There will be focus within this study on the unique and dynamic life world of the South African registered nurses as they strive to deal with, and adapt to, their private personal world, establish new relationships within a multinational community and co-exist in a new country with a unique culture.

1.5.1.3 Health

Health refers to the state of wellness or illness of an individual. It is a dynamic process relating to the degree of ability or inability of a person as body-psyche-spirit to maintain him/herself optimally in relationships (Kotzé, 1998:4). The proposed study is concerned with the health of the South African registered nurse, which refers to him/her functioning on a physical, psychological and social level within Saudi Arabia.

1.5.1.4 Nursing

Nursing is an interpersonal, comprehensive service to man at all stages of life, ill or well, which encompasses a dynamic, systematic process of management, clinical care and teaching, of which accompaniment is inherently part, so as to affect change that would facilitate prevention of illness, disability and suffering, promotion and regaining of wellness, and where this is not possible, would facilitate a peaceful, dignified death (Kotzé, 1998:4). The study will focus on the professional capacity of the South African registered nurses as they endeavour

to nurse in a foreign land and competently render holistic nursing care to the population of Saudi Arabia. The research design and methodology will now be discussed.

1.6 RESEARCH DESIGN AND METHODOLOGY

An overview of the research design and methodology will now be presented. A more detailed discussion will follow in chapter two of this study.

1.6.1 Research Design

Botes (2000:56) states that the research decisions that are made in the design phase deal with the research strategy (overall approach), methods of data collection, methods of data analysis, the target population and methods of sampling, as well as methods of validity and reliability. The research design and method are described according to strategy, models, trustworthiness and strategies of reasoning. In this research study, a qualitative, exploratory, descriptive and contextual design with a phenomenological approach to inquiry will be used, reflecting the experiences of the South African registered nurses living and working in Saudi Arabia.

1.6.2 Research Methodology

The research methodology involves data collection and data analysis and can be divided into two phases.

1.6.2.1 Phase 1 – Exploration And Description Of The Lived Experiences Of South African Registered Nurses Whilst Living And Working In Saudi Arabia

This phase comprises a purposive sampling strategy, data collection activities by means of unstructured phenomenological interviews and the researcher's field notes, data analysis according to the descriptive method of Tesch (1990 cited in Creswell, 2003:192) and literature control. This will be comprehensively discussed in chapter two.

1.6.2.2 Phase 2 – Development Of Orientation Guidelines To Support South African Nurses Working And Living In Saudi Arabia

This phase will entail developing orientation guidelines from the data analysis and interpretation, as well as the literature control. This will serve as a basis of support to South African nurses working and living in Saudi Arabia.

1.7 MEASURES TO ENSURE TRUSTWORTHINESS

Guba's model (cited in Krefting, 1991:214-222) will be used to ensure trustworthiness of the research. Guba (1981 cited in Krefting, 1991:215) identifies four criteria for trustworthiness, namely truth value, applicability, consistency and neutrality. Truth value is ensured by using strategies of credibility, applicability by using strategies of transferability, consistency by using strategies of dependability and neutrality by using strategies of conformability. These strategies will be discussed in chapter two of this study.

1.8 ETHICAL CONSIDERATIONS

The researcher will adhere to the ethical standards as established by the Democratic Nursing Organisation of South Africa (DENOSA) for nursing practice and research during the research process (DENOSA, 1998:2.2.1). The following standards will be utilized as a guide throughout the research study and will be described in detail in chapter two, as applicable to this study:

- The research will be conducted in such a way that the participants will not be exposed to any harm or exploitation.
- The research will be conducted in such a way that will foster justice.
- The researcher will assure the right of self-determination of participants.
- Anonymity, privacy and confidentiality will be respected.
- The researcher will strive to conduct a high quality research, which is beneficial to the participants.

1.9 CHAPTER DIVISION

Chapter 1: Overview of the Study

Chapter 2: Research Design and Methodology

Chapter 3: Discussion of Data Analysis and Literature Control

Chapter 4: Guidelines, Conclusions, Limitations and Recommendations

1.10 CONCLUSION

The researcher is responsible and accountable to truthfully voice the personal and professional experiences of the South African registered nurses whilst living and working in Saudi Arabia. She will endeavour to add new meaning to their experiences by developing orientation guidelines that may be used to assist them when migrating to Saudi Arabia. Chapter two will provide the reader with an in depth description of the research design and methodology.

Bedouin dress



CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

“Presented research is not the final word, nor can the method do everything, but I do believe that something worthwhile will be achieved by means of it”

- Giorgi

2.1 INTRODUCTION

Chapter one presented an overview of the research study. The research problem statement was described and the research objectives defined. This chapter presents a more detailed discussion of the research design and methodology. Data was collected by means of in depth interviews to assist in the actualization of the objectives.

Little research has been done to explore the experiences of the South African registered nurses living and working in the Kingdom of Saudi Arabia. The aim of this study was to provide the registered nurses with an opportunity to relay their experiences and to voice how these experiences have impacted upon their lives. Their experiences have provided the basis for the development of orientation guidelines to support South African registered nurses' migrating to live and work in Saudi Arabia in the future.

2.2 RESEARCH OBJECTIVES

This research study had a primary and a secondary objective.

- The primary objective of this study was to explore and describe the lived experiences of South African nurses related to living and working in Saudi Arabia.
- The secondary objective of this study was to develop orientation guidelines to support South African nurses working and living in Saudi Arabia.

2.3 RESEARCH DESIGN AND METHODOLOGY

An overview of the research design and methodology will follow:

2.3.1 Research Design

In this research study a qualitative, exploratory, descriptive and contextual design with a phenomenological approach has been used, reflecting the experiences of South African registered nurses living and working in Saudi Arabia. The data were interpreted and reported in the following ways:

2.3.1.1 Qualitative Research

In qualitative research more subjective methods are used, as researchers in this field are not interested in casual laws, but in people's perspectives as far as beliefs, experiences and personal meaning systems are concerned. By bringing into the equation the perceptions of the participants themselves, issues are viewed in a way that could not be realized through other techniques (Ritchie, 1999:253). Kirk and Miller (1986:9) describe qualitative research as a particular tradition in social science that essentially depends on watching people in their own territory and interacting in their own language, on their own terms. In this research, the observation was made of South African nurses on foreign territory, namely in Saudi Arabia. Qualitative research requires personal rather than detached engagement in the context. It requires multiple, simultaneous actions and reactions from the human being (the researcher) who is the primary research instrument for data collection and analysis (Meloy, 1994:68).

Qualitative research methods are descriptive and result in rich, thick, complex and holistic descriptions of participants' subjective experiences (Creswell, 1998:15). The researcher has, therefore, used a qualitative approach to create this holistic picture representing the South African registered nurses' "truth" – their description of their life world, according to the way in which they saw and experienced it, whilst living in Saudi Arabia. The researcher based the research on the realities and viewpoints of the participants (which were unknown and, as such, not understood at the onset of the research). The research design typically evolved over the course of the project; this is referred to as an emergent design according to Polit and Hungler (1997:197).

2.3.1.2 Exploratory Research

This type of research is done in a relatively unknown field and the goal is to gain insight and understanding of the problem (Uys & Basson, 1996:38). Exploratory research is conducted in order to satisfy the researcher's curiosity and desire for better understanding, to test the feasibility of undertaking a more extensive study, to develop the methods to be employed in any subsequent study, to explicate the central concepts and constructs of a study, to determine priorities for the future research and to develop new hypotheses about an existing phenomenon (Babbie & Mouton, 2001:80).

By exploring the registered nurses' experiences of living and working in Saudi Arabia, the researcher sought to become familiar and gain insight into understanding these experiences. This allowed for the development of the orientation guidelines specific to supporting South African registered nurses' migrating to Saudi Arabia in the future.

2.3.1.3 Descriptive Research

Polit and Hungler (1997:456) describe a descriptive study as a research that accurately portrays the characteristics of persons, situations, or groups, and/or the occurrence frequency of certain phenomena, as its main objective. It is also described by Uys and Basson (1996:28) as the methodological collection of accurate data on the domain phenomenon to be studied. The purpose is to explore and describe phenomena in real life situations (Burns & Grove, 1997:28). Accordingly, the researcher utilized this approach to describe the experiences of registered nurses living and working in Saudi Arabia. The data gathered from the participants assisted the researcher to obtain complete and accurate information for the research study. The interview method, usually used in descriptive research, was the method of choice for this research.

2.3.1.4 Contextual Research

Contextual research involves the immediate environment and physical location of the people being studied (Holloway & Wheeler, 1998:192). Context also refers to the cultural and historical situation, which is important for an understanding of the phenomenon and the meaning that the participants give to

it. In order to describe and understand events within the concrete, natural context in which they occur, Babbie and Mouton (2001:272) explain that it is necessary to understand them against the background of the whole context as this (context) confers meaning to them, and one can then truly claim to “understand” the events. The researcher should not only understand the context in which the participants act, but should be aware of, and take into account, their own location in time, space and culture.

This research study was contextual in nature as the participants were interviewed within the physical environment and cultural context in which they were currently living and working, namely the Kingdom of Saudi Arabia.

2.3.1.5 Phenomenological Approach

The purpose of this approach is to describe what people experience in regard to some phenomena, how they interpret it and the meaning these lived experiences hold for them (Brink, 1996:119). This approach examines the human experiences through the description provided by the people involved, and these experiences are referred to as *lived experiences*. In this research, the focus was on the lived experiences, professionally and personally, of South African registered nurses living and working in Saudi Arabia. In attempting to describe these lived experiences, the researcher focused on what was happening in the lives of the participants, what was important about the experiences and what was learned from them. This approach led to the development of concepts and themes that ultimately assisted in the development of the orientation guidelines to support nurses migrating to Saudi Arabia in the future.

The success of this research was, therefore, dependant on having a phenomenological approach throughout the study. Through this approach the researcher endeavoured to bring the 'human side' of the participants to the fore. The research methodology will now be discussed.

2.3.2 Research Methodology

The research methodology involves data collection and data analysis and can be divided into two phases. Phase 1 involved the exploration and description of the lived experiences of the South African registered nurses whilst living and working in Saudi Arabia. This phase comprised the sampling strategy, data collection activities, data collection method, data analysis and literature control. Each of these processes will now be discussed.

2.3.2.1 Sampling Strategy

Criterion based, purposive sampling was used in the recruitment and preparation of research participants. For the in depth interviews, participants were selected so as to maximize the richness of information obtained pertinent to the research question. The sample was, therefore, purposive and not random.

Brink (1996:141) and Polit and Hungler (1997:237) describe purposeful sampling as a sampling method that is based on the researcher's judgment about subjects that are typical or representative of the phenomenon under study in cases where the researcher is especially knowledgeable about the problem being studied. The researcher, in such a case, intentionally selects the participants she wishes to participate. The advantage of purposeful sampling is that it allows the researcher to select the sample on the basis of his or her knowledge of the phenomenon being studied.

The researcher drew a purposive sample from the available registered nurses that met the research population criteria. Criterion sampling was successful, as all the individuals studied represented people who had experienced the phenomenon being studied. This is an element critical to phenomenological studies (Creswell, 1998:119). Possible sampling bias was identified as a potential disadvantage of this sampling method. In order to participate in this study participants had to meet specific criteria, which included:

- Being registered nurses.
- Being English or Afrikaans speaking, as these are the languages understood by the researcher, the participants and the independent coder.

- Being representative of different gender groups.
- Being representative of the different cultural groups according to a South African cultural profile.
- Having current registration with the South African Nursing Council.
- Having resided in Saudi Arabia for a period of 3 – 6 months.
- Indicating their marital status – single, married or divorced.

2.3.2.2 Data Collection Activities

Polit and Hungler (1997: 455) define data gathering as the gathering of that information which is needed to address the research problem. The data gathering process is a process of gathering that information that will tell us more than we usually know.

There are various existing traditions, each of which has their own data collection activities. The phenomenological tradition was used in this research study. Table 2.1 outlines the data collection activities, procedures and approaches that are used in a phenomenological tradition. In the third column the researcher indicated how this phenomenological tradition was applicable in this research.

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Table 2.1 Data Collection Activities

DATA COLLECTION ACTIVITY	PHENOMENOLOGICAL TRADITION	APPLICATION TO RESEARCH TOPIC
Who was being studied?	Multiple individuals who have experienced the phenomenon.	South African registered nurses living and working in Saudi Arabia were the focus of the study.
What were the access issues?	Locating individuals who had experienced the phenomenon.	<p>Access was limited to registered nurses living and working in one hospital in Riyadh, Saudi Arabia.</p> <p>Due to the in depth nature of the interview it was convenient for the researcher to interview registered nurses who were easily accessible.</p> <p>Written permission was obtained from the South African registered nurses who were willing to share their experiences.</p>
How were the sites or individuals selected for the study? (Purposeful sampling strategies)	Locating individuals who had experienced the phenomenon, a criterion sample.	<p>Criterion sampling was most successful as all individuals participating represented the people who had experienced the phenomenon – thus only the registered nurses living and working in Saudi Arabia who met the specific sample criteria were interviewed.</p> <p>Specific sample criteria were formulated (refer 2.3.2.1 – sampling strategy).</p>
What type of information was typically collected?	Interviews were conducted and data saturation determined the sample size.	The researcher gathered data until saturation had occurred, that is when duplication of data occurred and new data no longer sparked new insights related to the South African registered nurses' experiences.

DATA COLLECTION ACTIVITY	PHENOMENOLOGICAL TRADITION	APPLICATION TO RESEARCH TOPIC
How was information obtained and recorded?	<p>Well-described interview protocol.</p> <p>The goal was to obtain information and understanding of issues relevant to the general aims and specific questions of the research project.</p>	<p>The process of information collection involved primarily in depth interviews to ensure that the experiences of a small group of individuals, that is South African registered nurses, was described.</p> <p>Each interview was not longer than one hour.</p> <p>Each interview was audio taped and transcribed verbatim.</p> <p>The researcher made field notes following every interview so as to keep a detailed record of what occurred during the interview.</p>
What were the common data collection issues?	<p>Bracketing one's experience.</p> <p>Creswell (1998:235) states that bracketing is the first step in phenomenological reduction, the process of data analysis in which the researcher sets aside, as far as humanly possible, all preconceived experiences to best understand the participants in the study.</p>	<p>The role of the researcher as a person was magnified in the interview process, because the interviewer herself was the main instrument in obtaining knowledge.</p> <p>The researcher laid aside any personal knowledge and experience regarding living and working in Saudi Arabia.</p> <p>This was done to avoid any misinterpretations regarding this phenomenon as it was experienced by the South African registered nurses.</p>
How was data analyzed? How information was typically stored?	<p>Transcriptions and computer files.</p>	<p>The researcher made use of Tesch's data analysis method (cited in Creswell, 1994:155).</p> <p>A computer was used as an aid to the study.</p>

Adapted from Creswell (1998:112)

2.3.2.3 Data Collection Method

The researcher made use of unstructured phenomenological in depth interviews as the main method of data collection. An interview is a particular field research data gathering process designed to generate narratives that focus on specific research questions. It is personal and intimate, with the emphasis on depth, detail, vividness (intensity) and nuance (subtle difference in meaning) (Crabtree & Miller, 1999:93).

An in depth interview can be defined as one or more face-to-face interactions between an interviewer and interviewee, where the purpose is to understand the interviewee's life experience or situations, as expressed in his/her own words (De Vos, 1998:298). The researcher utilized such interviews to gain insight into the experiential worlds of the South African registered nurses who met the criteria stipulated for the research population.

The researcher used open, direct and verbal questions to elicit the experiences and gain information from the selected research participants. The researcher posed a series of predetermined question(s) to each participant in a systematic manner. The participants were given the opportunity to discuss issues beyond the confines of the question(s). The researcher made use of these types of questions to gain information specifically relating to the South African registered nurses' perspectives on living and working in Saudi Arabia.

The following general opening question was posed to the participants:

"What are your experiences with regard to living and working in Saudi Arabia?"

The sub-question was:

"How can a registered nurse be assisted to function effectively in Saudi Arabia?"

As mentioned previously, data were collected by means of phenomenological in-depth interviews. The researcher took cognizance of her defined role in order to ensure that high quality interviews were conducted. The role of the researcher will now be discussed.

2.3.2.4 The Role Of The Researcher

The use of self as a primary instrument for gathering and analyzing data was an important factor in the process of this qualitative research study and implies an openness on the part of the researcher with regard to examining new ideas (Burns & Grove, 1997:80) and listening to participants' stories of living and working in Saudi Arabia from a position of not knowing. Accordingly, the researcher assumed a "non-expert position" in terms of the research phenomenon and strove to be sensitive regarding encouraging participants to share their own knowledge and maximizing opportunities for collecting and producing meaningful information during the data collection and analysis process.

This meant that the researcher utilized bracketing (Burns & Grove cited in de Vos, 1998:337) by placing her knowledge and preconceived ideas about the phenomenon between brackets and focusing her awareness and energy on the experiences of participants and the research process (intuiting). Bracketing implies that she willingly laid aside what was known about the experience being studied to achieve an open context and to facilitate "seeing" all facets of the phenomenon. Intuiting is the process of actually "looking at" the phenomenon and developing insight into it. It requires concentration and complete absorption of the experience being studied (De Vos, 1998:337). In order to achieve meaningful bracketing and intuiting, continual self-evaluation was a prerequisite for the researcher in an attempt to avoid bias relating to preconceived ideas and notions.

The way in which the participants viewed the researcher was of cardinal importance. Had they viewed her as a stranger or intruder, the outcome of the study could have been affected. Consequently, the researcher needed to be sensitive with regard to the physical setting, the participants, their behaviour and conversation, as well as the information being gathered. This implies the creation of an atmosphere that encouraged freedom of expression by portraying a non-judgmental and respectful attitude based on the notion that all participants had dignity and equal worth. According to Burns and Grove (1997:428), the quality of the data collected depends on the quality of the

interviews and observation. Establishing rapport, of which empathy and trust were the foundation, was essential in collecting quality data.

The researcher needed sound communication skills to ensure high quality interviews. Communication skills used will now be discussed.

2.3.2.5 Communication Skills

Without communication there can be no interview. In order to encourage the participants to articulate their experiences freely, the researcher used non-directive communication techniques that included:

- **Probing:** This technique refers to the interviewer's ability to identify and explore experiences, behaviours and feelings that should assist the participant to engage more constructively in the other steps of communication (Okun, 1992:70). Accordingly, the researcher (as the interviewer) pursued the given answers and probed in a non-threatening and reassuring way to obtain more information. Examples of questions and/or statements that were used include *"How did that make you feel?"*, *"Would you elaborate on that?"* or *"Tell me more"*.
- **Paraphrasing:** Paraphrasing involved listening to the participants' basic message and then restating those thoughts or feelings in different words. The degree of interpretation could have involved merely rephrasing an answer, for example the participant could have been asked, *"You mean that..."* or it might have involved attempts at clarification, *"Is it correct that you feel that..."* (compare Kvale, 1996:135).
- **Summarizing:** In summarizing at the end of the interview the researcher synthesized what had been communicated, which means that she tied together the different views and feelings into one single statement by focusing on essential cognitive and affective themes that had emerged. This both enhanced the feeling of progress in communication and created a sense of movement in exploring ideas and findings (compare Okun, 1992:25).
- **Silence:** Silence can further an interview. The researcher used silences and pauses during the conversation, which allowed the participants time to express emotions, to reflect on issues and then to break the silence

themselves with significant information (compare Kvale, 1996:134). Silence was also used to slow down the pace of the interview.

- **Clarifying:** Clarifying is an attempt to focus on or understand the basic nature of the participant's statement if the response is unclear, vague or confusing. The researcher asked for clarification when both she and the participant could not make sense of a communicated message and, by so doing, prompted mutual understanding (compare Brammer, Shostrom & Abrego, 1989:71).
- **Reflecting:** The researcher used reflecting by repeating what the participant had said in order to clarify the latter's ideas and validate that the understanding of the researcher corresponded with that of the participant (compare Kaplan *et al*, 1994).
- **Responsive listening:** The researcher employed responsive listening to attend to verbal and non-verbal messages of the participants (for example eye contact, body language, gestures and posture) and the apparent and underlying thoughts and feelings of the participants. This implied genuine understanding (empathy), acceptance and concern and was essential in establishing rapport (compare Okun, 2002:81).
- **Minimal verbal responses:** The researcher adopted a less active role, allowing more time for the participant to talk. Minimal verbal response indicated that the researcher was listening to the participant and following what was being said. The interviewer made use of gestures like head nodding and/or verbal cues such as "*mmm*", "*uhh*" and "*I see*" (compare Stuart & Sundeen, 1991:122).

Lastly, the researcher demonstrated skills in analyzing and interpreting the vast amount of data that were gathered (verbatim transcripts and audio tapes from interviews, field notes and consensus conversations with experts). This was collected in such a way that sense was made of the lived experiences of the participants. The researcher agrees with Yin (1994:103) that the *ultimate goal of a researcher is to treat the evidence fairly and to produce compelling analytical conclusions*.

The researcher values research ethics and acknowledges that these are about acquiring and disseminating trustworthy information in ways that cause no harm to the participants. Ethical considerations will be discussed in section 2.5. The actual interview process will now be discussed.

2.3.2.6 The Interviews

The pre-interview (planning), the actual interview (implementation) and post-interview (evaluation) as part of data collection will be discussed.

A Pre-Interview (Planning)

Planning was a vital part of the interviewing process. Crabtree and Miller (1999:99) call it *staging the scene*. Staging the scene included setting the scene, learning the part, equipment checking and the pilot interview. Each of these sections will be discussed.

- **Setting the scene**

According to Crabtree and Miller (1999:100), setting the scene includes the initial pre-interview contact to set up the interview. The ensuing steps were followed:

- The researcher made contact with each potential participant individually.
- The researcher explained the objectives of the research and invited the participant to participate.
- The researcher obtained consent from the participants before any interviews were conducted to ensure protection from any harm (see annexure C).
- The researcher interviewed the participants in their off duty time at an agreed date, time and venue (either the participant's apartment or the researcher's office was utilized).
- Disturbances were kept to a minimum by placing a "Do not disturb" sign on the door and taking the telephone off the hook.
- The researcher informed the participants about the use of an audio tape recorder and note taking, and explained the rationale for their utilization.
- The researcher notified each participant of the length of the interview and reassured him/her that confidentiality and anonymity would be maintained.

- **Learning the part**

This refers to knowing as much as possible about the local setting and the participants' themselves.

- The researcher, who had lived and worked in the same setting as the participants for three and a half years, was familiar with the context.
- The researcher, being a South African, was familiar with the different cultures of the participants, namely Xhosa, Coloured, European-English and Afrikaans cultures.

- **Equipment checking**

Prior to the interview the researcher ensured that:

- The environment was conducive for conducting the interview, namely clean, quiet, private, a comfortable temperature and non-threatening.
- The tape recorder was in working order and extra batteries, blank tapes and a back up tape recorder were available. According to Depoy and Gitlin (1998:227), it is important when using an audio tape to test the equipment to make certain that it will record both the researcher's and the participant's voices adequately.

It was essential that the researcher planned for every contingency to avoid the risk of losing data and ensure a quality interview (Depoy & Gitlin 1998:227). Hence, a pilot interview was conducted as one of the contingency measures.

Pilot Interview

The researcher conducted a pilot interview in order to assess whether the sequence and wording of the questions posed were understandable to the interviewees and within the framework of a phenomenological approach to enquiry. Conducting a pilot interview enabled the researcher to assess whether the research questions generated the desired effect. It also served as an assessment tool for the interviewer with regard to the technique of interviewing. Furthermore, Crabtree and Miller (1999:98) state that once the main question/s are asked, the interviewer must be prepared to keep the story flowing and maintain narrative competence.

The Interview (Implementation)

The interview was conducted after staging the scene. As discussed in 2.3.2.6, the interview process required the researcher to take cognizance of the interviewer's role and attitude. Throughout the interview the researcher incorporated the following aspects:

- The researcher put the interviewee at ease by merely chatting generally to “break the ice” and reinforcing the ethical considerations, namely the right to confidentiality and anonymity.
- The researcher did her best to display these communication skills and attitudes so as to ensure that the participants shared information freely and openly.
- The researcher was sensitive to any changes in the type of communication, especially during the deep stages where the participants tended to reveal information that evoked emotion, for example if the participant started to cry the researcher allowed the time needed for him/her to regain composure (called *toning down*).
- The researcher remained alert and evaluated the content of the ongoing conversation continuously and used bracketing to avoid any misinterpretation and bias.
- In the closing stage of the interview, the researcher summarized the areas covered in the interview and clarified any misunderstandings or questions that the interviewee may have had (compare Crabtree and Miller, 1991:101 - 105).

Post-Interview (Evaluation)

Once the official interview had ended, the researcher turned the tape recorder off and engaged in “small talk” for 5 – 15 minutes. This time served to assess:

- How the interviewee felt about the interview.
- Whether the interviewee needed referral for a debriefing or counselling session, as this was possibly the first time that he/she had conceptualized his/her experiences. Verbalizing their experiences could have been traumatic, especially if the experiences were negative.

The researcher thanked the interviewee for his/her participation and valuable contribution to this study (Crabtree and Miller, 1991:105).

In this research study, the researcher kept field notes. The types of notes and rationale for their use will now be discussed.

2.3.2.7 Field Notes

Keeping extensive field notes of observations and other forms of data collection was of cardinal importance in order to capture the context of observations. Wilson (1998:434) states that a researcher needs a system for remembering observations that are made, and for retrieving and analyzing it. Field notes kept included the following:

- **Observational notes:** Observation and interviews go hand in hand (Parahoo, 1997:331) as this allows for a more complete understanding of what is being studied. The observational notes contained the *'who'*, *'what'*, *'when'*, *'where'* and *'how'* of human activity experienced through watching and listening (compare Wilson, 1989:434). Thus, observational notes presented an account of what happened during the contact sessions with little or no interpretation (compare De Vos, 1998:258).
- **Theoretical notes:** Theoretical notes are described by De Vos (1998:259) as *self-conscious, systematic attempts by the researcher to derive meaning from some or all observational notes*. The researcher attempted to identify patterns or themes that were found repeatedly in the course of the research by interpreting, inferring and hypothesizing, as well as through developing new concepts and linking these to older ones or relating observations to any other observations (compare De Vos, 1998:259).
- **Methodological notes:** The researcher kept these as instructions to herself, for critique of her own tactics and reminders about methodological approaches that might improve the interview situation in terms of the proposed research design and method (compare Wilson, 1989:434).
- **Personal notes:** Creswell (1994:152) describes personal/reflective notes as the researcher's own reactions, reflections and experiences. The researcher displayed openness to self-evaluation by displaying a reflexive stance. Being reflexive implied that the researcher acknowledged her own inner dialogue

and attempted to focus on her own judgments and feelings regarding the research phenomenon and process (compare Wilson, 1989:434). These notes were used to provide further insight into the living and working experiences of the South African registered nurses in Saudi Arabia.

- **Personal journals:** Polit and Hungler (1997:254-256) describe the use of personal journals as a type of unstructured self-report where participants are asked to maintain a log concerning some aspect of their lives over a specified period of time. The researcher asked each participant to keep a personal journal for ten days after the interview. A journal, being more personal, may have revealed aspects of their experiences in Saudi Arabia that were not captured during the interview. Information from the personal journals was integrated when final themes were identified.

2.3.2.8 Analysis Of Data

The recorded interviews were transcribed and then analyzed together with the field notes and reflective journals. The researcher attempted to capture the essence of the recorded accounts of the participants during the data analysis. Data were analyzed according to the descriptive method of Tesch (cited in Creswell, 1994:155) to reduce the data into themes or categories. Tesch's approach proposes eight steps to engage a researcher in a systematic process of analyzing all qualitative data that is generated:

- i) To get a sense of the storyline, the researcher reads through all the transcriptions carefully. Ideas that come to mind may be jotted down.
- ii) The researcher selects one interview – the most interesting and shortest. Ask yourself, "What is this about?" Focus on the underlying meaning of the text and write down your thoughts in the margin. This process will be followed with all data generated.
- iii) The researcher will formulate a list of all themes, clustering similar topics together. These themes are formed into columns, namely central themes, unique themes and leftover themes, and imply making comparisons and contrasts.
- iv) The researcher takes this list and revisits the data that were collected, based on reduction of the total list of themes by grouping inter-related

themes together, thus following a process of comparison and contrasting themes with each other and the whole.

- v) The researcher finds the most descriptive wording for each topic and turns it into categories and sub-categories. Coding refers to the process whereby data will be divided into smaller parts, conceptualized and then synthesized in a new way (De Vos, 1998:271). Coding is the researcher's most common method of organizing field notes. Pre-conceived ideas or pre-coded protocols will not be used. Instead, codes will be developed as part of 'making sense' of the South African registered nurse's world, as described in the interview.
- vi) A final decision will be made about the abbreviation for each category, and then the codes will be alphabetized.
- vii) A preliminary analysis will be performed after assembling the data that belongs to each category.
- viii) Existing data will be recoded if necessary.

Once the researcher had coded the data and developed themes, a clean set of the transcribed interviews was handed over to an independent coder experienced in the field of qualitative research. The independent coder was asked to assist with the identification of the themes. On completion, the researcher and independent coder communicated via email to discuss themes and categories so that consensus was reached. Both the researcher and the independent coder agreed that data saturation had been achieved and that there was no need for further interviews to be conducted.

These categories, themes and sub-categories portrayed the storyline in a meaningful, descriptive way.

2.3.2.9 Literature Control

The literature control was conducted after the themes had been developed through data analysis. The findings of this study were combined with existing literature to determine current knowledge of the phenomenon (Burns & Grove, 1993:706). The literature control provided a framework as well as a benchmark for comparing and contrasting results (or themes or categories) of this research

with other findings (Creswell, 1994:23). If no specific literature was found to support statements, the researcher highlighted this during the discussion of results.

2.3.2.10 Phase 2

Phase 2 entailed developing orientation guidelines for support from the data analysis and literature control. These will serve as a basis of support for South African nurses, present and future, who are planning to migrate to Saudi Arabia.

2.4 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is described by Polit and Hungler (1997:470) as *a term used in the evaluation of qualitative data, assessed via criteria of credibility, transferability, dependability and confirmability*. Guba's model (cited in Krefting, 1991:214) was utilized to ensure trustworthiness of this research study. Guba's model is based on the identification of four aspects of trustworthiness, namely:

2.4.1 Truth Value

Truth value is based on the criterion of *credibility*. This refers to the findings of the research study being based on the discovery of human experience as it was experienced and observed by the informants (participants). It was not tampered with in any way by the researcher. Strategies to ensure credibility included authority of researcher, field experiences, interviewing technique, member checking, peer examination, reflexivity and structural coherence (Krefting, 1991:215). The researcher's attempt to establish the credibility of this research by applying these strategies is set out in table 2.2.

2.4.2 Applicability

This describes the extent to which findings could be implemented in different contexts with other groups. *Transferability* is the criterion against which applicability is assessed. It refers to how similar the findings of the research study would be in contexts outside that of the original study. The purpose of this research study, as with other qualitative studies, was not to generalise findings, but rather to gain in-depth understanding of the research phenomenon. The

researcher, thus, attempted to enhance the possibility of transferability by providing a comprehensive description that served as a base of knowledge. Nominated sample and dense description were strategies used to ensure applicability in this study, as set out in table 2.2 (compare Krefting, 1991:216).

2.4.3 Consistency

Consistency means that if conditions and subjects were identical, the findings would stay the same. In qualitative research the participants, the researcher and the specific circumstances of the study can vary greatly within the research. It is, therefore, acknowledged that it is difficult to expect consistency in results if a study is replicated even if the same subjects or similar contexts were used. The criterion for consistency is *dependability*, which refers to the researcher attempting to account for the changing conditions to the chosen research phenomenon and the changes in design. Strategies used by the researcher in this study to ensure dependability were dependability audit, dense description of research methods, triangulation, peer examination and code-recode procedure (compare Krefting, 1991:217). The application of these strategies is set out in table 2.2.

2.4.4 Neutrality

This means that no prejudice is evident in the research procedure and research results. *Confirmability* is the criterion against which neutrality is measured. This refers to whether the results attained from the research can be confirmed by another. It places the evaluation on the data. Strategies used by the researcher in this study to ensure neutrality were confirmability audit, triangulation and reflexivity (compare Krefting, 1991:217). The application of these strategies is set out in table 2.2.

CRITERIA TO ENSURE TRUST-WORTHINESS	STRATEGY	CRITERIA	APPLICABILITY
		<p>Peer examination</p> <p>Interviewing techniques</p>	<p>analyzed the data.</p> <p>Participants interviewed were from various cultures and of different ages and both genders (see inclusion criteria).</p> <p>Two supervisors, both experienced in qualitative research, were used to decrease any form of bias.</p> <p>Literature control was done through the use of recent journals, newspaper articles, internet searches, etc.</p> <p>Discussions were held with impartial nursing colleagues who have experienced living and working in Saudi Arabia.</p> <p>Experts in qualitative methodology did independent checking of data. Consensus was reached between the researcher and independent coder.</p> <p>In depth interviews with a phenomenological approach were conducted. The same questions (open-ended) were asked to all the participants to determine logical rationale was present.</p> <p>The researcher followed all the steps in conducting in depth interviews to the best of her ability.</p>

CRITERIA TO ENSURE TRUST-WORTHINESS	STRATEGY	CRITERIA	APPLICABILITY
		<p>Structural coherence</p> <p>Authority of the researcher</p>	<p>Communication skills - verbal and nonverbal - were used to encourage participants to talk freely.</p> <p>A pilot interview was conducted to enhance interviewing skills.</p> <p>The participants' experiences of living and working in Saudi Arabia were the main focus of the research study.</p> <p>The researcher, supervisor and co-supervisor ensured that there were no inconsistencies between the data and the interpretation thereof.</p> <p>The researcher, having lived for three and a half years in the field, was familiar with the phenomenon being studied.</p> <p>Supervisors with extensive experience in conducting qualitative research guided the researcher.</p>
Applicability	Transferability	<p>Nominated sample</p> <p>Dense description</p>	<p>A purposive criterion-based sample was drawn from the available participants.</p> <p>A complete description of research method and design, including literature control, was given to maintain clarity.</p> <p>The dense description has been written in such a way that another researcher will be</p>

CRITERIA TO ENSURE TRUST-WORTHINESS	STRATEGY	CRITERIA	APPLICABILITY
			able to follow the proceedings of the study.
Consistency	Dependability	Dense description Triangulation Peer examination	The research design and methodology has been fully described (as discussed above). The combinations of transcribed interviews, personal journals and researcher's notes were used in data collection (as discussed above). Independent checking by experienced colleagues in the field of research was done (as discussed above).
Neutrality	Confirmability	Confirmability audit Triangulation and reflexivity	An independent coder was utilized in the analysis of the data. Data were collected and analyzed by means of transcribed interviews, personal journals and the researcher's field notes (as discussed above).

The table above was adapted from Krefting (1991:214).

2.5 ETHICAL CONSIDERATIONS

*What danger is the pilgrim in,
How many is his foes,
How many are the ways to sin,
No living mortal knows.
- Bunyan*

As a researcher, one has serious ethical obligations with regard to people whom you encourage to talk openly and frankly to you. Accordingly, the question of interest pertains to how the researcher could reassure the participants that the processes of gathering and analysing data would not harm them. It follows that there was a need to produce scientifically valid results using ethically acceptable methods of data collection and analysis.

The researcher believes that she achieved this by using the most appropriate research method, selecting data collection methods that would intrude as little as possible upon the lives of the participants, performing rigorous data collection and analysing procedures and taking responsibility for the appropriate dissemination of results. For the purpose of this research, the ethical standards established by the Democratic Nursing Organisation of South Africa (DENOSA) for nursing practice and research (DENOSA, 1998:2.2.1- 2.3.4), were adhered to in order to ensure ethical conduct during all stages of the research process (planning, implementation, evaluation and reporting). The following standards were utilized as a guide throughout the research study.

2.5.1 The Research Was Conducted In A Way That Did Not Expose The Participants To Any Harm Or Exploitation

The researcher made every effort to protect participants from physical, emotional, spiritual and social harm. The researcher made arrangements for counselling sessions for the participants should the need have arisen (DENOSA, 1998:2.2.2).

2.5.2 The Research Was Conducted In A Way That Fostered Justice

Research strategies and procedures should be fair and just. Each participant has the right to fair and equitable treatment before, during and after their participation in the study. Fair treatment in this study incorporated:

- The fair and non-discriminatory selection of participants.
- No victimisation of a participant who refused to participate in the research, or who withdrew at any stage of the research process.
- The honouring of agreements made between the researcher and the participant, as indicated on the consent form.
- Available individual support should a participant have needed debriefing after any data collecting process.
- Participants could access the researcher to clarify any point in the study (compare DENOSA, 1998:2.2.2).

2.5.3 The Researcher Assured The Right Of Self-Determination Of Participants

This meant that the individuals had the right to decide voluntarily whether or not to participate in the study. They also had the right to withdraw at any time. The participants signed an informed consent form (see Annexure C) that included the following:

- The title of the research.
- The objectives of the research.
- Research methods and procedures to be followed.
- The type of participation required of the participants.
- How the results would be utilised.
- How the participants could contact the researcher should they have had any queries.

The researcher informed the participants that she intended to publish the results of the study (compare DENOSA, 1998:2.2.3).

2.5.4 The Researcher Ensured That Anonymity, Privacy And Confidentiality Were Respected

- **Anonymity:** Participants were nameless in relation to the research information. No names were available to anyone beyond the immediate research team.
- **Privacy:** Private information in this research included attitudes, beliefs, behaviours and opinions.
- **Confidentiality:** The researcher protected all data gathered within the scope of the study from being divulged or made available to any other person beyond the immediate team (compare Brink, 1996:39; DENOSA, 1998:2.2.3).

2.5.5 The Researcher Made Every Effort To Conduct A High Quality Research, Which Would Be Beneficial To The Participants

The researcher, supervisor, co-supervisor and independent coder involved in this research had the ability (knowledge, skills and attitude) to execute the research process.

The researcher adhered to the principles of planning, implementing, evaluating and reporting in this research study. Throughout the whole process, she endeavoured to demonstrate integrity. Trustworthiness of the research process and results were achieved by complying with Guba's model of trustworthiness (Guba & Lincoln cited in Krefting, 1991:214). Thorough and complete documentation was kept throughout the research process. The researcher aimed to produce research that was meaningful and of value to the nursing profession (compare DENOSA, 1998: 2.3.3).

2.6 CONCLUSION

The research design and methodology followed in order to discover the South African registered nurses' experiences whilst living and working in Saudi Arabia have been comprehensively discussed in this chapter. Data collection by means of unstructured phenomenological interviews and researcher field

notes, as well as data analysis according to the descriptive analysis of Tesch (1990 cited in Creswell, 1994:155), were described. Measures relating to trustworthiness and ethical considerations were discussed, including their application throughout this study.

In chapter three, data analysis will be discussed further, including the creation of themes. A literature control was implemented to compare findings from data collected with existing data in the literature. This will see the completion of Phase One of this research study.

Map of Saudi Arabia



CHAPTER 3

DISCUSSION OF DATA ANALYSIS AND LITERATURE CONTROL

“A lived experience does not confront me as something perceived represented; it is not given to me, but the reality of lived experience is there-for-me because I have reflexive awareness of it, because I possess it immediately as belonging to me in some sense.”

Max van Manen

3.1 INTRODUCTION

“At a little after four-thirty in the morning I am awakened by a distant sound. From beyond my window I hear the resonating voice of the Imam, calling the faithful to prayer. As I lie within the comfort and safety of my room, my mind drifts to the streets that surround my compound walls. It is out there, where the inhabitants of another world stir as another day begins. It is a world far removed from the one I have known. I am living in a foreign country-Saudi Arabia.”

Lynn Priestly (2000:18)

In chapter two, a full description was given of the research design and method. In this chapter, the discussion will revolve around the results from the phenomenological, in depth, unstructured interviews. The results presented will be based on the emergent themes and sub-themes identified from the collected data. The discussion will be presented as a narrative and supported by colloquial quotations from the participants.

3.2 OPERATIONALISING OF DATA ANALYSIS AND LITERATURE CONTROL

The operationalising of data analysis and the implementation of the literature control will now be discussed.

Interviews

Eleven in depth interviews, each lasting between 45 – 60 minutes, were conducted. Data saturation was reached when no further new themes emerged.

The eleven participants interviewed all met the inclusion criteria; accordingly, they:

- Were registered nurses who completed their basic training in South Africa.
- Were currently registered with the South African Nursing Council (SANC).
- Were English or Afrikaans speaking, as these are the languages understood by the researcher, the participants and the independent coder.
- Were representative of different gender groups (one was a male and the remaining ten were females).
- Were representative of the different cultural groups according to a South African cultural profile (five were Coloureds, two were Xhosa, two were White, one was Zulu and one was Ndebele).
- Were married, divorced, widowed or single.
- Were all of the Christian faith.
- Were aged between 25 – 54 years.
- Had all been living and working in Saudi Arabia for a period of 3 – 6 months at the time of the interview.

The pilot interview was included for data analysis. Interviews were carried out according to the format presented in chapter two. Interviewees were pleased to participate and have an opportunity to share their experiences, as well as make suggestions that could be useful to registered nurses coming to Saudi Arabia in the future.

The King Faisal Specialist Hospital and Research Centre (KFSH&RC) is a 661-bed, tertiary care facility. It serves as a referral centre for the region, caring for patients from all over the Kingdom of Saudi Arabia and the Middle East. KFSH&RC offers the healthcare professional an opportunity to provide services to a clinically demanding population. The United States of America (USA) nursing model is used. This was initially chosen because of the affiliation KFSH&RC has with the USA. The nursing skills and standards of the USA have become the yardstick against which this multinational nursing community has been historically measured (Davis, 1992:36).

There are 1942 nursing staff members in total. A colleague once referred to KFSH&RC as a mini United Nations because of the enormous cultural diversity of the staff members (31 nationalities are represented in nursing). Participants in this study were all employed by KFSH&RC and worked in departments throughout the hospital. KFSH&RC comprises thirty-three inpatient units with a bed occupancy rate of 88%. The out patient environment at KFSH&RC spans a wide range of clinical specialties and provides access to sophisticated and technically advanced equipment for procedures, investigations and therapy. Approximately 1600 outpatients are seen at the hospital during an average workday. The emergency services account for approximately another 120 patients daily.

Independent Coder

An independent coder was appointed to assist with identifying and ensuring trustworthiness of the themes relating to the experiences of the South African registered nurses' living and working in Saudi Arabia. The independent coder had also completed a Masters Degree programme and had an understanding of the qualitative research process. After discussions with the coder, supervisor and co-supervisor it was confirmed that data saturation had been reached. Consensus on themes was reached via email as formal discussions could not be held due to the researcher living in Saudi Arabia. Emergent themes identified clearly expressed the storyline as told by the registered nurses.

Literature Control

The broad aim of any literature review is to synthesize the critical evaluation of existing work on a topic (Crookes & Davies, 2004:145). The researcher conducted a literature review in order to:

- Outline what was known about the topic.
- Verify if identified themes had been previously documented.
- Identify the context in which the topic was being explored.

Accessing appropriate literature from internet searches, journals, articles, textbooks and the newspapers presented a challenge due to the dearth of available information on the research topic.

3.3 IDENTIFIED THEMES

Throughout literature, “theme” refers to an element (motif, formula or device) that occurs frequently in the text. It is a form of capturing the phenomenon one tries to understand (Van Mannen, 1990:78, 87). A theme can, furthermore, be described as a statement of meaning that either runs through all or most of the pertinent data, or one that is in the minority which carries heavy or emotional impact (Ely, Anzul, Friedman, Garner & McCormak Steinmetz, 1991:150).

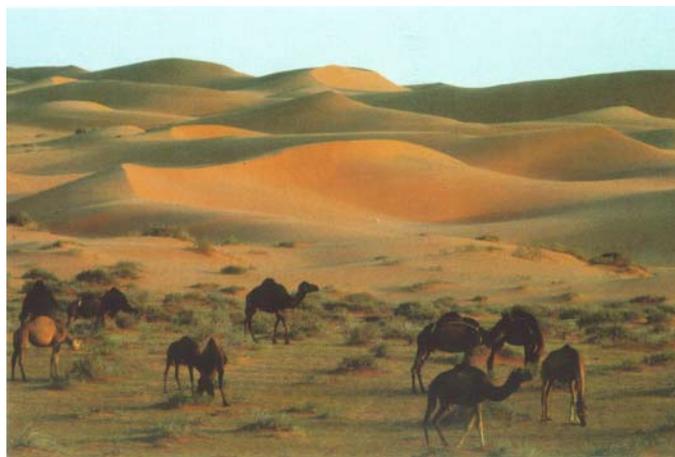
Van Mannen (1990:79) states that phenomenological themes may be understood as the *structures of experience* and are the process of insightful invention (my interpretive product), discovery (the interpretive product of my dialogue with the text of life) and disclosure of meaning (the interpretive product “given” to me by the text of life itself).

A central theme of ‘Cultural Diversity’ was clearly identified from all the interviews. Several sub-themes were associated with this central theme. The central themes and sub-themes that emerged from this study are set out in Table 3.1.

Modern day Riyadh



Typical desert scene in Riyadh



Typical Saudi Arabian Bedouin



Table 3.1: Identified Themes Related To The Experiences Of The South African Registered Nurses Living And Working In Saudi Arabia

CENTRAL THEME	SUB- THEMES	
<p>3.4.1 Cultural diversity encountered in all aspects of the registered nurses' lives while living and working in Saudi Arabia.</p>	<p>3.4.1.1 Sub-theme 1</p>	<p>Participants' religious/spiritual adaptation:</p> <ul style="list-style-type: none"> • Adaptation and experiences regarding religious intolerance. • Adaptation and experiences regarding the practice of Ramadan. • Adaptation and experiences regarding prayer times. • Personal religious experiences.
	<p>3.4.1.2 Sub-theme 2</p>	<p>Participants' environmental adaptation:</p> <ul style="list-style-type: none"> • Adaptation and experiences regarding the physical environment. • Regarding the instability of the political environment. • Adaptation and experiences regarding the social environment: <ul style="list-style-type: none"> - Regarding dress code. - Regarding segregation and discrimination.
	<p>3.4.1.3 Sub-theme 3</p>	<p>Participants' emotional / psychological adaptation:</p> <ul style="list-style-type: none"> • Adapting to a new environment. • Support systems. • Emotional experiences.
	<p>3.4.1.4 Sub-theme 4</p>	<p>Participants' professional adaptation:</p> <ul style="list-style-type: none"> • Ethnocentrism in the work environment. • Communication in a multi-cultural professional environment. • Communication with patients and family members. • Experiences in the professional environment. • Financial compensation for service. • Recruitment agencies.

3.4 DISCUSSION OF THEMES AND LITERATURE CONTROL

The participants in this research study described their feelings and experiences related to living and working in Saudi Arabia. The participants' experiences have been reflected in one central theme: cultural diversity encountered in all aspects of the registered nurses' lives while living and working in Saudi Arabia. Additionally, cultural diversity was found to be the common thread that permeated through each sub-theme.

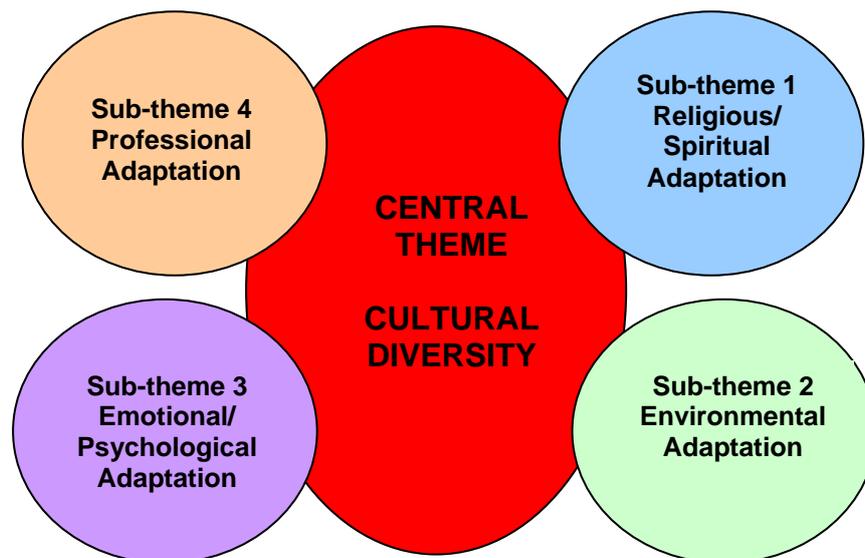


Figure 3.1: Diagrammatic Representation Of The Central And Sub-themes

3.4.1 Central Theme: Cultural Diversity Encountered In All Aspects Of The Registered Nurses' Lives While Living And Working In Saudi Arabia

Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe and material objects and possessions acquired by man as a member of society. Additionally, culture represents a way of perceiving, behaving and evaluating one's world and it provides the blue print or guide for determining one's values, beliefs and practices (Andrews & Boyle, 1995:10).

Diversity is the *quality of being different or varied* (Collins Gem English Dictionary, 2003:169). Furthermore, Anderson (1992:21) says that every country has its own culture and practices that others are expected to acknowledge. Saudi beliefs preserve the Saudi culture and society.

For the purpose of this study, “Cultural Diversity” pertains to the diverseness of culture experienced by the South African participants working in Saudi Arabia who have been exposed to the realities of this country, which has a different culture to that of their own.

South Africans have been exposed to the diverse cultures of their ‘rainbow’ nation and to the Muslim community as part of every day life. South African nurses working in Saudi Arabia had previously encountered Muslims as patients in hospitals, as well as in their every day life. Many participants felt that their prior exposure and experiences within the context of the Muslim community would assist them in facing the challenges and diversities awaiting them upon their arrival in Saudi Arabia. As this study unfolded it became evident that these were false assumptions and that the participants had been misguided in their preconceived thoughts, as illustrated by the following quotes:

*“To me the living with the Muslim culture is fine because I come from Cape Town and was brought up in a small Muslim environment... **but here it was like a shock...**”*

“I had tried to prepare myself as best I could, but no amount of preparation could have readied me for what awaited.”

One of the participants who had recently converted to Christianity after practising as a Muslim in South Africa had heard that life as a Muslim in Saudi Arabia was very different to life as a Muslim in South Africa.

“I had practised the Islamic faith for about 6 – 7 years before...it was a challenge that I was going to come to an Arabic country where there were

Muslims involved ...or living, and I could actually see what was going on first hand. I've often heard that the life that is being lived in Saudi is totally different to the life that Muslims live in South Africa so ...it is really something that I wanted to experience and find out for myself..."

Saudi Arabia is considered a closed society in many ways, as very little is known about the country. There is strict border control that severely limits the influx of travellers. Visas are limited to people arriving in Saudi Arabia for the purpose of employment and to Muslim pilgrims. Tourism is virtually unheard of. Until recent years, even expatriates working in the Kingdom were unable to travel freely unless they had permission from their employers and written documentation to do so.

Saudi Arabia is known to the Western world through limited portrayal in the media. Whether based on fact or fiction, life in Saudi Arabia still holds an element of mystery for the outsider. It is due to this "element of mystery" engulfing this closed country that the participants never really knew what awaited them. It could be said that they came on "hearsay" and "preconceived" ideas.

The term "closed" in the context of Saudi Arabia means that strict control is maintained over information given to the rest of the world, as well as over what is screened on television, broadcast on radio or printed in newspapers. Even personal mail is not immune from scrutiny by the censors. Anyone wishing to work in Saudi Arabia has to be sponsored by the employing organisation and tourism is prohibited.

"I must say it is something much different to what I expected...it is nothing like I expected..."

In order to provide a more comprehensive understanding of what the participants have experienced, the researcher has deemed it necessary to describe briefly certain aspects of Saudi Arabian culture.

Saudi Arabia hosts a diversity of cultures, but in the main there appears to be parallel systems that create two vastly different lifestyles:

- The Bedouin of Saudi Arabia, who is a desert dweller.
- The modern Saudi Arabia which embraces, incorporates and accepts all known luxuries to man.

There are two different calendars:

- Heggarian or Hijrah (H), which is the official Islamic calendar used in Saudi Arabia. This calendar has twelve lunar months, the beginnings and endings of which are determined by the sighting of the crescent moon. The lunar year is approximately 354 days long, therefore, the months rotate backward through the seasons and are not fixed to the Gregorian calendar. The Heggarian or Hijrah year is eleven days shorter than the Gregorian year (Anon.2005). Weekends are on Thursday and Fridays.
- Gregorian (G), which is the Western calendar and weekends are on Saturdays and Sundays.

The two calendar systems in themselves have caused confusion for the participants, as illustrated in the following quote:

“...because their weekends here are also different to our weekends and you get up in the morning thinking it is a Monday...and you have to run to a calendar but the calendar doesn't actually help you cause it has two dates on...”

Friday is also the day reserved for public executions. As barbaric as such practices may seem in this day and age, in Saudi Arabia execution and the amputation of digits and limbs is an accepted form of punishment. This practice was very foreign to the participants and the realization that it was in fact “reality” instilled feelings of fear and horror. Dunne (1994:24) states that, when in Saudi Arabia, you have to get over the cultural hurdle first. Furthermore, she writes that one has to be prepared to accept the Heggarian calendar and that executions are still performed on Fridays.

Saudi Arabia is a country of double standards, a country of dichotomies. There is what Westerners would consider two sets of laws that govern the country; one set is applied to males and the other is applied to females. Women are not allowed in the company of a male who is not a relative. A relative is defined as a father, a brother or a husband. However, the majority of women have their own drivers who are from other countries. This practice is accepted and tolerated by those proponents of Saudi law who abhor the mixing of men and women, as only men are allowed to drive in Saudi Arabia. A Bedouin female is permitted to drive in an emergency, but only if her sons are deemed too young (Miller-Rosser 2005: 5). In contrast, South African women are encouraged to drive and to be independent and they have the liberty to mix with males when and if they please.

“Another thing strange in the culture which stood out to us was the segregation between men and women ... you are not able to sit where a man sits which is totally different...I mean it was shocking for us that everywhere you go women socialize with women and men with men...men are separate...”

Men guard their females jealously. When out driving, one sees cars with blacked out windows to prevent prying eyes from seeing inside. The houses have six foot walls around the perimeter for privacy. Two entrances may be visible, one for males and one for females, as custom dictates that males and females must remain segregated. Under Islamic law, a man may practice polygamy. He may take up to four wives simultaneously, with or without the consent of current wives. A woman, on the other hand, may take only one husband at a time (Miller-Rosser, 2005: 6).

“When I got on the plane from Dubai to Saudi a man with a ‘tablecloth’ on his head and the white dress said to me “Excuse me, will you be my wife in Riyadh?”... now I am sitting there and I think maybe he is making a joke, but then I realized that he was not...”

Men greet each other with a kiss on each cheek. Additionally, it is not uncommon for a man to walk hand in hand with another man. Affection between male and female is seldom expressed. The above is divergent from the South African culture in that heterosexual couples express affection for one another freely and openly, segregation does not occur and the practice of polygamy is prohibited. If men were seen walking hand in hand with each other, their sexual orientation would be put in question.

“...well there are two major things for me...the one is the intermarriages and the other is the lack of closeness, tactile contact between male and female... in the park it is unusual and strange to see a couple holding hands...but the other strange thing is that men are affectionate to one another...they kiss and hold hands and no one blinks or gives it a second thought...but if it happens in my country, South Africa...you know...WOW we would think ...what is happening here?”

Body touching between cultures also varies and is often gender related. Arab men touch in public arenas more frequently than women. Traditionally orientated women seldom touch men in public places, but are comfortable to touch appropriately other social friends, relatives and familiars in their homes. Often gender touching may be viewed as associated with homosexual behaviour, but in non-Western cultures touching and holding hands is not interpreted as such (Leninger, 1995:76).

Islam is the only religion tolerated in Saudi Arabia. The essence of Islam lies in the five pillars of Islam (further discussed in 3.4.1.1). There are no priests in Islam as prayers are lead by the “Imam” (leader of congregational prayer). Muttawaa (religious police) are also known as ‘Authority for the Promotion of Virtue and Prevention of Vice’. There are 3,500 officers assisted by thousands of volunteers, whose job it is to enforce religious doctrine (Muslim Shari’a law as defined by the Saudi government) and to root out “un-Islamic” activities. They have the power to arrest any unrelated males and females caught socializing and to ban consumer products and media, such as games and toys, various Western musical groups and television shows. The Muttawaa

recently launched a website where people can file anonymous tips about “un-Islamic” activities. They have a presence in all walks of Saudi life, including the professional and social environments. They impose strict codes of morality on the Saudi population that are further extended to Western men and women (Anon 2005).

“You hear all the stories about the Muttawaa... you are not supposed to do this and that, and you don’t know to what extent. The other night I said “I am dying to have a whisky now” and someone said “you are dying to go to jail as well now”...you are not supposed to say it...you have to watch what you say...you have got to watch your behaviour...you have got to be on the watch all the time...”

In South Africa, freedom of religion and the open expression of one’s faith is allowed and freely practiced without reservation. Having to be vigilant in ‘what’ one says and ‘how’ one behaves in the social environment for fear of dire consequences from the authorities is extremely intimidating. Religious intolerance will be discussed in sub-theme 3.4.1.1.

*“You may be jailed for some of these problems that we back home would regard as just minor issues **but you will be jailed in this country...so you should actually behave in a different way.”***

Women in Saudi Arabia have a restricted role in public life, few political rights and are not treated as equal members of society. In the opinion of many people, life for women in Saudi Arabia is more difficult than in any other country in the world, particularly with regard to freedom of movement (women, as already explained, are forbidden from driving and may not travel without being accompanied by a male relative), freedom of speech and freedom concerning dress restrictions (Ham 2004:37).

Although it appears that women were held in high esteem during the time of the Prophet Mohammed, they seem to have suffered a decline in status with the emergence of urban centres and city-states (Miller-Rosser 2005:23).

Hassan (year unknown:2), a Muslim theologian, wrote that, according to the Quran, women and men are equal. Women are entitled to an equal opportunity along with men for the actualization of their human potentialities. In the face of this truth within the Quran, how do Muslims rationalize the commonly held theological misconceptions used to justify women's secondary status? The answer is largely due to the prevalent norms of the Muslim culture in Saudi Arabia, which has incorporated the many sayings attributed to the Prophet Mohammed that make up the Hadith literature, a leading source of Islamic tradition. While the Quran has absolute authority as God's Word and is, therefore, the primary source of Islam, the Hadith literature has been the lens through which the Quran has been interpreted through the ages. As important as the Hadith literature is, controversy surrounds every aspect of it, from the authenticity of individual sayings to the literature as a whole. In theory, all Muslim scholars agree that they must reject any Hadith that contradicts the Quran. Nevertheless, the aHadith invoked to justify women's secondary status are not only retained, but also enjoy overwhelming popularity among Muslims in general, and Saudis in particular.

The dominant, patriarchal interpretations of Islam have fostered the myth of women's inferiority. Patriarchal authorities have distorted the truth of Islam almost beyond recognition. They have made Islam a means of keeping women in bondage, physically and spiritually. The worst violation of human rights in Muslim societies is that of the rights of women, who are deprived of the freedom to be fully human (Hassan, year unknown: 3). In contrast, South African women participate in public and political life as equals to men and permeate the workforce with confidence and competence.

Nevertheless, it needs to be acknowledged that one can actually see changes occurring in this regard in Saudi Arabia. Women are slowly being integrated into the work force, particularly in the banking, teaching and sales sectors – albeit in ladies sections only. More and more females are coming into the nursing profession. This represents enormous progress, as nursing is seen as a “lowly profession” and socially unacceptable in Saudi society (as nurses have to “touch” male bodies while rendering nursing care) (Miller-Rosser,

2005:23). Many differences can be noted between Saudi and Western women, as well as the Saudi and Western cultures – more specifically the Saudi and South African cultures. However, unless one has lived within the environment, one remains ignorant and open to stereotypical comments. The participants actually living and working in the environment have been exposed to many of these differences, the most blatant of which, according to the interpretations from the data analysis, has been the segregation between males and females in places like restaurants, shops and even the work arena. In addition, all women are subjected to restrictions and discrimination.

“Another thing that stood out and was strange with the culture was the segregation between men and women.”

Saudi Arabia has experienced an invasion of Westerners, along with the different aspects of their lifestyles. Many young adults are going abroad to study and returning with their changed way of life and way of thinking. Exposure to Western culture and values by expatriate workers in the Kingdom, educational opportunities and access to television and internet facilities, has resulted in many Saudis grappling with modern technology, while still struggling to maintain their cultural beliefs, norms and values.

The central theme has highlighted certain aspects of the Saudi Arabian culture applicable to this study. The diverseness of the South African and Saudi Arabian cultures has been outlined. In the following sub-themes, namely religious/spiritual adaptation, emotional/psychological adaptation, environmental adaptation and professional adaptation, the lived experiences and adaptations to this diverse culture, as highlighted by the participants' living and working in Saudi Arabia, will be discussed.

3.4.1.1 Sub-theme One: Participants' Religious/Spiritual Adaptation

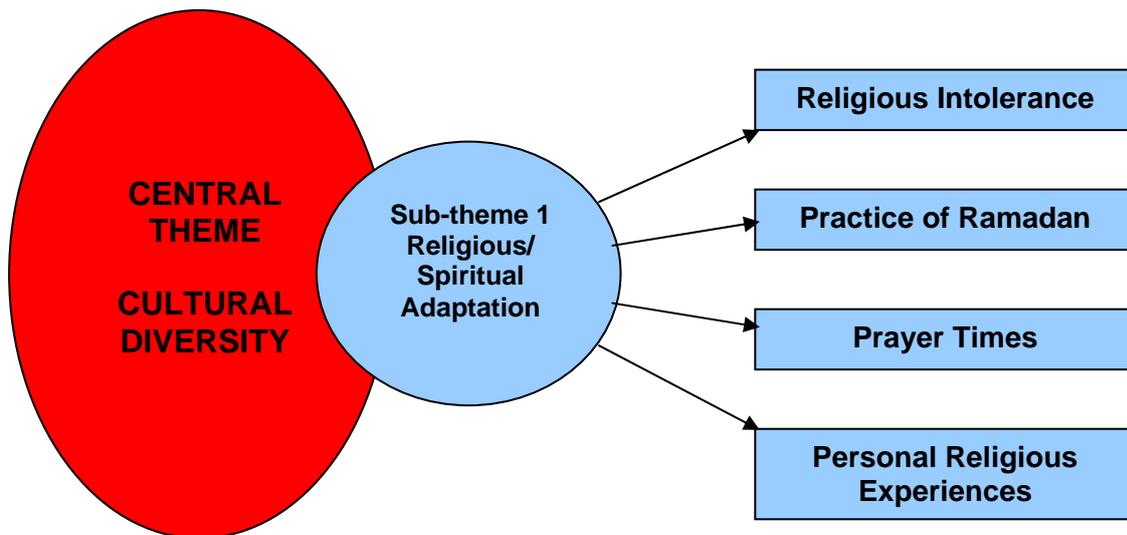


Figure 3.2: Diagrammatic Representation Of Sub-theme One

Saudi Arabia is an Islamic country. All aspects of the Saudi Arabian culture are influenced by the Islamic religion. Islam teaches that on judgment day, the actions of all people will be assessed. Those who have led a good life will go to paradise and those who have lead an undesirable life will go to hell. Ham (2004:33) explains that Islam is more than the state religion in Saudi Arabia – it is an all encompassing way of life. Officially, all Saudi's are Muslim. Although many of the large population of expatriates living in the Kingdom of Saudi Arabia are apparently Hindu or Christian, the practice of other religions is forbidden.

The Quran is the word of Allah (God) directly communicated to the Prophet Mohammed. It comprises 114 Suras (chapters) that govern all aspects of a Muslim's life, from his/her relationship with Allah to minute details about daily living (Ham, 2004:34). Islam places numerous limitations on individuals. These include prohibition of consumption of pork in any form (Sura, 2:165), the meat of animals not killed in the prescribed manner (Sura, 5 :1-5), food which has not had the name of Allah said over it (Sura, 6:115), as well as the prohibition of gambling (Sura, 5:90-95), adultery (Sura, 6:115), theft (Sura, 5:40-45) and the ingestion of alcohol (Sura,5:90-95).

Anderson (1992: 22) confirms that the use of alcohol is illegal in Saudi Arabia and can result in a jail term or deportation. There is no legal blood alcohol level as there is in other countries, including South Africa. Any alcohol level found in the blood is illegal. Persons who consume alcohol are considered guilty and, if they are with others consuming alcohol, they are considered guilty by association. A South African male registered nurse had the misfortune of being jailed for a weekend due to being in the company of others who were consuming alcohol. Although not a participant in this study, the researcher had the opportunity to speak to him about this experience eighteen months after it occurred. It was evident that even the memory of the experience was very traumatic and painful. He subsequently exited the Kingdom as soon as his contract was completed.

The duties of Muslims incorporate acts of worship that form the five pillars of Islamic faith. These are **shahada** or affirmation of the faith, **salat** or daily prayer (Sura, 11:115), **zakat** or almsgiving (Sura, 107), **sawm** or fasting during the month of Ramadan (Sura, 2:180-185) and **hajj** or pilgrimage to Mecca (Sura, 2:190-200). These acts of worship must be performed with a conscious intent, not out of habit. Shahada is uttered daily by practising Muslims, affirming their membership in the faith and expressing an acceptance of monotheism of Islam and the divinity of Muhammad's message (Ham, 2004:35).

For the participants, this required a major adaptation. Prince Turki, the nephew of the King of Saudi Arabia, stated in an interview that Islam is a religion of tolerance as portrayed in the following quote, *...a society whose makeup is based on religion, a religion of tolerance and a religion of understanding and a religion of extending hands of friendship to other people* (Al-Faisal, cited in Farnsworth 2002:4). The participants' related experiences were to the contrary. They were faced with religious intolerance daily and had to adapt to the differing practices of the Islamic religion, specifically pertaining to Ramadan and prayer times.

Participants' Adaptation And Experiences Regarding Religious Intolerance

Ham (2004:52) writes that the practice of any religion other than Islam is strictly prohibited, whether in public or private. This extends to bringing into the country printed religious material or other symbols...The authorities are very serious about enforcing this.

Intolerance towards any other religion has been a glaring reality for the South African registered nurses', as all other forms of religion are banned from being practised within Saudi Arabia.

"We do have Muslims back home and we accept the way they are, but here I don't know why they can't accept Christians and our practice."

The consequence of not respecting the religious law is jail. Additionally, one may be deported. Again, this is a sentiment that has instilled fear into the nurses, as indicated in the following quote:

"...No, no I am not going to go to church either here, I have got my Bible, I got my everything at home and for me it is quite safe...I am not going to exploit myself in any way...did you know there was a man arrested three weeks ago for trying to open a church... If you are going to attend church you are going to go to jail."

The participants explained that there are church services and Bible studies which are held "underground". Certain codes are given for the word "church" as this term can never be used. One participant referred to it as "going to a meeting" and another referred to it as "going for coffee". Some of the participants were prepared to risk going to church and face the subsequent consequences if caught.

"Yes, we go to fellowship and worship and we call it "coffee" because we are restricted here where we are...it is forbidden to practice any other religion."

Alternatively, other participants felt more secure staying at home and worshipping within the confines of their room, as mentioned in a previous quote. However, no matter how they chose to worship, they were all very aware that they had to constantly be careful as to what they said in conversation, over the phone, in emails and in letters.

“...And also I’ve been warned about this often to be very careful what you say on the telephone and be very careful what you write in emails...Whether it is for us a treasure that needs to be protected or whether it is out of respect for the country that we are in, I haven’t quite been able to determine...Fear is a factor too...we can be put in jail and even beheaded, but I think it is a whole safety issue and taking care of yourself...We definitely don’t want to go to jail or be sent home...”

All of the participants were of the Christian faith and all viewed the religious intolerance and being forbidden to practise their faith as a negative experience, invoking feelings of fear, worthlessness, hopelessness, disregard and disrespect.

“You know there is a sense of worthlessness...there is a sense of hopelessness...there is a sense of total disrespect and disregard. It is very restricting because basically every word that comes out of your mouth you have to watch. Basically you don’t know if you can trust the person next to you, because you don’t know which way they are inclined...this can be very demoralizing...you have got to give up so much of yourself.”

This was also the experience of the participant who had converted to the Christian faith. There is a difference between Muslims practising Islam in Saudi Arabia and those living and practising Islam in South Africa.

“The big difference I think that there is, is that here in Saudi there are a lot of dual standards. Where back home I find that people are much more committed to the Dean of Islam...and the preaching as far as I know about the dean of Islam is practised more seriously and taken more seriously than it is

here. I find that here is a lot more interpretation to suit personal needs basically and what is taught in the dean of Islam is not practiced in the way I thought it would be practised.”

Participants’ Adaptation And Experiences Regarding The Practice Of Ramadan

“Oh believers, prescribed for you is the fast, even as it was prescribed for those that were before you...the month of Ramadan, wherein the Quran was sent down to you to be guidance to the people, and as clear signs of the Guidance and Salvation. So let those of you, who are present at the month, fast it” (The Quran, Sura 2:175-185)

The ninth month of the Muslim calendar is Ramadan, a period of obligatory fasting that commemorates the Prophet Muhammad’s receipt of God’s revelation, the Quran. Fasting is an act of self discipline that leads to piety and expresses submission and commitment to God. Fasting underscores equality of all Muslims, strengthening sentiments of community during Ramadan. All but the sick, weak, pregnant or nursing women, soldiers on duty, travellers on necessary journeys and young children are exempted to eat, drink or smoke during the day. Official work hours are shortened during the Ramadan period and some businesses close for all or part of the day. When Ramadan falls in summertime, a fast imposes considerable hardship on those who must work. Each day the fast ends with a signal that light is insufficient to distinguish a black thread from a white one. Iftar or Ftur, the breaking of the days fast, is a time when people come together to eat, drink and pray (Ham, 2004:47). Id al Fitr, a five day feast and holiday, ends the month of Ramadan and is the occasion of much visiting and celebrating.

Out of respect to the Muslim population who are fasting during Ramadan and in order not to put temptation in their way, non-Muslims are not allowed to eat and drink in public places, even to the extent of having to place a water bottle in a paper bag when walking down the hospital corridor. Participants, even

though respectful, experienced feelings of discrimination, frustration, unfairness and even presented with the effects of dehydration.

“Fasting in Ramadan ...just because of the Muslims are fasting we as Westerners aren’t allowed to eat and drink to do anything in front of them...for me it is like a hypocrite...I mean you are doing this for your religion and the first thing you do is lock all the doors that stores food...if you are really doing this for your religion you have got to be able to sit in a cafeteria and be able to withstand the cravings... but that is my personal opinion...I mean all the Westerners are walking around with headaches because they are deprived of fluids as well. Because if you want to drink water, you have to go to the kitchen and who will cover you and stay on the unit every time you are thirsty...You are not even allowed to eat a beechie...even the areas that you are allowed to smoke they lock the doors and that is not fair...”

During the month of Ramadan, Muslim staff members are only required to work 72 hours of the prescribed 88 hours in two weeks of regular shifts assigned to employees. Of these 72 hours, they are only required to work a maximum of 6 hours per shift. They do not have to repay the hours that they are given off. This means that all non-Muslim staff members are required to cover for the Muslim staff during the hours that they are given off, adding an additional load to their already heavy assignments. Participants accepted the fact that the non Muslim staff members were given all the added hours “gratis”, but did verbalize feelings of frustration and exhaustion.

“Muslim nurses work less hours during Ramadan. They work six (6) hours a day so they come on later in the morning whereas you are on 06h45 they come in at 09h00 and go off at three (15h00). The Westerners still have to do the twelve (12) hours which is quite tiring... Because the schedule has to be readjusted which effects us Westerners because now you know that you are constantly going to have someone away from 15h00 till 19h00 and 07h00 to 09h00 so what happens you have to fit someone else in so people are working split weekends and extra shifts at awkward times... so it is frustrating...”

During Ramadan the participants felt as if night and day had been reversed, with evenings given over to crowds of people shopping, sitting in traffic jams and, above all, eating long into the night. Patients slept for most of the day and were awake all night, a practice which impacted on the nursing routine as patients did not want to be disturbed during the day. This was a source of great frustration to the participants.

“Right now we are experiencing Ramadan which is a very big culture shock for me...in the sense that as soon as Ramadan came everything seemed to have flipped over... Patients sleep during the day and they are up till whatever time at night...”

No literature could be found to support the participants' experiences.

Participants' Adaptation And Experiences Regarding Prayer Times

The Call To Prayer

Allahu akbar,Allahu akbar

Ashhadu an la ilah ila Allah

Ashhasu an Mohammed rasul Allah

Haya ala as-salat

Haya ala as-salat

The Muslim believer has to pray “salat” in a prescribed manner after purification through ritual ablutions at dawn, midday, mid-afternoon, sunset and nightfall. Prescribed genuflections and prostrations accompany the prayers, which the worshiper recites facing Mecca. Prayers imbue daily life with worship and the day is structured around an Islamic conception of time. A special functionary, the muezzin, intones a call to prayer to the entire community at the appropriate hours; those out of earshot determine the proper time from the position of the sun (Metz, 1993:3).

During prayer times, all shops and businesses close. Men are called to mosques and women sit patiently outside waiting for the shops to reopen

(further discussed in sub-theme 3.4.1.2). In the hospital, departments such as personnel, administration and travel, which are primarily manned by Muslims, close. Male employees pray in congregation in the mosque on the hospital grounds whilst female employees pray in the allocated prayer rooms. On day shift (07h00 – 19h00) the Muslim employees are called to prayer and, therefore, leave their units/departments for approximately 20-30 minutes, three times a day. During these times, the non-Muslim nurses have to cover the patients and responsibilities of their Muslim colleagues. From the participants' experience, this evoked feelings of frustration:

“And the Arab nurse in the ward... you must do her job while she is going out to pray...I have also got my religion but I have got time to do it at some other time when I am off duty...but she has to do everything here at work...it is really unfair...”

No literature could be found to support the participants' experiences.

Participants' Personal Religious Experiences

It was evident that all of the participants, in order to counteract the negative experiences, emotions and feelings, derived strength from spending time alone with their Maker and having the inner assurance that they were not alone. Most participants admitted to having grown closer to their God since coming to Saudi Arabia. These were viewed as positive experiences.

“Well, I must admit it is such a morale booster knowing that I have my gospel CD's and I have got my Bible behind closed doors...they don't know anything about it...and I can actually in the privacy of my room read my Bible and I can sing and dance in front of my mirror before the Lord...and I can walk through the hospital humming and they don't know what it is that I am humming... and I think to myself often when I get stares and looks...and wherever I go out I have my mobile CD player with me and there is always a gospel CD in and I think to myself...you know they can say anything to me but they don't know what I am listening to...it is just such a safety wrap and it gives one such strength and security and confidence to face the next day...”

Many participants had spiritual support systems amongst friends, as well as back home in South Africa. They viewed these support systems as essential elements and also felt that it was of vital importance that one was secure in one's faith for personal strength from day to day, as well as to be able to stand firm when approached by those seeking to convert people to Islam.

"You have all these people explaining the Islamic religion to you and why they are right and you are wrong. It is easy if you are not stable in your faith, to be swayed as you won't know what is right or wrong ..."

"I have also come across quite a few Christians who have converted (to Islam) during my time here, so it is also something that the South African nurses should be ready for."

From the psychological perspective, Andrews and Boyle (1995:274) found that having *one's experience discredited or made to seem unimportant, is painful and situations do not go away simply because they are ignored*. The apparent intolerance to the participants' faith and the lack of freedom to practise it openly has been a painful experience for them, evoking many negative feelings. The participants have tried to overcome the negative by positively seeking solace in worshiping within the confines of their rooms. Whichever way they have chosen to maintain their walk of Faith, the adaptation has been difficult. Nevertheless, they have managed, as aptly expressed by the following participants:

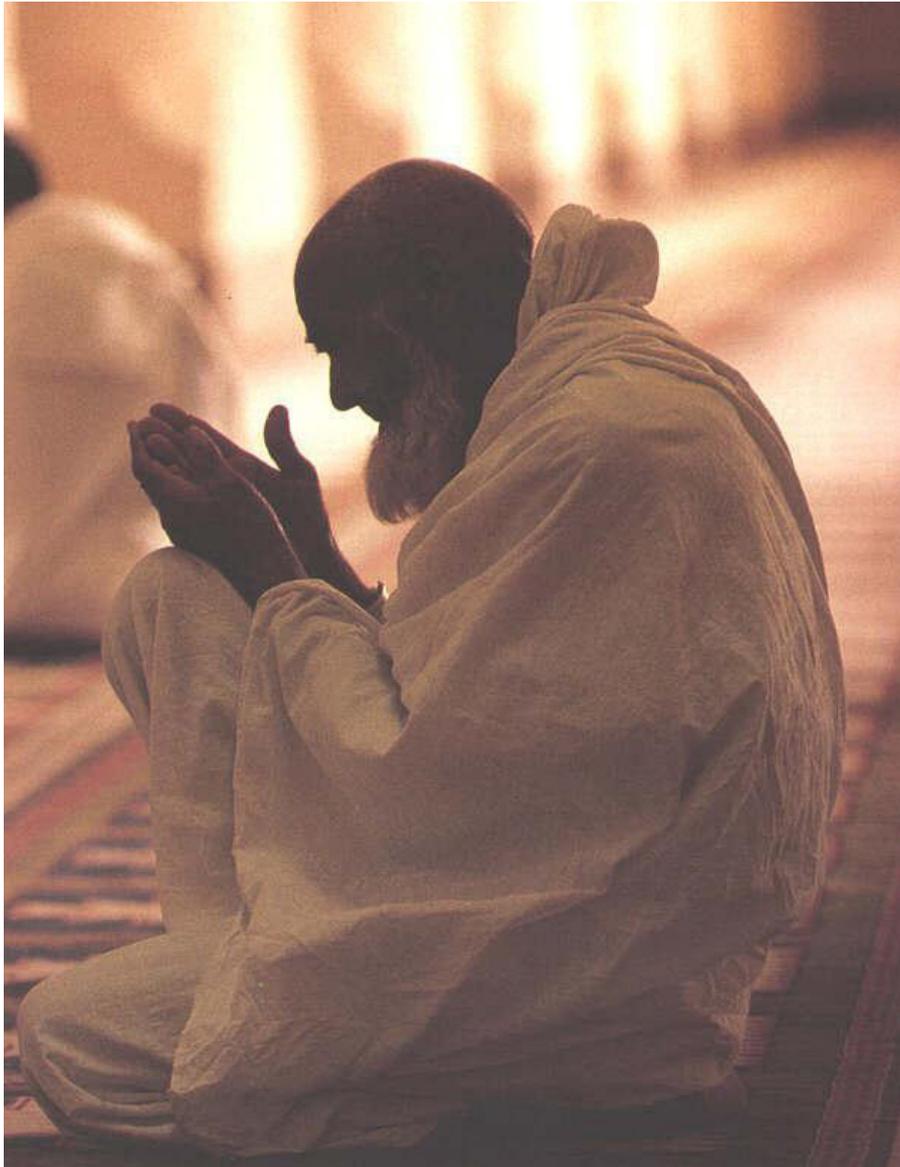
"But when you are in your room you pray, but it is not enough to just pray in your room. Sometimes you just feel the need to go to church and feel that spirit...it was really difficult in the beginning because I am used to going to church every Sunday and the fact that I didn't have a Bible... but anyway I managed to get a copy..."

"...maar ek moet my ook maar aanpas want dis mos nie my eie land nie...so ek probeer maar positief te wees en aanvaar dis mos nie my religion nie..."

(...but I will have to adapt because this is not my own country...so I try to be positive and accept...since it is not my religion....)

No literature could be found to support the participants' experiences.

A Muslim Man at Prayer



3.4.1.2 Sub-theme Two: Participants Environmental Adaptation

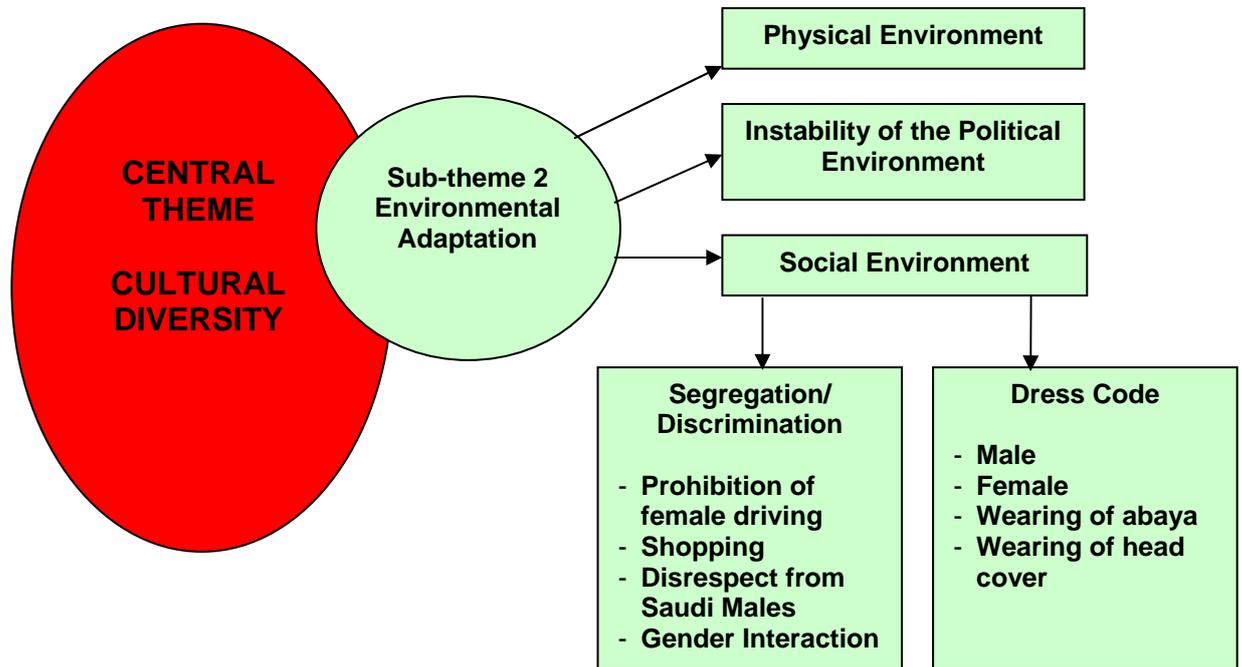


Figure 3.3: A Diagrammatic Representation Of Sub-theme Two

The participants in this study identified two main components, namely physical and psycho-social environmental adaptation, which will now be discussed in detail.

Participants' Adaptation And Experiences Regarding The Physical Environment

The environment can be defined as all phenomena, tangible and symbolic, that impinges on and influences development, beliefs and behaviour. The physical environment includes phenomena such as climate, geography, housing, sanitation and air quality. It is a factor in the development of any culture (Andrews & Boyle, 1995:19).

The south-western part of Saudi Arabia forms the Arabian continent and shares borders with Kuwait, Qatar, the United Arab Emirates, Oman and Yemen. Northern borders include Iraq and Jordan, to the west lies the Red Sea and the Gulf of Aquaba and to the east is the Arabian Gulf and Iran (Miller-Rosser, 2005:12).

The country extends across approximately 2,149,690 square kilometres with 95% comprising desert or semi-desert. Across the deserts are sun-baked grounds that have great difficulty coping with the sporadic and often torrential rains. In contrast, the highlands have been described as remarkably picturesque due to their evergreen forests. Throughout the year the country suffers extreme temperatures. The heat of the desert (as well as the city) can and does reach temperatures exceeding 50 degrees Celsius and is accompanied by scorching hot winds. These conditions are made worse by hazardous sand storms (Ham, 2004:40).

The main natural resource of Saudi Arabia is oil. Current estimates indicate that Saudi Arabia has roughly 25% of the world's proven oil reserves, with a lasting estimate of approximately ninety years. In addition to oil the Kingdom is rich in mineral deposits, with gold having been discovered at some six hundred sites throughout the country.

All of the participants in the study arrived at the King Khalid International airport in Riyadh and were taken aback by the obvious opulence surrounding them. They were met by the public relations representative from the hospital and, as they walked out of the air-conditioned airport, the extreme heat was their first introduction to the Arabian climate. The females were required to don the traditional abaya (black cloak) from this point. This was Saudi Arabia.

Participants were transported to their individual compounds. For many, the concept of compound living was just as foreign as the country itself. For all of them, this was the first experience of living within a walled enclosure and it came with its share of positives and negatives. In some ways, the compounds offered a world-within-a-world, a self-contained place of retreat when the idiosyncrasies of life in Saudi Arabia became too difficult. The strong sense of community felt in many of the compounds, coupled with the other residents' wealth of knowledge, provided the soft landing that participants needed. All had entered the Kingdom for the first time and were surrounded by a country that could be quite alienating.

“I made vetkoek and koeksisters and I invited all the South African people I know... and the one thing I realize here...the black and whites here...we are not so different...we think we are different in South Africa but once we get here we all unite together...”

“The other positive thing is about the South Africans here... You know, for the first time when I look at people I can see that everybody says ‘I am proudly South African’...not one will say a negative thing about South Africa...And it really gladdens my heart, because it is unlike being at home where you have negativity towards the country as a whole...But I mean once they are here it is totally different and I find that the South Africans are so great... as soon as they hear your accent...like one heard me in the tearoom and said “Oh welcome you from South Africa...welcome”...and chatted away...”

Swimming pools, supermarkets, beauty salons, coffee shops and gyms are all provided to help the transition, as well as break the sometimes monotonous routine.

“When I did manage to look around the compound I was in, I did realize that there was everything...recreational stuff...you name it...and that for me...I knew I would be comfortable in that regard.”

Ham (2004:52) writes that within the compounds you are generally free to do as you like. Retreating to the relative comfort and security of the compound (away from the security fears and potential hassles which lie beyond the compound walls) can be attractive in those early days of culture shock and becomes a way of life.

Participants were accommodated in one, two or three bed roomed flats or villas. Most were pleasantly surprised at the standard of accommodation. Separate bedrooms and, for most, separate bathrooms plus air conditioning and modern conveniences such as dishwashers, stoves, televisions, microwaves, washing machines and fridges were standard. Depending on their seniority, participants either lived alone or shared with another person/s.

“I am happy about the accommodation. It is very good...it has everything you need and I don't have to pay anything...not a cent... electricity is free, water is free and it is well furnished.”

Ham (2004:50) explains that accommodation is one aspect of expatriate (expat) living that receives very few complaints. Furthermore, he states that, in these days of elevated security concerns, expatriates live in compounds consisting of high quality and spacious Western-style houses or high rise apartments that are custom-built for western expatriates. He continues that one can expect air-conditioning and full time security on the compounds and that single female expatriates, who are generally employed as nurses, may find that they have to share accommodation with other women.

Participants were physically comfortable in their assigned units; however, some experienced conflict with their flatmate/s, which was a source of unhappiness and stress. If matters could not be resolved, the housing department accommodated them in another unit which proved to be successful.

Accommodation for females at KFSH&RC - Riyadh



“In the beginning I found I was very constricted...as if I was living in a granny house because I was afraid to touch anything...because the flat was

congested with all her things... There was no place for my stuff. The TV ...she would come in and change the channel according to her timetable and what she wanted to watch, even if I was watching something else... The kitchen had our fridge but was full of her things...The freezer was full of her things...it was just not nice... I felt alienated...very, very alienated...I was miserable...I don't want to tell lies...I was miserable...I didn't feel like I'm welcomed. I tried to push myself out from housing...although they were delaying me that I must get somebody else on my own but I officially didn't know anybody...They said I must phone people and get a person I can stay with...Fortunately I found a lady from South Africa who was alone and we moved in together... It is working out well...we are able to discuss...being African I am able to talk my own language and be at home."

The physical climate had an affect on the health of many of the participants. Clinical manifestations of dehydration, headaches and exhaustion were caused by the extreme heat to which they were exposed. Skin rashes developed and were attributed to the water as well as the dry and hot conditions.

Participants expressed amazement at the almost non-existent crime rate in Saudi Arabia; a far cry from the situation in South Africa. They experienced freedom with regard to walking in the streets and shops without the constant anxiety of having to 'look over their shoulder' for fear of being attacked or robbed, as they had done back home. This was perceived as a very positive experience.

"I feel free here... you can wear gold chains and everything you want to and nobody is going to glance a second time at you. You know in South Africa if you walk anywhere, they grab your bags and your chains and your everything so you are not free to walk around..."

"Another thing I am happy about here... You can buy a cell phone... You can answer it anywhere and nobody will come and grab it and do whatever...or take everything. We are actually free...If you drop something someone will

pick it up and give it back to you...it's not like..."On my God I am scared of these tsotsies"...I think it's a free country from a crime perspective...we feel free...you can relax when you go to the shops."

Ham (2004:51) supports this sentiment by stating that crime continues to be all-but-unknown, other than some petty theft. Compounds, particularly in these days of terrorist threats, have high security, while street crime is extremely rare in Saudi Arabia.

Instability Of The Political Environment

The land is still ripe to produce more terrorists. It's a question of providing a fertile ground for this ideology to grow in. If we're able to fix the problem and grow something decent again, then we will be safe.

Hussein Shobokshi (cited in Law, 2005:1)

Ham (2004:51) stated the following in relation to the political situation in Saudi Arabia: This is a critical period for Saudi Arabia. *By living in the kingdom, you'll enjoy a front row seat from which to watch history unfold.* He further stated that one of the most enduring reasons given by Al-Qaeda for its terrorist attacks was the presence of non-Muslims in Saudi Arabia, but that Saudi authorities were cracking down hard on any terrorist activity.

Although counter terrorism efforts have succeeded in diminishing terrorist capabilities in Saudi Arabia, terrorist groups continue to target housing compounds and other establishments where Westerners may be located. Saudi government facilities are also targets. In addition to car bombs and armed assaults involving multiple gunmen against such facilities, terrorists have used ambush attacks to kidnap and/or assassinate individual Westerners.

"At times I feel very unsafe due to the whole situation in the Middle East recently...the Iraq war and the killing of westerners in this country...Our South Africans are also seen as Americans wherever we go...People do not see us

as South Africans...I didn't visit the other parts of the country...I didn't go outside Riyadh...I didn't feel safe at all...and I'm sure it restricted my movements. At times I didn't want to go to the big main shopping places...the papers were full of bombings and you know terrorists and whatever...wanting to blow up those shopping centres...I never went on my own...I had to always take a friend along so that you could be together with somebody else...So yes it is at times very unsafe for us to be here."

August 10, 2005 the US Consul sent out an information sheet on Saudi Arabia which warned that there had been a number of anti-Western attacks in Saudi Arabia since May 2003. *Terrorists have targeted housing compounds, businesses and Saudi government facilities with vehicle explosives and automatic weapons, causing significant civilian deaths and serious injuries, and in separate incidents have held hostages and killed individual Westerners. On December 6 2004, terrorists carried out an armed attack against the US Consulate General in Jeddah, which resulted in casualties among Consulate staff and damage to consulate facilities. The US mission continues to receive reports that suggest terrorist actions against US private and official interests in Saudi Arabia are a strong possibility.*

The following chronology of attacks on Westerners in Riyadh during the period 2003 and 2004 illustrates the unstable political situation in Saudi Arabia:

February 20, 2003 – Briton working for defence contractor BAE Systems shot dead in Riyadh.

May 12, 2003 – Suicide bombers attack housing compounds in Riyadh, killing 35 people. At least 200 wounded.

November 9, 2003 – Suspected Al Qaeda suicide bombers blow up Riyadh residential compound housing foreigners and Saudis, killing 18.

June 8, 2004 – Unidentified gunmen shoot dead an American in Riyadh who worked for the US contracting firm Vinell.

June 12, 2004 – A US national is shot dead in the Saudi capital Riyadh in the third attack on Westerners this week.

June 16, 2004 – Al Qaeda guerillas show images of a blindfolded American hostage, saying he would be killed if Saudi Arabia fails to free jailed militants within 72 hours.

June 18, 2004 – Abdulazziz al Muqrin, Al Qaeda's leader in Saudi Arabia, is shot dead by Saudi forces along with three militants after they beheaded American hostage Paul Johnson.

June 24, 2004 – Saudi Arabia says it will allow foreigners who feel threatened by the wave of militant violence to carry guns for their protection.

July 20, 2004 – Saudi Arabia says its security forces have killed two suspected militants and wounded three others in a heavy exchange of fire in Riyadh.

Saudi security forces found the head of Paul Johnson in a fridge when they raided a villa in Riyadh.

August 3, 2004 – An Irish engineer is killed in his office in the Saudi capital, Riyadh.

September 15, 2004 – Three suspected Muslim militants gun down a Briton in the Saudi capital, Riyadh, in a suburb east of the city near a shopping complex.

October 12, 2004 – Saudi security forces shoot dead two gunmen in heavy gunfire in the east of the capital, Riyadh (Anon.2004).

“When you look around you, when you approach the whole physical area and you see cannons and stuff all on the corners and the barbed wire and the way security’s maintained...it’s quite scary and that immediately tells you that there should be some potential danger around otherwise it wouldn’t have been that way.”

The unstable political environment has been a source of anxiety for participants. They were advised to always keep abreast of the latest travel and security warnings issued by western governments and to always notify the South African embassy of their presence. According to a US travel warning posted by the South African Consular circular, expatriate South Africans were warned:

Citizens are advised to exercise caution and maintain good situational awareness when visiting commercial establishments frequented by Westerners or in primarily Western environments; keep a low profile, varying times and routes for all required travel. US citizens who remain in Saudi Arabia despite this travel warning are strongly urged to register with the US Embassy in Riyadh (May 17, 2005. Travel warning Saudi Arabia. United States Department of State Bureau of Consular Affairs Washington, DC 20520).

South Africans are advised not to compromise their personal safety during this time. Continue being vigilant and ensure that you have your own personal safety and security measures in place. It is advisable to also review such precautionary measures periodically (30 October 2004. Consular Circular to all South African Expatriates in the Kingdom of Saudi Arabia).

Security at compounds and places of work was generally good; nevertheless, the thought of having to watch the security situation nervously and be willing to pack and leave at a moment's notice had a wearing and nerve-wracking effect on many participants.

“Well it is unpredictable...there are days when you feel terribly insecure, especially when you read the newspapers, you listen to the news, you hear what is going on...but at the end of the day coming from South Africa we went through a period like that and we just learnt to take one day at a time and to survive no matter what...My greatest fear though is perhaps not being able to get back if for instance something should happen...how would I get back to my people...I wouldn't want to die in a strange land...I would love to go home...”

For some who had experienced the political unrest in South Africa, adaptation to the fortifications of boom gates and two-to-three meter high concrete walls and barbed wire was less traumatic and it appeared as if they did not share the same level of anxiety as other participants.

“I’m 42 years old and I was in South Africa all around terrorists and everything and there were bombs everywhere...there is no difference here. I have been here for four months and I haven’t seen one bomb one anything...it is very underground whatever there is.”

“I felt quite okay but I think it (political situation) is very much a personal thing ...Because for other people, I’ve heard the way we talk about it you know...people could feel very anxious about it and it could scare a lot of people. I am not that kind of person...Shortly before we came there was a bomb explosion, people warned me that I was going to an area where there were bombs and difficulties...and I made peace with it before I came.”

As these quotes indicate, the emotional reaction of the participants varied according to their previous life experiences. Some had arrived in Saudi Arabia during a time of unrest and bombings and they verbalized the fear and anxiety that they, and their families in South Africa, had experienced. For other participants, who had not actually experienced this, the apprehension and uncertainty of knowing about the unstable political situation was evident. Most of the participants, having only being in the Kingdom for a short period of time, had not reached the stage of resignation **to**, and acceptance **of**, the unstable political situation in Saudi Arabia.

*“Here in the east one never knows what is going to happen...You don’t know when bombs are going to drop...You don’t know when a war is going to break out...You don’t know how the next person is going to treat you...You don’t know whether **you are even going to live the next day**...Yes, you are **very uncertain**... and yet there is nothing you can say or that you are going to do to make that feeling better...”*

“People at home this past week have been asking me and telling me “please look after yourself...please take care...I hear there are bombings going on”...”

“What I did, for example, was the minute there was a bomb blast or anything...I would call immediately to reassure them (family) that I was not affected...I’m safe...just to reassure them.”

Participants’ Adaptation And Experiences Regarding The Social Environment

The social environment includes all those structures associated with the socialization of a person into a group in society. The family is the primary source of socialization and, by extension, of culture. Studying the dynamics of the family is a crucial part of learning the cultural background of any person. Religious orientation is a large part of a person’s culture. The economic and political systems of the group are social in nature and culture specific. The health care delivery system is also an aspect of the social environment (Andrews & Boyle, 1995:19). In Saudi Arabia, cultural mores are not just enforced by social pressure, but by the law. There are Muttawaan, or religious police, who ensure that the religious and social mores are followed by all individuals in Saudi Arabia, regardless of nationality. Infractions can result in severe penalties; consequently, it is essential that persons be made aware of the cultural expectations regarding dress codes and the segregation/discrimination between men and women.

*“Okay, let’s start with the social part. I think everybody talks about a culture shock but it **really is like culture shock...**”*

“There is no social life; it can be really depressing at times. You are always afraid that you are going to be caught out by Muttawaas and you can’t dress the way you like.”

- **Participants’ Adaptation And Experiences Regarding Dress Codes**

The religion and culture of Saudi Arabia dictate conservative dress for both men and women alike.

Cultural dress for men

A man's headdress consists of three items, namely a taiga, a gutra and an iqal. A taiga is a small white cap that keeps the gutra from slipping off the head, the gutra is a large square cloth and the iqal is a double black cord that holds the gutra in place. Some men do not wear the iqal. The gutra is made of cotton and traditionally Saudis wear either a white or a red and white checked one. The gutra is worn folded into a triangle and centred on the head. Normally men wear a white thobe but during winter months some may wear coloured ones made of heavier materials. Saudi men do not have to wear traditional dress. They have the freedom to wear "Western" clothes, as long as they dress conservatively (shorts, sleeveless shirts and gold jewellery are not worn).

Expatriate males do not have to adopt the cultural dress of the Saudi men. The dress code for men is not as strict as for women. Men can wear short sleeved shirts, T-shirts and jeans. However, men still dress conservatively in public and shorts are rarely worn (Anderson, 1992:21).

The male participant in this study had the freedom to wear in public the clothes that he was accustomed to back home, with the exception of shorts and sleeveless shirts. Adaptation to a different style of dress was, therefore, of no consequence to him. For this reason he did not comment on dress code.

Cultural dress for Saudi women

One of the most important community values in Saudi Arabia is the modesty and chastity of women. When Saudi women appear in public, they wear a voluminous black cloak called an abaya, a scarf covering their hair and many have a full face veil. Most Saudi women cover themselves in public and in the presence of men who are not close relatives (Butler, 2005:5).

All women living within the boundaries of Saudi Arabia are expected to respect the dress code of the Saudi culture, with South Africans being no exception.

Expatriates, however, do not have to cover their faces and only have to cover their head when instructed to do so by the Muttawaan. Although the participants were aware of the dress code prior to coming to Saudi Arabia, their experiences of 'actually' wearing the abaya and scarf were varied.

Wearing of the abaya

The female participants unanimously agreed that wearing the abaya was a hindrance, especially due to the Arabian climate and the sweltering heat.

"When it is hot...you just want to scream because this becomes like a burden that you are carrying on you...You know back home you would be dressed as comfortable as possible...Now you must sit and be covered from head to toe and, whew, in 45 degrees it is a bit much..."

Certain participants, especially those who did not place emphasis on how they dressed, saw the advantage of wearing the abaya and derived a sense of freedom within its confinement.

"It doesn't matter what you wear under that abayah...you can wear your pyjamas...Nobody would know...nobody would care..."

A few participants, whose objective in coming to Saudi Arabia was to save money, rationalized that wearing an abaya actually enabled them to save financially, as they did not feel compelled to compete with others in the fashion arena.

"And you know about the abaya... I am not here to look nice and there is nobody here to look nice for...To me it is a saving...I don't have to buy clothes and whatever...because I can buy three clothes for the whole year ...Nobody will see because I am wearing the abaya"

Those participants who enjoyed 'dressing up' and looking good found it a little more difficult to adapt, and feelings of frustration and irritation were noted:

"Yes well, it irritates me a bit, because I don't like wearing black. You know as girlies sometimes we just want to look pretty but whenever you go out you have to put this black abaya on..."

The psychological impact was real for many participants who had to work through the feelings of 'lack of self worth' that 'covering up' instilled:

"... you feel like looking smart and then it hits you and you think, oh my goodness now I have to wear a black 'frock' over my smart clothes ...but ok, ok I still try to feel good..."

Participants eventually came to the realization that it was important that they felt "ok" within themselves "despite" having to wear the abaya, as illustrated in the quotes:

"Nobody really knows what you wear underneath as long as you feel OK."

"I have not allowed the abaya to take away my femininity...So if I put on the abaya it is not going to deter me from still putting on whatever makes me feel beautiful underneath...I won't let it interfere with who I am."

With time, the participants adapted to wearing the abaya and, having no other choice, 'made a plan' in all situations no matter where they were.

"Yes, you do get used to it you know, and also because everyone else is doing it you don't feel so out."

"It was strange climbing a mountain with an abaya, very strange...half the time I had it tied around my waist...so that was the only way..."

Wearing of the head cover

Islam dictates that women be modestly dressed, which is strictly adhered to. In public a woman must wear an abaya and her *hair must be covered* (Miller-Rosser, 2005:26). Expatriate women are not obliged to cover their heads, but are encouraged to carry a scarf with them in public. If asked to cover their hair by the Muttawaa, they should do so (Anderson, 1992:21).

“I wear it around my neck...and if I’m asked to put it on then I will put it on.”

Participants placed less emphasis on the wearing of a head covering due to the fact that they were not required to wear it every time they left the hospital premises. They were all aware that the Muttawaan had the right to ask them to ‘cover their head’ at any time. All participants had experienced this at one stage or another. They described the wearing of scarves as hot and uncomfortable.

“The Muttawaa when you are out there shopping they shout “cover your head” but the scarves make you feel so warm; it is not nice.”

One participant and a friend decided to ‘test the waters’ and, out of rebellion, not ignorance, went down town without a scarf.

*“We are told everything on our orientation...because we people just ignore it...we think “Ag man, do we really need a scarf”...so there comes the Muttawaa... “Ladies please cover your heads”...She pretended to look for hers...**but we were scared**... We ran into a shop and they went by and we caught a taxi home.”*

Many participants had been verbally abused (shouted at) and even harassed by the Muttawaa. Having only recently arrived in the Kingdom, they expressed feelings of fear, anger and indignation. Adaptation brought with it resignation, highlighting the reality that no matter how they felt it

would not change the cultural dress code, nor would it change the male dominant society in which they were living.

“Just stay away from males, avoid them...and if they scream at you like they did the other night at me, just ignore them and cover your head...always cover your head, be on the safe side always cover your head... You are in a foreign country and you have to respect their culture.”

From a psychological perspective, over and above the feeling of resignation (passive endurance of difficulties), there was always the awareness in the participants' minds that failure to comply with the cultural expectations of dress in this closed country would have consequences, thus creating an element of fear.

“So the closedness of the country ...abayas, closing faces, covering up, the Muttawaas, the religious police... those are actually scary for the South Africans.”

An ironical observation made by many participants was that, despite wearing the abaya and the head scarf, they still seemed to attract the leers and stares of the male population. Many of the participants had the perception that covering their bodies drew more attention, as the males were apparently left wondering what they would find underneath and, therefore, stared at them all the more. On occasion males would 'accidentally' brush against and touch the participants, or make unwanted sexual innuendos, even though they (the males) knew that this was "haram" (forbidden) within the Arab society. Experiences such as these left the participants feeling dirty, naked and 'like a prostitute'.

“... and sometimes I really feel naked, it doesn't matter what I am wearing... if a member of the opposite sex looks at me for too long I feel naked...”

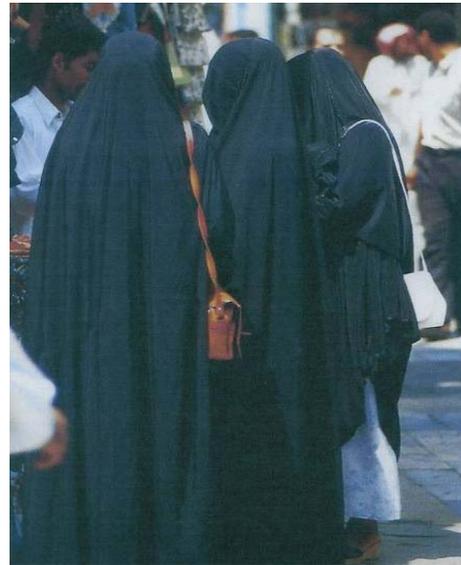
"And the men...when they look at you...they look at you like some prostitute or something. Sometimes they come and they want to touch

you...You feel so dirty because at home people don't do that...You just walk freely."

"But here you always have to be careful...like you know the law is strict...they (men) can't do anything but you still don't feel comfortable...The way they look at you...as if you are naked...although you are covered with the abaya...but you feel naked."

No literature could be found to support these experiences.

Saudi male and female traditional dress remains the same – both personally and professionally



- **Participants' adaptation and experiences regarding discrimination/segregation**

Cascading down from the central theme is the reality of the segregation and discrimination between males and females in Saudi Arabia. Participants were exposed and subjected to this reality from the time they landed on Saudi Arabian soil. They have had no option but to adapt and conform to this aspect of Saudi culture that is so completely diverse from that of their own.

Ham (2004:53) states that Saudi Arabian women undoubtedly have the most difficult time. Segregation between male and female is the norm. Public space is an uncompromisingly male domain that they cannot freely enter. Males may sit and enjoy a cup of coffee and a snack in the comfort of the myriad sidewalk cafes, but a woman must get her beverage and a snack from a cubby-hole window and make do with a bench – if she is fortunate enough to find one nearby. Anger is a common emotion when this discrimination is encountered. Apart from the indignity of such treatment, freedom of movement can be seriously inhibited by it.

Areas that had a particular impact on the participants included the following:

- The prohibition of females driving in the Kingdom.
- Shopping.
- Disrespect from Saudi males.
- Interaction with the opposite sex.

The prohibition of females driving in the Kingdom

“Females aren't allowed to drive here...I don't know why females can't drive?”

Most participants had the means and independence to drive in South Africa. All female participants had been informed when coming to Saudi Arabia that they would not be able to drive. However this paradigm shift

only became real when they actually experienced the 'loss of independence' and had to give way to 'forced dependence' on others for alternate transport, namely taxis or hospital shopping buses.

'In South Africa, as a female or as a nurse, we tend to be very independent... You come and go as you wish... you drive... you get in the car and go wherever. Suddenly you have to be phoning a limo to come and pick you up; you are getting dropped off and picked up...'

"You know the one thing that can easily let one down is the fact that you are not allowed to easily get to where you want to be without being dependant on transport. You have got to wait for a cab or you have got to wait for a hospital bus... You have got to wait for a driver to get you to where you want to be..."

"Not being able to drive I find sort of ok cause I find driving tedious... but it also takes away my independence and that is what I don't want to lose... You know being dependant on limo's... and the drivers are lousy in any case... Wow, they are terrible drivers... no road sense... and then you get the 12 year olds driving too..."

The participants who had not been accustomed to driving and had been reliant on public transport in South Africa did not place as much emphasis on the loss of independence. They focused more on the expense of taxi fares and the way in which people drove in Saudi Arabia.

"There are plenty of taxis... we call them limos here... They are reliable although on your first month they exploit you, those drivers, because you don't know how much to pay from here to there... but as time goes on you learn."

"Use the hospital taxis... just sit back and enjoy the ride, even if they drive like hell."

Shopping

Shopping during off-duty time was identified as one of the main activities for the participants. However, shopping although enjoyable, was not without its frustrations.

“...that’s all what Saudi life is about here...you just go shopping, shopping...you know otherwise you would stay in your room and just get so depressed...”

The participants had to rely on the taxi to fetch them. If it was prayer time they would just have to wait until a taxi became available, as most drivers would be at the mosque, praying.

“I feel like a little invalid sometimes cause I know that at home if I want to go somewhere I just get in my car and you are gone...whereas here you phone and the limo says “I’ll send you a guy in 40 minutes because it is prayer time” and you go absolutely weak...cause what you could have done in 40 minutes...so that is frustrating.”

Secondly, the participants had to contend with the closure of all the shops and restaurants during prayer times.

“Prayer times ...that can also be frustrating because you plan...like I’ll go this time and I’ll come back this time...and while you are still at the beginning they close the shop...You have to wait and its frustrating...the only time you know there will be no disturbances is after the last one at eight, and then you know you are free that time to go... but sometimes you have to go to work the following day...and if you only start shopping at nine o’clock it is tiring...”

Certain shops prohibited females from entering them and only males were allowed to frequent them. Again, this was interpreted as discrimination against females.

“In the shops there is a sign for males and a sign for females... and some shops females can't go into...I really don't know why they have to be so discriminating against sexes...I find that abnormal cause really there is no interaction between men and women.”

Carpets are a popular shopping purchase for Westerners



Gold souks are plentiful in the shopping areas in Riyadh



The majority of shops are manned by mostly male shop attendants. With the exception of one or two malls with a ladies floor, no garments were allowed to be fitted in the shops. All items had to be taken home for fitting and the garments that did not fit had to be taken back to the shop – an event which proved to be a frustrating and expensive exercise for participants in regard to both time and money. Many participants, who were unaware of the prohibition of trying on garments, were made to feel very uncomfortable by the male shop attendants.

*“And what is also strange here is that in the shops all assistants are males...all males...so when you fit things on you feel awkward doing it over your abaya... and like I said I have hardly bought myself anything decent ...you can't try on the size. I attempted that and they **shouted stop, stop, stop**... I don't know why they don't employ females in female stores so that*

you can feel ok... I felt terribly uncomfortable and I also think it is very unfair...there is not a balance between male and a female especially as far as employment is concerned ...the men run the show..."

"And then you are not allowed to try anything on in the shops...there are no dressing rooms...so you have to take it home and try it on...if it doesn't fit then you have to take it all the way back...and its expensive taking taxis all the time..."

With regard to the woman's right to seek employment, it should be stated that Islam regards her role in society as a mother and as a wife as the most sacred and essential one. However, there is no decree in Islam that forbids a woman from seeking employment whenever there is a necessity for it, especially in positions that fit her nature and in which society needs her most. Examples of these professions are nursing, medicine and teaching (Al Thani, 1980: page unknown).

In Saudi Arabia, employment of Saudi women is a current issue under discussion. An article written by Mr Al-Eqtisadiyah (2005:page unknown) entitled "*Women demand more private sector jobs*" states that fifty percent of the current jobs available in the private sector do not suit either the nature of Saudi women or their culture. Additionally, the article states that the private sector should come up with ways and means to accommodate Saudi women, who represent half of the Kingdom's population. This is imperative as it is impossible for the government to bear alone the burden of employing thousands of men and women graduates. The private sector has been accused of lethargy as private institutions provide thousands of jobs for male graduates, while completely ignoring Saudi women by failing to either create new job opportunities or provide a suitable work environment for them.

A hospital supervisor said that the private sector should provide more job opportunities for Saudi women so that they can prove themselves in the market just as Saudi men. Furthermore, she stated that new laws must be

created to guarantee that women retain their legal rights in the private sector, as they are subjected to harassment from male visitors and restrictions from supervisors. A Saudi working for an advertising company stated that there was an obvious reason why the private sector was not employing Saudi women. This was because fifty percent of the jobs were unsuitable, for example in factories, workshops, showrooms, supermarkets, restaurants, etc. All of these sectors could not employ Saudi women, as it would be against the law for them to work in a mixed environment, with the exception of the medical field.

Disrespect from Saudi males

Hassan (1989:1) explains that Muslims, both women and men, consider it self evident that men are superior to women. Furthermore, he writes that they justify many manifestations of inequality as inherent Islam; women are regarded in a number of contemporary Muslim societies as less than fully human because it is widely believed in some contexts that one man is equal to two women.

The juridical deliberations in the exclusively male orientated traditional centres of Islamic learning, the madrassa, have disregarded female voices and treated them as “absent” in the emerging discourse connected with women’s issues and human rights. The redefinition of the status of a Muslim woman in modern society is one of the major issues that challenges Muslim jurists’ claims to be the authority on legal-ethical sources of Islam. Such a redefinition is dependent upon Muslim women’s participation in the legal-ethical deliberations concerning matters whose situational aspects can be determined only by women themselves. Without such participation in the interpretive process, Muslim women stand little chance of overcoming being reduced to the legally silent, morally segregated and religiously veiled half-the-man (Sachedina, year unknown:13).

“Well one of the obvious things that struck me was the total disrespect for women. I experienced it in simple every day happenings, like I would walk through a gate and I would step aside...They have this movement with their

hands where they hurry you along instead of stepping aside and letting you pass... It's things like when the lift opens and there are males involved...It was just a look that you got that was to warn you...don't go in there...and if you didn't give way, they would basically just walk you out of the way."

"It is because some males in this position of security they have this air of superiority around them and with that they can say and do anything to you...they can be as rude as hell to you and you just have to be quiet...So you can't tell them off because you will be the one to land in jail...So you have to make peace with the fact that if they are anyone in uniform, you have to keep quiet and live with it...go afterwards and stick a voodoo doll full of needles, if you have to but please don't retaliate...you are not in your own country... And these people don't have a system and you can't fight against a non-existing system...and women don't have citizenship here...I recently found that out..."

The male participant in this study also experienced disrespect from male Saudis when shopping. This evoked feelings of anger and frustration.

*"And even in the shops...like you will be standing in line for half an hour and you will be next in line...So then this man comes with his robe on and everything else and he comes out of nowhere...out of the back of the line and says "salam aalaykom" and he gets served....**and that makes me mad**, because if he leaves and the next person also comes out of the back line and says 'salam aalaykom'...and he gets served...and you are just standing getting ignored..."*

Gender interaction

As a consequence of strict segregation between the genders, participants experienced very little communication between men and women in public.

"The only thing that is a big bone of contention is...and I understand the reason for it but it is still not a nice thing, and that is the whole thing of segregation...the whole thing that we don't have free socializing

*opportunities. I mean the other day we almost got arrested for talking to a man in the Kingdom and that's scary, **that's really scary**. You know you are so used to doing this kind of thing, and actually at home you depend on those kind of social interactions and here you are cut off completely, you feel as though you are in a monastery and there are a lot of nuns there and they are only allowed to talk to each other...**it is very restrictive and very irritating.**"*

Men and women do not shake hands in Saudi Arabia, a concept that proved to be confusing for many participants and even humiliating for one.

"I wasn't sure whether I should greet them by hand...so I just stood and said 'Hello, how are you?' and I felt like an idiot because normally I would hug a person...just a friendly hug and that is nothing to me...but here I am even too scared to stand too close to a guy... so that I find a bit strange."

*"**I am too scared to interact...**I am not sure what I must do and mustn't do...I'm not sure if I can shake their hand or what."*

*"One of the humiliating experiences was that I tried to greet a Saudi man by putting out my right hand and he reprimanded me...he said 'It is not in my culture to shake hands with you'...and that was in front of other people...**and it was very humiliating.**"*

Eye contact should be avoided with anyone of the opposite sex in Saudi Arabia. Any deviation from the accepted norms could be interpreted as a desire to start a relationship, whether this is the intention or not.

"You are not allowed to even look at men...not that men are so important in our lives but normal conversations...you know, normal social activities."

Western couples should avoid physical contact with each other in public. Even if modern-minded Saudis are seen to be holding hands, they should not be imitated. Eating out in restaurants with someone of the opposite sex

who is not a relative or husband is not allowed. Muttawaan are renowned for paying visits to restaurants to find those who are disobeying Islamic law. Consequences of such a liaison for a Western male will include arrest, a warning and a record kept for future reference. If the male persists with continuous fraternisation, he risks imprisonment for an undisclosed period and then deportation. A Western female will also be arrested and can be deported with “prostitute” stamped on her passport.

The segregation of males and females in Saudi society is important. Socially, women are not permitted to be in the company of men unless they are related – a father, brother or husband. Dating is strictly forbidden. A single Western female found in the company of a single man who is not a relative can be punished by harassment, jail or even deportation (Anderson, 2002:21). A single Saudi woman would be held until her male relative was called to give the reasons why she was in the situation.

“Women..... I mean they are not allowed to do anything...if you walk around with a man in the street they are going to arrest you...it is not fair.”

“Young people coming to the country sometimes overstep the mark... You know we had the South African nurse that landed up in jail because she went to a restaurant with another lady and the lady’s boyfriend... She landed up in jail, she is a very young South African nurse. Maybe as South Africans we are not aware of all the dangers and pitfalls; it is a very closed society.”

Within the hospital, there are three cafeterias – one for men, one for women and a family dining room. Female nurses may provide nursing care for male patients. Male nurses are not permitted to provide any direct patient care to a female patient and are not even permitted to enter her room unless she has a male relative present or the male nurse is accompanied by a female nurse or physician. The most innocent behaviour on the part of the male nurse could be misconstrued by the female patient and could result in the male being deported. Housing is segregated and

visiting is not allowed. Social amenities, such as the swimming pool and tennis courts, have separate days assigned for male and female utilization.

“Recently we had some of the South African male nurses visiting the single female quarters to have a party there...They landed up in jail.”

With all the restrictions placed on Westerners, participants found that their compound was the safest haven in which to socialize. Many were happy to stay at home or to visit with friends on other female compounds.

“Ek vind nie problem daarmee nie, want ek is nie ‘n socialite nie...so as ek uitgaan gaan ek meestal saam met my vriendinne uit...sodat dit nie ‘n probleem is om ‘n man te hê in my midde nie...so, not a problem...I don’t know what women do if they want to socialize with men...” (I find that I don’t have a problem with that, because I am not a socialite...so if I go out I usually go with my female friends...and it is then not a problem not to have a male in our midst...)

“I don’t go out a lot. That’s another thing I don’t go out a lot...only if I really need to. I watch TV. There are many channels to watch that we pay for from the social club...and when we get tired... that’s another thing that will make me fat...I eat and watch TV and sleep.”

“So really since I have been here as far as socializing goes, it has been shopping, staying on campus and having a support group of friends.”

For those participants who felt the need to socialize outside the confines of the compound walls, limited opportunities were available. Participants who enjoyed travel and nature went on trips offered by the hospital's social club, while many joined a club called HASH. The HASH community organizes walks/runs in the desert every weekend.

For the participants who were ‘party goers’, parties on ‘mixed’ (male and female) compounds occurred frequently. Various compounds in Saudi

Arabia are rented by major companies. These compounds house families and single men separately, thus the term 'mixed' compounds. Given that the Muttawaan have little or no jurisdiction over these compounds, social evenings are held frequently. Accordingly, male and female interactions took place without the fear of harassment and being caught.

"If you want to socialize with males you have to go out to a place where males are...and that for me is very strange...When you walk in, there's all these men standing there and here a group of girls walk in...It is just so strange...whereas back home we get used to walking in with our partners."

Many participants, however, expressed concern regarding the behaviour of some of their fellow South Africans when socializing at these parties.

"...and then of course you are not allowed to date and court and that is why if you go to a party on a mixed compound...the people go crazy."

"They start acting like bachelors and doing things that they would never do at home... and I mean like if you are not used to doing it back home then why do it here and change everything you believe in... It is almost as if they know they can get away with lots."

"I went to one party and I didn't like it...not at all. The majority are married to people but not to each other...I don't like that scenario...They are overseas and their spouses are at home...families are at home and they are having a 'good' time here."

" If you have got a relationship you must remember it as positive and I mean I don't think these people ever want to remember it at home, because they can't explain it to anybody at home that they had an affair this side..."

For many participants adaptation to the diverse social environment was a struggle. The segregation between males and females was perceived as

abnormal and evoked varied responses from the participants. Feelings of frustration, irritation, anger and boredom were experienced.

Ham (2004:52) states that, apart from travelling and eating out, there is little else with which to occupy your time in Saudi Arabia. Entertainment, in general, is very thin on the ground; there are neither cinemas nor bars in Saudi Arabia. Moreover, he warns that if you can't live without Western forms of entertainment, Saudi Arabia is not for you.

“People tend to socialize on the compound and not in the city because there is not activities like back home...for instance you don't have bars, you don't have sports clubs, you don't have movies... with the result you get together with friends in the compound to watch DVD's or for a birthday party... You also can't bring males onto the compound.”

“There is no social life in this city for Westerners.”

Desert ruins on the outskirts of Riyadh



3.4.1.3 Sub-theme Three: Participants' Emotional/Psychological Adaptation

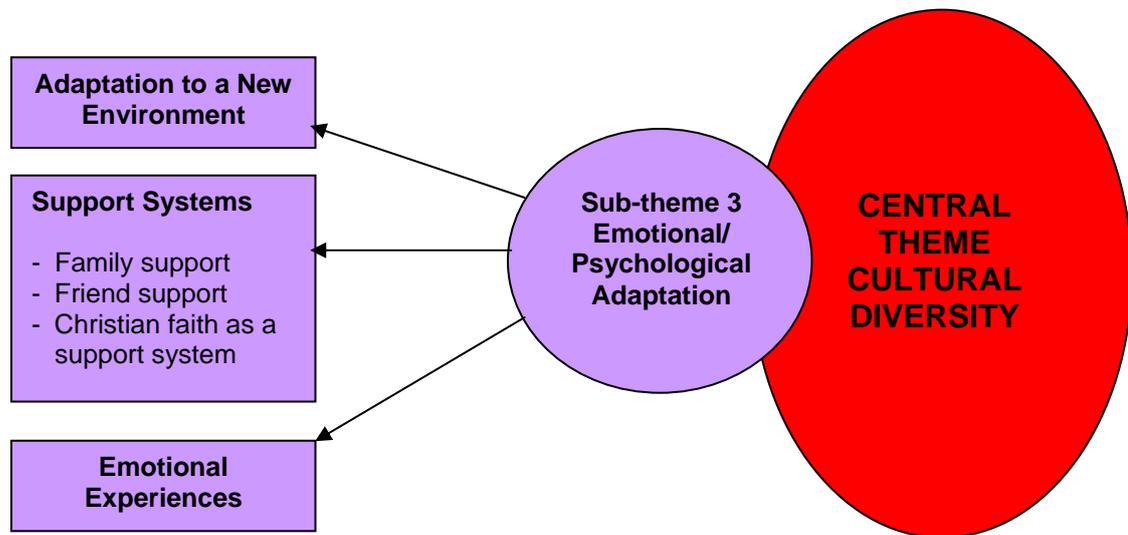


Figure 3.4: A Diagrammatic Representation Of Sub-theme Three

Theories in psychology refer to various ways in which each of us can positively influence our own psychological well-being. By monitoring our feelings and behaviour, we can determine the kinds of actions and situations that cause us pain and, conversely, the kinds that benefit us the most. By trying to analyse our motives and abilities, we can enhance our capacity to make active choices in our lives, instead of passively accepting what comes. A few suggestions for staying psychologically health, according to Atkinson, Atkinson, Smith, Bem and Hoeksema (1996:584), are as follows:

Accept your feelings – Anger, sorrow, fear and falling short of ideals are all unpleasant emotions and we may try to escape anxiety by denying these feelings. At times we try to escape anxiety by facing situations unemotionally, which may lead to a false kind of detachment that could be destructive. We may try to suppress all emotions, thereby losing the ability to accept as normal the joys and sorrows that are part of our involvement with other people. Unpleasant emotions are a normal reaction to many situations. There is no reason to be ashamed of feeling, for example, homesick or angry or guilty. These emotions are natural and it is better to recognise them than to deny them. Discussing the situation with a friend or taking a long walk can dissipate

anger. As long as one can accept the right to feel emotion, one can express it in indirect or substitute ways.

Know your vulnerabilities – Discovering the kinds of situations that upset us or cause us to overreact may help in guarding against stress. Trying to pinpoint the cause of our discomfort may help us to see the situation in a new light. Many people feel especially anxious when they are under pressure. Careful planning and spacing of work can help us avoid feeling overwhelmed.

Develop your talents and interests – People who are bored and unhappy seldom have many interests. Often the more we know about a subject, the more interesting it (and life) becomes. In addition, the feeling of competency gained from developing skills can do a great deal to bolster self-esteem.

Become involved with other people – Feelings of isolation and loneliness form the core of most emotional disorders. We are social beings, and we need the support, comfort, and reassurance provided by other people. Focusing all of our attention on our own problems can lead to an unhealthy preoccupation with oneself. Sharing concerns with others often helps us view troubles in a clearer perspective. Also, being concerned for others can reinforce our feelings of self worth.

Know when to seek help – There are limits to self-understanding and self-help. Our tendency towards self-deception makes it hard to view problems and emotions objectively. When one feels that one is making little progress in gaining control, it is time to seek help. The willingness to do this is a sign of emotional maturity, not a sign of weakness (Atkinson et al, 1996:584).

- **Adapting to a new environment**

Leaving home and loved ones was traumatic for all of the participants, mostly from an emotional perspective. As mentioned by Andrew and Boyle (1995: 432), there are certain reasons that motivate a nurse to choose to migrate to a particular country, including political stability of the country, personal/emotional reasons and/or matching host country needs with the expertise of the nurse.

The latter two reasons were the motivating factors for the participants in this study. The primary personal reason was financial gain and international

exposure (personally and professionally) was the secondary reason. Participants held on to these reasons when saying their farewells in an attempt to diminish the pain and sadness that the separation from family and friends brought.

“It was very traumatic (leaving the family behind)...It was extremely traumatic...I cried all the way...I was tearful for the first three months... Sometimes I just felt I could not cope at all... but you know the trauma doesn’t stop after three months it just continues... the past six months being away from home is just too much.”

Furthermore, Andrews and Boyle (1995:430) state that whenever people are immersed in another culture, they go through a period of cultural adjustment. The W model is a well know pattern of cultural adjustment and is one of the few concepts agreed by professionals involved in cross-cultural education. Fig 3.5 illustrates the theory. There are five stages of cultural adaptation, as illustrated in the points on a W indicating the troughs and peaks of emotional and cultural adjustment. This pattern may depend on the length of stay and the purpose for being in another culture.

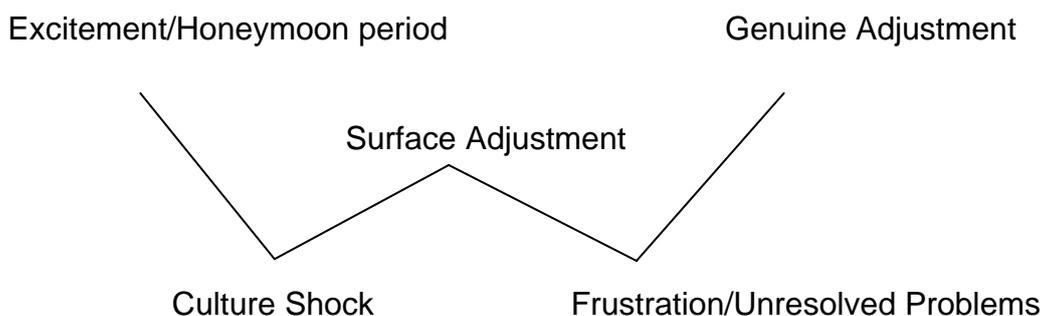


Figure 3.5. The W Model Of Cultural Adjustment

The five stages mentioned by Andrews and Boyle (1995:430) include:

- **Excitement or “honeymoon” period** – characterized by enthusiasm resulting from the newness and sense of adventure.

- **Culture shock** – the excitement is gone. Things are not ‘like back home’. Social cues and relationships are difficult. There are feelings of alienation and homesickness and a temporary dislike of the host culture.
- **Surface adjustment** – during this stage, the nurse is beginning to catch on. Things are starting to make sense, rudimentary language skills are acquired and the nurse is able to communicate some basic ideas and feelings, making some relationships in the local culture. The nurse begins to feel more comfortable.
- **Frustration** – and a deeper level of unresolved problems arise. The assignment in the culture may seem very long, and the nurse may experience feelings of boredom, frustration, and isolation.
- **Genuine Adjustment** – genuine adjustment is characterized by acceptance of the new culture as just another way of living. The nurse may not always approve of cultural practices, but understands the differences and begins to peel back some of the rich layers of the culture. The nurse has established genuine, real relationships with people in the host country.

Having been in the Kingdom for between three to six months it was evident that participants were experiencing or had experienced the first three stages identified in the cultural pattern, namely, excitement or “honeymoon period”, culture shock and surface adjustment. The excitement stage began from the time the participants boarded the plane in South Africa as many had never had the opportunity of international travel. The exposure to flying on an international airline as well as experiencing a brief stay in Dubai was exciting for them, albeit exhausting and frustrating at times.

"The morning we landed in Dubai it was fine because we knew we had to get a voucher and go to a hotel, but it was the whole scenario of coming through customs and being told to wait here and stand there. Eventually a driver picked us up. By then you are so tired emotionally and physically that you just want to get to a place where you can just bath and sleep."

"The driver picked us up two hours before our flight was scheduled to take off for Riyadh...We get to Dubai airport and go to the ticket counter and get told that we were not booked on the flight...and we were sent on a mission...and one of the frustrating things was they could see we were Westerners, we could not talk Arabic and so people were shoving us...and that was the time I really wanted to scream."

The introduction to Saudi Arabia encompassed exploration of the city, the shopping, the hospital, the compound, the meeting of new people, and the exposure to a very different culture, both in the 'living' and the 'working' environment. By the participants' own admission this initial introduction was indeed a "honeymoon period" and feelings of excitement as well as moments of anxiety and apprehension were experienced.

"We got to Riyadh...it was great getting met by you...a South African...that was the first relief...a familiar face...somebody that speaks the same language...that was a huge relief..."

"Getting to the hospital accommodation...it was absolutely shocking cause it was far, far better than any of our facilities have in South Africa...To me it was a five star facility...You are made as comfortable as possible...you have everything in working order and even a little food basket was waiting for you..."

"I went to the photographic department ...I went to the plastic surgery department...and...Wow...the information and photos they had was unbelievable..."

It became evident when interviewing the participants that they had exited the "honeymoon period" and entered into the second phase of cultural adjustment, namely, the stage of culture shock. This was especially noticeable from an emotional perspective. All were experiencing a 'roller coaster' of emotions. The 'lows' ranged from the sadness of being so far away from home, the immense feeling of home sickness, the missing of

their loved ones, the worrying about problems back home, the loneliness and isolation, the frustrations of having to abide by the diverse rules, the fear and apprehension of making a mistake in action and/or word, to the consequences that faced them if they transgressed. The 'highs' ranged from happiness at meeting new friends, to a new sense of security due to the crime free environment and to relief and achievement when meeting financial objectives.

"I am not a person to cry. I am not a tearful person, but I am telling you here I cried. You sort of want something familiar and there is nothing familiar around you, especially when the loneliness sets in and there is lots of times I used to withdraw completely, not even speak to my flat mate, just withdraw and sleep and get up the next morning and so on."

"If you are not emotionally strong...if you are not very mature...you should stay away from this country. ...You will at the end ruin your own life as well as that of your families...and I know of some of my friends that have gone back and that are still traumatised .You really have to be really well prepared emotionally... support structures...physically... because we work very hard."

Ham (2004:52) states that the possibility of transgressing some seemingly obscure law is a constant concern in the Kingdom. One area of constant anxiety to all expatriates is surrendering your passport upon arrival. While you are in Saudi, your employer safeguards your passport, a practice that prevents you from leaving the country if you have decided you've had enough. Participants verbalized that this had been a cause of feelings of apprehension and anxiety.

"When you get here your passport is taken away from you so that already causes insecurity...because in South Africa you know how much your ID and passport mean to you...Suddenly you get into a country and that is taken away from you and you are given a book called an Igama, which doesn't mean anything in any other country except here...so that creates

an uneasiness with you. Because if anything happens to me I know I may be able to get out of Riyadh but I won't get further than that with an Igama...so that it is scary for me."

Guilt and heartfelt pain were emotions experienced by the participants who had left a family, more specifically children, behind. It was apparent that the absence of one parent had had unexpected consequences, which were evidenced in the child/children's behavioural patterns. More than one participant testified to the fact that their child would not talk or communicate with them, while others reported that their children had become withdrawn, would not eat, had started stealing and that school work had deteriorated. These behavioural changes had occurred since their departure.

"Net wat my eendag baie hartseer gemaak het...Ek het vir my man gebel en hy het gesê dat die tweede jongste van my eet nie graag nie...en die onderwyser het hom ingeroep oor die middelste ene...die middelste ene is verskriklike stil en oor sy ma nie daar is nie...is hy ekstra stil...En hy het die aand die kos ingeskep...Hoe roep hy nou die middelste ene...Hy moet kom eet...Toe sê hy, hy is maar besig... Hy sê hy gaan kyk en hy is besig om vir my 'n brief te skrywe...en hy skryf in die brief in... "Hy verlang so na sy mammie...hy weet nie hoekom sy mammie weggegaan het...hoekom het sy daddy nie Saudi toe gegaan nie...hoekom het sy mammie gegaan". Daardie aand toe sit ek die foon af en ek huil...en die next oomblik toe bel ek om die middelste een te praat...Hy praat nou nog met my kort...hy antwoord my net...As ek hom vra "Hoe gaan dit?"..."Goed" hy antwoord net die nodiges...nou daardie is my stil kind wat so sterk was op die lughawe...wat vir my gesê het "Mammie hoekom huil jy...gaan vee jou trane." (Just something that made me very heart sore one day....I phoned my husband and he told me that my second youngest was not eating well...and that the teacher had called him in about the middle one because he is very quiet and because his mother is no longer there he is unusually quiet. That night when he dished up he called the middle one to come eat and he answered that he was busy. He went to look and saw that he was busy writing a letter to me...and he wrote in the letter that he was missing

his mommy...and did not know why his mommy had gone away...why did his daddy not go to Saudi...why did his mommy have to go? That night I turned my phone off and I cried...and the next moment I phoned to talk to my middle one...his response was in monosyllables and when I asked him how he was he said fine. He only answered the necessary...that is my child who is so quiet and who was so strong at the airport...who said to me, mommy why are you crying, wipe your tears.')

"It has been very tough emotionally...very difficult (being separated from my daughter). We had a strained relationship at one stage... She could not understand why I had left her for so long...So she had a bit of anger directed towards me and wouldn't talk to me for a while...and now at least she is a bit more vocal in expressing how she misses me and how much she needs me...I feel terribly guilty and selfish because its my own professional and personal goals and sometimes I am very resentful for doing it...However you have to focus on your goals. "

In the workplace the 'roller coaster' of emotions continued. Participants experienced negative and positive feelings, namely inadequacy, depression, discrimination, frustration, anger, worthlessness, exhaustion - mental and physical, stimulation and achievement.

"I have gone through a lot of emotions...a lot of emotions...I've gone through total panic, total panic... "What am I doing here...what did I get involved in...sort of questioning...why did I actually come?" You know it was total panic and then extreme anxiety...I had so much anxiety and emotional exhaustion to the point that I had lots of physical complaints because of that...you know lots of headaches, I had a stiff neck, lower back pain, knees ached...you name it...and even one girl said "You look terrible"... You know to be physically tired is fine but to be emotionally tired is bad and painful."

Theron (2003:2-7), having thrice made the cultural leap into the new, suggests that to be successful in adapting to a new culture one needs to be mindful and adhere to the following:

- *Always expect a challenge:* Placing yourself in a totally foreign environment without any family or friends is hardly ever easy. One must be prepared for an exciting, but challenging time (Theron, 2003:2). A participant shared similar experiences:

"It has been a tremendous trial and test of everything in me...One of the things I have really and truly learnt to see more clearly or understand more clearly was appreciating every single person in my life...not only family and friends...even professional mentors..."

- *Keep an open mind:* There is no greater guarantee for unhappiness than to take your prejudices with you. Forget about the way things were done back at home; if you are going to make value-judging comparisons, you are going to get hurt and antagonise the people you most want to accept you (Theron,2003:2). A participant shared as follows in this regard:

"You know, I respect peoples religion or prayers or whatever...so either you have to shop very, very quickly, or just be prepared to wait when the shops are closed for prayer....and I think because of that, what I have personally experienced is just to be patient..."

- *Learn the language* – You cannot understand a person or their soul until you can speak their language. It doesn't matter how broken and badly your use of the language is, you will find people will smile and help you, rather than ridicule you (Theron, 2003:2).

"I have an Arab PCA (patient care assistant) on the unit who teaches me a new word everyday and I teach him an Afrikaans word...And if they see you want to do it...everybody teaches you."

- *Go out of your way to make friends* – Be open and friendly. You need to strengthen your position, and for that you need to establish your presence as a valuable and worthy edition to your environment. Be yourself, kind, open-minded and honest. Be willing to make compromises and soon you will have made friends (Theron, 2003:3).

“Friendships and really just companionship is really important...it’s important to form friendships...and I think that happens spontaneously and by being selective you will choose the ones that work for you.”

“I think it’s essential that you need a to buddy up with people who already know what’s around and what’s going on.”

- *Don’t become dependent* – It is a terrible trap to fall into, that of focusing all of your time and energy on someone you may know. Don’t become reliant on others from your homeland just because you can communicate with them. Act as though you have no support, because that is true - you must develop your support network in your new life yourself (Theron, 2003:3).

“It is important to remember to realise that people are, if you are going to lean to heavy on them, they have the right to say “I cannot carry you”...so there are a lot of things that you have to do on your own.”

- *Get to know your new world* – Explore as much as you can, on your own or with someone else. Ask questions and read brochures or books. Make yourself at home where you are now. Go out of your way to see the good, the beautiful and the interesting in your new home (Theron, 2003:3).

“I go out for walks in the desert o the weekend with the HASH...I have also gone to the opera society on Sunday...I also go shopping by myself...I get into the limousine and I do my thing.”

- *Keep yourself active* – Continue practising the hobbies or past times you had back home, or start new ones. Avoid spending your free time moping about the differences between here and "back home", because you will depress yourself (Theron, 2003:4).

"I do a bit of art...they have "art attack" on channel 34 every night and I try that because it is very simple art...I am creative but not that creative to sit and paint a vase with flowers in or whatever...I think I have something here that I did..."

- *Never feel sorry for yourself* – If you come across as happy and appreciative of what you have, who you are and where you are, then becoming part of your world will be so much easier (Theron, 2003:4).

"My head nurse said to me one day "don't destroy yourself...it is not worth it"... and I thought "what is she talking about?"... And then she said "pull yourself together"...and I thought about it for a very long time and said "ok...its not working so I must change my attitude."

- *You and you alone determine your happiness* – Thinking that others can make you happy or not, will not find you true and lasting happiness. So be your best friend and nurture your capacity for happiness...then your new environment will not be able to get you down (Theron, 2003:4).

"You have a lot of time to yourself...you are going to have to live with yourself...so you are going to look in the mirror and see yourself everyday...so if you are fleeing from somebody you just better hope its not yourself...you make your own happiness..."

Support Systems

Man's existence is an existence of relationships and involvement with the world, time, fellow beings and God

Kotzé, 1998

Victoria Hine, founder director of Lifeline Shanghai, based in South Africa, stated that "The idea of establishing a support service is essential for expatriates". Furthermore she went on to say "Given the glamorous myth surrounding expatriate communities, I think many people feel it is embarrassing or shameful to admit to be in need of support. The result is with no one to talk to, problems only get bigger and bigger and can result in drastic measures. Every day, someone, somewhere will be having a little breakdown. It's all right for expatriates to have problems and challenges. It doesn't make them bad people...and it's really OK to talk about it". Expatriate life can be isolating and with this isolation comes depression. People just want affirmation that what they are feeling or experiencing is not so unusual and that it will pass (Pascoe 2005: page unknown).

"But...you need support professionally...you need support socially...socially is a big thing."

"So I think the most important part of support would probably be to have support groups here. I know that you for example, were ...for us... you were a very important support person. Even the braai on the roof was an important support thing because there you get to talk to people...fellow South Africans who are experiencing the same thing as you and...who you can trust to guide you and support you and help you. Then you can vent your feelings and reflect ant they can give you valuable feedback."

It was evident that some participants had entered the third stage, **surface adjustment**, as they sought and formed various support systems to help them cope with the cultural adjustment. These support systems were the

participants' life lines to successful adjustment, as they journeyed through all the phases of cultural adaptation.

Participants were grateful for the support that they received from the Coordinator and presenters whilst in General Nursing Orientation (GNO). They viewed the GNO as a period where they met other new staff, bonded with fellow countrymen and developed friendships and support groups.

"You get support from you the GNO coordinator...You get support from your buddies in your group...your own little peer group...the class in general and you find that everyone is supportive and welcoming..."

"It was really helpful to have people around you to show you, I think you were part of the orientation team so your telephone number was right next to my telephone in case I needed it."

Other areas of support were from colleagues on the units, fellow South Africans and the hospital formed Social Club. The Club arranges trips, activities and internet facilities for the KFSH&RC employees. However, most participants identified three main areas of support, namely, family, friends and Christian faith as assisting them through their time in Saudi Arabia.

"H has been here for three years and was very helpful...She came and actually took us around, we went shopping and we had our cell phones connected. Otherwise we would probably have fallen into the trap of sitting isolated in our rooms for the first couple of days...not going anywhere because we were too scared."

"I must say I really appreciated it when they opened our internet café facility where we live, because I couldn't keep up with writing emails at work and the telephone is difficult because it is just so expensive."

"It is to do with coping mechanisms and support groups around us that makes the difference. If your family supports you...if everything goes well at

home...maybe the success rate is higher you know and you will adapt just a little bit better on this side."

- **Family support**

The meaning of personal world- it is the intimate dimension of man's life-world: where he is trusted and where he can trust – with confidence, can confide, can fail without the fear that his secrets, his weakness will be betrayed.

Kotzé, 1998

For all participants it was vitally important that they had the support and understanding of their families. Staying in touch with them via emails, letters and the telephone was considered to be a "life line" and a necessity. Participants verbalised that they were able to cope better if they knew that all was well with their families back home in South Africa.

"Communication home is very important, you know that your family is concerned about you, and you want to hear from them, and I think it is good psychologically to hear a voice from home."

"They all phone...my brother...my grandmother...and I phone them...and they tell me everything that is happening at home."

Participants appeared to have adjusted more easily to their environment if their family considered their separation from home as a means to enhance their personal growth.

"And for me to fly overseas they feel great they say "our child makes something" like progressing whatever...they don't feel bad at all...they were happy...they even made a party for me when I left."

"She (mother) doesn't mind, she wants me to grow, she knows that I know how to take care of myself she trusts my decisions."

Refer Chapter 4 Orientation sub-guideline 4.4.2.1. for further discussion and literature regarding family support.

- **Friends' support**

The meaning of personal world – it is the intimate dimension of man's life-world: where others need him and where he is available to them and where others know that he needs them and will be available to him.

Kotzé, 1998

Participants verbalised that it was very important to have a solid friendship base that you could draw on if need be. With families and loved ones being so very far away, friends became all the more important. They were close by and could, more often than not, identify with what one was going through. If there was a need to unload it was easier to unload with somebody face to face, rather than having to pick up the phone and tell loved ones. Friends were in the same situation and were able to respond with sympathy, and at times had the answers to what was going to happen, what could be expected or how to handle a situation.

All participants recognized that they would not have coped nor survived if it had not been for the support of friends, old and new.

"If you do not have friends you will not survive here... you need to be able to discuss with friends whatever you go through...your frustrations."

"If you do not have friends it is impossible to survive...I've come across a number of colleagues...at the bank and other places and they felt very bad...they were tearful you know they...they couldn't make friends...they didn't have support structures...and this was my advice to them, to try and find among the 215 South Africans somebody or a couple of people that they could at least discuss some of their emotions and some of the issues with them."

“Fortunately I have a friend outside at another hospital so we are always comparing and we are able to support each other.”

Refer Chapter 4 Orientation sub-guideline 4.4.2.1. for further discussion and literature regarding friend support.

- **Christian Faith as a support system**

The spiritual dimension represents the core or nucleus of humaneness. As a spiritual being, transcending him/herself, man is open and by virtue of his openness and his nature of intentionality, man is continually becoming-growing and changing.

Kotzé, 1998

It has been discussed in 3.4.1.1 as to how important it was for participants to have a living and real faith that they could turn to and rely on. Over and above this, fellow Christians served as an essential support system.

“If I was not a Christian and if I did not have the faith I have then I would not survive...for a Christian in this country it is an enormous challenge...There is an enormous network of Christians here, you know, that keeps you going ...but if it wasn't for the faith I believe in... that there is a purpose where we are and whatever we do...God has a purpose for us... and my family also pray for me and of course I pray for them....if it wasn't that we as a family are so close to God...I would never ever survive...”

Refer Chapter 4 Orientation sub-guideline 4.4.1.1. for further discussion and literature regarding Christian support system.

Emotional Experiences

Throughout this chapter it has been evident that the participants' experienced many varied emotions and feelings – fear, anxiety and stress; frustration and anger; sadness guilt and pain; worthlessness; satisfaction and excitement.

"In a nutshell I have experienced happiness, sadness, depression, anger, frustration...relief, guilt...sometimes ecstatic when you achieve a little thing...like "Wow I finally performed a power point presentation"...and other times terrible sadness when you think of your loved ones left behind..."

Most participants had experienced the first three stages of cultural adjustment, namely, excitement, culture shock and surface adjustment. Related emotions and feelings (mentioned in the previous paragraph) experienced by the participants' were an integral part of these stages. Due to the participants having being in the Kingdom for a short period of time they had not as yet reached the **final stages**, namely, **frustration** and **genuine adjustment**.

Most of the participants felt that the "sacrifice" of coming to Saudi Arabia was worth it especially as far as financial gain. Many had managed to pay off debts and provide their families with much needed financial relief. This gave the participants a sense of achievement and pride and this compensated for the negative emotions experienced.

"I have only been here for four months but I have paid for my youngest sister's fees...I am finished...so it was taking long for me to pay all this at home, because if you have parents that are not working and you want to help your sisters it is very difficult...So at home you pay the rent and the fees and this...and you land up with a lot of credit and it is stressful...So I think for me it is less stress...I have paid my sister's fees and I don't owe anybody...and maybe from next year I can start working on my own things..."

"Yes (financially) from what I hear from my family back home, and from what I have seen that they have done, and what I can share with them and ask them please to do this for me...do that for me...it is worth it and is coming together."

For a few of the participants, the 'sacrifice' of coming to Saudi Arabia had not been worth the pain or the financial gain. Two of the participants in this study did not complete their contracts (South Africans sign a two year contract. If they break their contract at the end of the first year, they forfeit the two weeks

severance pay that they have accrued during the first year. If they resign before working a period of 240 days in either year, they will incur certain penalties, that is, 15 days pay is deducted for failing to complete their contract. If they fail to give 60 days notice prior to resignation a further 15 days pay is deducted. Severance pay in the second year is paid on a pro rata basis).The emotional anguish experienced in the workplace and that of being separated from their loved ones were the prime reasons. The time they had lost with their families was seen as a traumatic and negative experience.

"If I knew before I came what I know now...and the guidance that was needed for my children...I wouldn't come. It makes me feel very bad and I think for the rest of my life if my children aren't settled I will blame myself...the money is not worth being here...I have missed out on such a lot...if I can advise young people with young children...especially married people...please do not come to this country...I appeal to them...do not sacrifice your children and your families...do not sell them out...this is how I feel...I have sold them out."

Andrews and Boyle (1995:430) wrote that being aware that there is a pattern to feelings and reactions to the new culture is one step in making the nurse more effective in the international setting. However, some may decide that trying to adjust is too difficult and return home early at the "culture shock" stage.

"And if you can't adjust...then you must stay at home...One of the girls that came in with me went home because she just could not adjust."

The faceless interaction of Saudi women and men within the hospital environment compared to the Western nurse's interaction



3.4.1.4 Sub-theme Four: Participants' Professional Adaptation

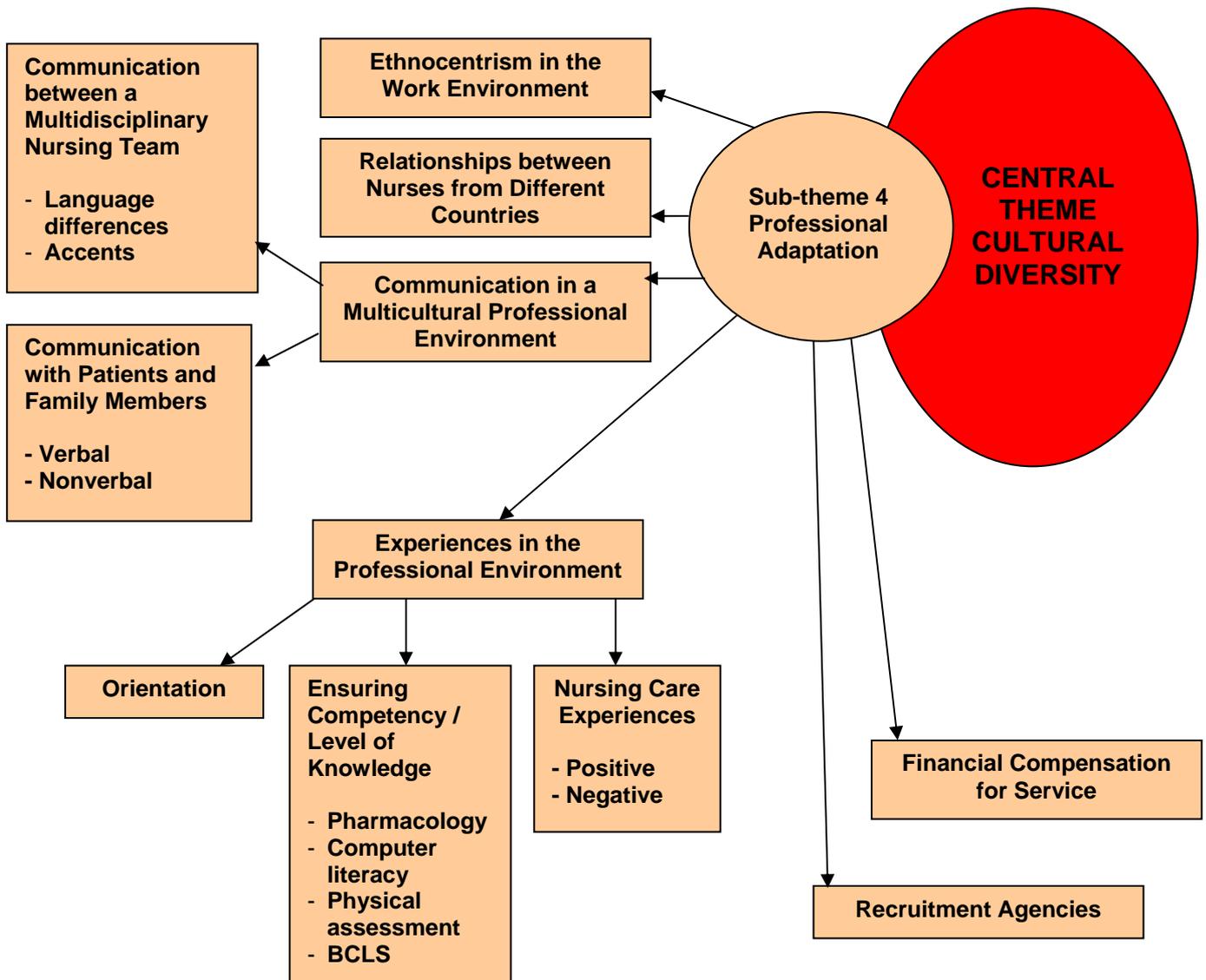


Figure 3.6: Diagrammatic Representation Of Sub-theme Four

Hassan (2004) stated in the Arab news that, despite the government's Saudization efforts, foreign workers keep pouring into the Kingdom. Only 500,000 Saudis are officially said to be working in the private sector, which is where the majority of the six million expatriates work. This puts the level of Saudization of the workforce in the private sector at eight percent, far below the thirty percent target set by the government.

Saudi Arabia has not trained enough Saudi nurses to provide for their own needs. The hospitals in Saudi Arabia rely largely on recruitment agencies worldwide to assist them in finding qualified workers who can adapt to an

international setting. Careful screening is imperative, as not all candidates are successful in cultural adaptation and the costs of “importing” staff are considerable.

Most nurses expect to experience culture shock when they arrive. They prepare themselves by talking to others who have known people who have worked in the Middle East. They read books and articles and attempt to absorb whatever information they can find. New nurses are excited and enthusiastic. But, what most fail to anticipate is “reality shock”. “Reality shock” can be defined as the value and expectation discrepancy between that which is anticipated and the work experience encountered (Davis, 1992:36-38).

Ethnocentrism in the work environment

Ethnocentrism is a tendency to view things only from our own perspective, to see others as foreigners, to judge things as right or wrong from one’s own cultural perspective, to think our ways are best, superior and preferable to others’ ways of doing things. It is often difficult to avoid the “West is best” mentality and to remain open to the things of great value in other cultures that bear learning. Traits such as intolerance, the inability to adjust and a demeanour of superiority are factors that most often lead to failure (Davis, 1992:36-38). A strong ethnocentric attitude can become a serious problem when one holds firmly to one’s own beliefs and standards and does not accommodate or even listen to someone else’s views. Learning to value, appreciate and understand the *why* of other cultures and their particular viewpoints is essential in transcultural nursing (Leninger, 1995:65).

All participants concurred that their attitude was a determining factor as to whether or not they were successful in adapting to living and working in Saudi Arabia. A positive attitude, a teachable and humble spirit (willingness to learn) and openness to the culture of the Saudi patients, multinational colleagues as well as new methods of nursing procedures and systems were traits the participants identified as being required.

"I don't think people come here with a negative attitude... because if you come here with a negative attitude you will be back home within one week...so all of us coming here are positive about this challenge."

"...and then attitude...they must have a good attitude...if maybe you have this bad attitude you will not cope here...you will feel lost and everything."

"This is not your country and you are not going to get everything you want and you are not going to live the way you want...you must accept the way they live because you can't change them...it is their country and their culture...the only thing is that you must know why you are here."

Dunne (1994:25) concurs: *You should not consider Western culture superior. A lot of Western people believe they have a mission to liberate all non-Western people from their culture. This is not a wise sort of behaviour or attitude of mind. In fact, if you have an attitude stay at home.*

"Also, these groups regard themselves as having a better training and better standards than we have in South Africa...and I don't think that is true. In fact, I think that we are exposed to such a lot of challenges there (in South Africa)... and that actually makes better nurses of us. We are more independent...we can adapt easily into any situation and I think we are very caring. But...the other groups do not have the same assessment of the South Africans...and that is actually professionally very difficult for me."

"The cultural differences for me are very intriguing...very interesting. One of the things I have picked up between the cultures is there is a bit of a struggle as to 'we do things better than that other culture'...OK...the other way is also... some cultures can handle stress and a fast pace better than others...or I should say nationalities..."

Learning to value, appreciate and understand the *why* of other cultures and their particular viewpoints is essential in transcultural nursing. Knowledge and awareness of other's views lead to creative ways to serve people. Strong

ethnocentric views are usually related to a lack of knowledge about other cultures and a resistance to learn and change. Fear of changing one's own beliefs and values can hinder professional relationships with patients, staff and systems. It also limits nurses' professional growth and is a major concern for nurses who practise transcultural nursing. Ethnocentrism can lead to a host of cultural problems, tensions and professional stresses (Leninger, 1995:65).

Relationships between nurses from different countries

Humans do not exist without culture; it is a universal phenomenon. The culture that develops in any given society is always specific and distinctive, encompassing all the knowledge, beliefs, customs and skills acquired by members of that society. Cultures have both stabilizing and dynamic qualities that allow people to live together. From the time of our birth, subtle and constant forces pressure us to follow cultural patterns and norms. These norms tend to regulate life and make for predictable, stable social interactions. Concurrently, culture is a dynamic process that permits and incorporates change as a matter of course (Andrews & Boyle, 1995:10).

Sub-cultures can be categorized by geographic region, religion, age, gender, social class, ethnic identity, occupational role, discrimination or locale. Sub-cultural groups are distinguished from one another and from the dominant culture by such characteristics as speech patterns, dress, gestures, etiquette, forms of worship, foods, eating habits and lifestyles. Professionals, for example, doctors, nurses and lawyers, are examples of occupational sub-cultural groups. Sub-cultures also exist within sub-cultures; nurses in a hospital are examples of this (Andrews & Boyle, 1995:12).

A variety of needs assessments at KFSH&RC have documented the stress of the cultural environment for all groups of expatriate nurses. Nurses report as much cultural pain in the adjustment of working with colleagues from different countries and different cultures, as they do when working with the culturally diverse Saudi patients. Stress is created as each person works at adjusting

and adapting. Each nurse arrives with her/his own cultural norms and values and within that, a set of ideas about work, about how things should be, about what quality care means and about work roles. The degree of “reality shock” experienced will be determined largely by the extent to which the individual imposes his or her values on the local society, other staff and the new work culture. A positive and open attitude is essential in the process of adjusting and adapting (Luna, 1998:10).

“...Like with my friend...I know her from back home...she has an attitude that ‘OK, I know’...Even when she came here she was very positive and said “I am going to make it, I know everything”...She has got an attitude...she thinks she knows everything...I think that’s what lead her to come to a decision to leave because everyone could see that she thinks she knows...so they just ignored her...so she felt isolated...”

In the Philippines, social acceptance and the ability to get along with people are highly valued. Filipino nurses will often carry out a doctor’s orders rather than question an authority figure. In Egyptian and other Middle Eastern cultures, saving face is of such priority that it can greatly affect an individual’s actions. In the Indian culture, shaking the head from side to side means “yes”, and shaking the head up and down means “no”.

“But every day there is a constant synchronising going on where the cultures are trying to fit into each other for the benefit of the team, the unit and the patients...and that for me has been very interesting.”

Forming and maintaining harmonious relationships with their fellow colleagues was not only essential for the participants, but also vital to their successful adjustment and adaptation to the work environment. Although it is established that nursing is a sub-culture with its own set of values and norms, the participants discovered that other nursing nationalities brought with them differing approaches to nursing care from within their own cultures, as well as differing attitudes towards their fellow colleagues. The participants, for example, experienced the Filipino nurses as clinically competent practitioners

who adhered strictly to policy and procedures, but who appeared to place less emphasis on the 'caring' aspect of patient care. Additionally, Filipino nurses were severely lacking in friendliness and cooperation, as they 'tested' other nurses until they found them competent. This practice subsequently led to all Filipino nurses being labelled as the 'Filipino Mafia'. The Indians, as with the other Asian cultures, were seen to keep very much to themselves, were quietly spoken and non confrontational when dealing with the multidisciplinary team.

"The Filipinos for instance...they are not very friendly and open initially but they can open up...but I don't believe in being involved in cliques."

"The Indians...if you tell them a thing is round...that will be round for the rest of their lives...There is just one way for the Indians...that which you initially tell them will stick for the rest of their lives...one doctor actually said to the Indian... "Please open up...everything is not just King Faisal way...you can do it another way..."

Another area in which nurses knowingly 'pitted' against each other was related to salaries. Management is well aware of the resentment and animosity that this discriminatory practice causes. Discrimination between salaries paid to the various nationalities fostered a negative attitude towards their approach to work amongst the poorer paid nationalities (Filipinos and Indians), as to the nationalities that earned more than they did. South Africans are paid a higher salary than some groups according to the salary scale established by the hospital where employees are paid according to the passport they hold, which is a concept that further promotes negativity between nationalities. The issue of salary discrimination is discussed further under the section 'financial compensation for services'.

"The Indians keep to themselves, I think it is a cultural thing...I think that they are one of the lowest paid here as well so they see the rest as a step higher than them...you don't always know what they think."

Although not mentioned by the participants, the American and Canadian cultures were perceived as confrontational, loud and aggressive and having a superior attitude. This often caused offence to the 'quieter' nationalities. Participants in the more senior positions stated that they continually had to prove themselves and their worth, particularly to their Western colleagues. This often gave rise to strained relationships. The constant necessity of having to invest in and work at relationships was emotionally exhausting for many participants.

"I worked a lot harder in South Africa, I achieved a lot more and I worked constructively...Did a lot of things more than I do here in a day but, at the end of the day, emotionally... because there are all these kind of intriguing situations that you have to manage ...And you have to invest in and form relationships and really give a lot of yourself...That you emotionally are actually exhausted at the end of the day."

Du Praw and Axner (1997:3) highlight some of the recurring causes of cross-cultural communication difficulties that should be kept in mind when entering into multicultural dialogue or collaboration:

- *Differing attitudes to conflict:* Some cultures view conflict as a positive thing, while others view it as something to be avoided. In the USA, for example, conflict is not usually desirable but people are encouraged to deal with conflicts should they arise. Face-to-face meetings are customarily recommended as the way to work through problems. In contrast, in Eastern countries open conflict is experienced as embarrassing or demeaning. Differences are best worked out quietly and a written exchange may be favoured to address conflict.
- *Differing approaches to completing tasks:* There are differences within cultural approaches to completing tasks. Reasons may include different access to resources, different judgements of rewards associated with task completion, different notions of time and varied ideas about how relationship building and task orientated work should go together. Europeans and Americans tend to focus immediately on the task at hand and let relationships develop as they work on the task. In comparison, the

- Asian cultures tend to attach more value to developing relationships at the beginning and more emphasis on the task to be completed at the end.
- *Differing attitudes towards disclosure:* In some cultures it is not appropriate to be frank about emotions, about the reasons behind a conflict or misunderstanding or about personal information. When dealing with conflict, one must always be mindful that people differ in what they feel comfortable about revealing. Therefore, before concluding that one has an accurate reading of the views, experiences and goals of the people with whom one is working, one must take their culture into consideration (Du Praw & Axner 1997:3).

Participants' experiences regarding communication in a multicultural professional environment

The multinational nature of KFSH&RC, with a workforce from approximately 40 different countries, creates a unique environment unlike any other in the world (Luna, 1998:10). In contrast to Luna's findings of 1998, there are currently (2005) 31 nursing countries represented at King Faisal Specialist Hospital.

Andrews and Boyle (1995:62) state that inherent in any nurse-patient interaction is communication. When communicating with others from cultural backgrounds unlike their own, and with those for who English is a second language, the probability of mis-communication increases significantly. Additionally, they maintain that cross-cultural communication is transmitted primarily by body cues (55%), paralinguistic cues such as voice (38%) and only 7% of communication is transmitted by words.

Participants were faced with the challenge of communicating with patients and their family members (the majority of who could not speak English, Arabic being their primary language), their colleagues, the multi-disciplinary team, the sitters (the person who stays with the patient) and friends. This spectrum included multi-nations as well as multicultures.

- **Communication between multidisciplinary nursing team**

In a complex world, one's own culture provides the "lens" through which we view the world; the logic by which we order it; the "grammar" by which it makes sense. In other words, culture is central to what we see, how we make sense of what we see and how we express ourselves. We all communicate with others all the time – in our homes, in our workplaces, in the groups we belong to and in our community. No matter how well we think we understand each other, communication is hard. How often do we hear people say "He doesn't get it", or "She didn't really get what I was trying to say"? Culture is often at the root of communication challenges. Our culture influences how we approach problems and how different people approach their work together. As people from different culture groups take on the exciting challenge of working together, cultural values sometimes conflict. We can often misunderstand each other, and react in ways that can compromise otherwise promising partnerships. Often, we aren't even aware that culture is influencing us (Du Praw & Axner, 1997:1).

Officially, English is the only language to be spoken amongst the multinational workforce at KFSH&RC. Nevertheless, many staff members soon revert to their individual dialects; although this was perceived as "inconsiderate", it was not seen as a major communication barrier. The main communication barriers identified by the participants were language differences and accents.

- **Language differences**

The way people communicate varies widely between, and even within, cultures. One aspect of communication style is language usage. Across cultures, some words and phrases are used in a different way. For example, even in countries that share the English language, the meaning of "yes" varies from "Maybe", "I'll consider it" to "Definitely so", with many shades in between (Du Praw & Axner, 1997: 2).

Participants stated that they understood that they would have to adapt to the Arabic language. They did not, however, anticipate having to adapt

to the varied communication styles of the multinational workforce. They concurred that, although English was the spoken language at KFSH&RC, even the nurses from the English speaking countries often did not use the same language in the same ways.

“The nurses from America, Canada, Europe, Australia...they actually have the impression that they are better than South Africans...you are judged according to the way you speak the English language... if it is not your first language...some of our South Africans have actually 4 languages as you know, and English is not the mother tongue of quite a number of us...if you can't speak the correct type of English they regard you as not being so competent...not being so skilled as they are.”

“One of the things that really takes a lot out of you is the constant concentration that I have to have to understand the different accents. To understand when people talk to you...you know...are you getting the meaning of what they are saying...are you understanding? So for me, I find that I listen more attentively now to people, and if I do communicate I try my best to make sure that I am clearly understood and that we are speaking the ‘same language’. Because...something as simple as enteral feeding...people say ‘I hung a gravity bag’ where as where I come from we say “Oh, his tube feed is up”. Which I mean a tube feed for me could mean...I'm giving it through a buretrol or through a vacoliter bag ...but they talk about ‘feed by gravity’... ‘Gravity feed’... ‘Gavage feeding’ which to me is a nasogastric feed...you know ...so things like that you need to make sure that people understand what you are talking about...and not just assume.”

“n Mens moet maar mekaar verstaan...jy moet maar vir jouself sê...”Sy is van n ander kultuur...ek moet haar leer ken...” Ek werk met n Czech...haar spraak is mos anders en haar manier van understanding is different...maar ons twee het een keer harde woorde gehad en agterna vind sy my en ek vind haar...sy het my nie goed verstaan nie...ek dink ek praat duidelik genoeg Engels...maar haar aksent...en haar manier

van verstaan is nie dieselfde nie” (“We have to understand one another and you have to say to yourself...”She is from another culture and I have to get to know her...” I worked with a Czech...her accent is different and her way of understanding of things is different... We once had a major argument and thereafter we found one another...she did not understand me and I did not understand her. I think my English is clear enough, but her accent and her way of understanding is not the same’.)

Practitioners need to be culturally aware in order to increase their effectiveness in their jobs and to reduce conflicts, misunderstandings and, most importantly, stress. They can increase this awareness by learning about the verbal and nonverbal communication styles of different cultures. The verbal communication of a culture may be direct (assertive) or indirect (non assertive), boisterous or silent. In Asian cultures, for example, there is a tendency to be less assertive in speaking and to be indirect. However, in African American cultures verbal communication appears to be assertive and there is a tendency to talk loudly – which may sound more intimidating than it actually is. Therefore, the perception that a loud, boisterous or intimidating communication style is disrespectful may be simply a matter of cultural differences (Montgomery, year unknown: 4).

- **Accents**

At KFSH&RC nurses from around the world mingle daily, creating a symphony of foreign vocal expressions. To the untrained ear, even the dialects of English-speaking professionals from Ireland, the United Kingdom, Australia, New Zealand, and North America are sometimes as baffling as the Filipino, Arabic, and Hindi verbal exchanges (Luna, 1998:8). Participants identified the different accents of the multinational workforce as the main barrier in communication. Not understanding what the person was saying, what a doctor was ordering or what someone was asking impacted on their self belief, self worth and morale. Participants experienced feelings of helplessness, frustration and stupidity and described these experiences as being very painful.

“The accents the biggest problem...answering the phone. I hated to answer the phone...I actually ran away when the phone rang...went around a corner because I couldn’t understand what the person was saying.”

“I would look at him and think what the heck is he (doctor) saying now and he would look at me and I could see that he was thinking that I was a total idiot.”

“It would be a simple command or I just couldn’t understand what he (the doctor) was saying and I would run out and call an Arabic nurse to come and see what he was saying and then I would feel so stupid and that was an extremely painful process.”

“It really takes constant concentration that I have to understand the different accents, to understand when people speak to you.”

Becoming more aware of our cultural differences, as well as exploring our similarities, can help us communicate with each other more effectively. Recognising where cultural differences are at work is the first step toward understanding and respecting each other. Learning more about different ways that people can communicate can enrich our lives. People's different communication styles reflect deeper philosophies and world views which are the foundation of their culture. Learning about peoples' cultures has the potential to give us a mirror image of our own. We have the opportunity to challenge the "right" way of doing things. We have the chance to learn new ways to solve problems that we had previously given up on. Learning about people from other cultures makes us less lonely. Prejudice and stereotypes separate us from those who could be friends and partners in the working environment (Du Praw & Axner, 1997:5).

- **Communication with patients and family members**

The Arabic language has been influenced by several socio-historic forces. These include Arabic's role as an art form, as a religious phenomenon and as a tool for nationalism. These forces appear to have shaped the role of the Arabic language in an entirely different pattern. Rather than viewing language as a means for transferring information with a stress on factual accuracy, language appears to be a social conduit in which emotional resonance is stressed. As an art form, the "magical sounds of words" combined with images have a powerful effect on the psychology of the Arab. The melodious sounds of the phonetic combinations and plays on words have been likened to music. The power of the Arabic language for Arabs is also derived from its religious association through Prophet Mohammed and the Koran. For the believer, the majesty of the language of the Koran is considered a miracle from God, for the prophet Mohammed was illiterate and unschooled. Arabic is also associated with contemporary nationalism, where both Arabic and the nationalist movement have complimented each other to such a degree that they can hardly be separated. When looking at these three socio-historic forces associated with the Arabic language, one can see that symbolism is embedded in the essence of the language (Zaharna, 1995:245).

When comparing the American and Arabic languages, the two cultures differ not only in how they view the role of language, but also in the way in which they exhibit distinct preferences for one particular rhetorical device over another in designing persuasive messages. Repetition in Arabic is a decidedly positive feature, but for Americans to repeat something over and over again would have a negative implication. In Arabic, a speaker gets to engage imagination and feelings of the audience, using metaphors that may seem outlandish to Americans. Americans may insert facts and figures to illustrate a point, whereas the Arab speaker may use one strong vivid example to convey a point. An Arab speaker also tends to be very generous in the use of adjectives and adverbs. Statements that seem to Arabs to be mere statements of fact, may seem to Americans to be extreme or even violent assertions. Words, for Arabs, may be more tied to

emotions than to concrete realities. In contrast, the American culture tends to directly link word to action (Zaharna, 1995:248).

When communicating with Arabic patients, it is necessary to take cognisance of the significant differences between the Arabic language and other cultural languages. Moreover, it is necessary to understand that, in Saudi Arabia, most patients have one or more family members or “sitters” staying with them. Consequently, communication with family, friends and sitters, who can be demanding of health care personnel to ensure that care and attention are given to the patient, is an integral part of nursing Arabic patients.

Although the nurses naturally want to communicate directly with the patient, there are likely to be significant others in the patient’s life with whom they have to interact. It is necessary, when caring for patients from culturally diverse backgrounds, to identify those significant others whom the patient perceives to be important in his or her care and who may be responsible for decision making that affects this care (Andrews & Boyle, 1995:62).

In Saudi Arabia familism, which emphasizes interdependence over independence, affiliation over confrontation and cooperation over competition, dictates that important decisions affecting the patient be made by the family, not by the individual alone. Participants verbalized that this was especially evident when nursing Saudi females. In fact, their perception and experience was that the female population in Saudi Arabia was completely dependent on the discretion of their Saudi male relatives to make any decision regarding their care. This conjured up feelings of disbelief and sadness for those Saudi females who had to undergo procedures deemed necessary by the male family member, but against the female patient’s will. They also felt helpless as the patient advocate in these situations.

“A husband and wife in the same room...the husband does all the talking...the husband does all the talking for the wife...or...the doctor

will look at the male partner and talk to the male partner about the woman and ignores the woman...And then only afterwards if there is a direct examination he will then address the female patient. The husband also gives consent...not the woman...So even if she doesn't want a procedure...if the male consents, it gets done."

Younge, Moreau, Ezzat & Grey (1997:310), who are all physicians practicing at KFSH&RC, state that there are many factors relevant to the communication problems that exist in Saudi Arabia. Cultural aspects reflect one such problem, where decisions made by the family did not always reflect the patient's wishes. Greater communication is required to guide treatment decisions.

Sullivan (1993:446) stated that a female patient may not even give her own history. Two or three other family members may be present in the interview room, all offering their own answers to the questions directed at the patient. They may even point to the place on the body where the patient's pain or problem is.

Participants experienced certain aspects of both verbal and nonverbal communication to be a hindrance when interacting with the Saudi population that is the patients, the sitters and the families.

- **Verbal Communication**

Andrews and Boyle (1995:70) reinforce that one of the greatest challenges in cross-cultural communication occurs when the nurse and patient speak different languages. They explain that nurses may find themselves in one of two situations – either struggling to communicate effectively through an interpreter or to communicate effectively when there is no interpreter. Participants, having been in the Kingdom for a short period of time, had not mastered the art of the Arabic language. They verbalized that they struggled to communicate with or without an interpreter. Many participants experienced a feeling of incompetence

due to this, and felt that the language barrier hindered them from performing their nursing duties effectively and in a timely manner.

“The language...sometimes you want to explain something to the patient but because of language it is difficult and then it is a waste of time...there is an interpreter but you have to go and find them and it's a waste of time...and the patient gets irritated.”

“You know language is a big thing, you have to be patient... you have got to sit and ask them over and over in the work situation...in shops...everywhere...you have to listen to these people...you have to try to be clear.”

“Lot of concentration, a lot of emotion, a lot of keeping control, control my emotions in relation to language barrier.”

Priestly (2000:19), a former KFSH&RC employee wrote: *My biggest frustration initially, was the loss of direct communication with my patients. My lack of spoken Arabic was a definite disadvantage. The language barrier often complicated the simplest task, turning it into a timely and drawn out affair. I often required an interpreter for detailed explanation to and from the patient or patient's caregiver. When it comes to interpreting, it is important that the interpreters fully understand what I am trying to convey in English. I must be sure they correctly interpret me before they go on to interpret this in their own language. It is a bubbling cauldron of potential error in communication.*

o **Nonverbal communication**

There are five types of nonverbal behaviours that convey information about the patient:

- Vocal cues, such as pitch, tone and quality of voice.
- Action cues, such as posture, facial expression and gestures.
- Object cues, such as clothes, jewellery and hair styles.
- Use of personal and territorial space in interpersonal transactions.

- Touch, which involves the use of personal space and action.

Unless nurses make an effort to understand the patient's nonverbal behaviour, they may overlook important information such as that which is conveyed by facial expressions, silence, eye contact, touch and other body language (Andrews & Boyle, 1995:67).

It has been established that the participants, when nursing Saudi females, were immediately at a disadvantage when it came to action and object cues. This was due to the cultural practice enforcing females to cover their head, face and body. *They don't realize that in the clinic or on the wards these customs (covering of the face and body) are not helpful and are frequently harmful (as clinical signs cannot be observed). The veils women wear can affect care. What can a doctor learn from the face of his patient – cyanosis, jaundice, fear, anxiety? The faces of women are not seen* (Sullivan, 1993:446).

Another aspect of communication style is the degree of importance given to nonverbal communication. Nonverbal communication does not only include facial expressions and gestures; it also involves seating arrangements, personal distance and a sense of time. In addition, different norms regarding the appropriate degree of assertiveness in communicating can add to cultural misunderstandings (Du Praw & Axner, 1997:3).

Touch, eye contact, space, distance and intimacy were aspects of nonverbal communication identified by the participants that hindered interaction with patients/sitters/families.

Touch

It was the participants' experience that the Saudi people are a non-tactile nation. This was an aspect of nonverbal communication that participants experienced to be diverse from their practice/culture in South Africa. The use of touch was seen by the participants to be therapeutic, as well as a

vehicle in establishing a rapport with the patients. However, in Saudi Arabia, they soon realized that the use of touch was not welcomed. Participants in the paediatric units experienced particular difficulty in adjusting to the “non-touch” environment.

“One of the obvious, obvious differences to nursing at home is that there is very little TOUCHING going on as far as nursing is concerned. And it is not only for us as nurses, but for bonding and parent child relationships. The obviousness is in the hands off approach that I have found here. Now where I come from, and I don’t know whether I am supposed to say this on tape...where I come from when we walk into a ward the children would run up to you and put their little arms around your legs and their little snotty noses would be against your uniform and it would be OK... Here, you basically have to ask permission if you want to touch, there is no spontaneity...there is hardly any interaction... we go in there, we do what has to be done and we get out. Parents don’t cuddle their children...and I have been here for nearly six months and I haven’t had or I have had very limited cuddling experiences with any of the children yet.”

“And that is something that lacks in the Saudi culture...you can’t touch and feel and do...you know like back home... because mothers are covered up here and all you have got contact with is the eyes.”

Andrews and Boyle (1995:69) write that touching children may have associated meaning trans-culturally. Eighty percent of the world’s people (including many Saudi Arabians) believe in “mal ojo”, which means “evil of the eye”. In this culture bound syndrome, the child becomes ill as a result of excessive admiration by another person. Touching the head of a child is seen as a sign of disrespect, as it is believed that the child’s strength resides in the head. “Mashala” is the phrase that has to be uttered by anyone who admires a child. By this utterance the child is protected from the “evil eye”.

"It's just I come to work and when I get there I know that there will be no emotion involved...you know like back home when I had a child that was going for a major surgery then I developed that kind of a bond with that kid...even if the parent is not there...then there is some bond with the child...you get used to the child and the patient gets used to you...but here it is difficult...they don't give you that chance...they want you to keep your distance as much as possible. You can't even...if the child is beautiful...you can't say "The child is beautiful" ...you must always say "mashala" and things like that."

Participants experienced nursing to be unrewarding and emotionless due to the lack of tactile contact with their patients.

"Hardly interaction with patients makes the job, I think, so unrewarding."

"It is a MAJOR adjustment...it's a MAJOR adjustment...I don't see parents sitting with their children on their laps...I don't see the responses that I am used to seeing back home. At home when children come in they are sick and they are lethargic and they are just lying there and are waiting to get better... and they get better and start interacting with you and they start smiling and laughing and chattering and everything just gets a bit louder as the day goes on... HERE ...every thing is so subdued... they lie in their cots ... the parents sleep in the beds and they lie in the cots ...and there is just no interaction... they wear these long dresses and their faces are closed and it's only their eyes that are open."

"You can't go to a male whose mother died and hug them or put your hand on their shoulder, it is not allowed...it is against their culture...they don't believe in contact even if you are heartbroken."

There is much to be learned about cultural touching as a major area of significance to transcultural nurses in discovering the meanings, forms, patterns and changes over time. Body touching and human caring are largely culturally defined and maintained as important modes of

communication, human expression and for healing and well-being. The therapeutic value of touching as healing is often known to nurses (Leninger, 1995:76).

Eye contact

Andrews and Boyle (1995:68) affirm that most nurses are taught to maintain eye contact when speaking with patients and that eye contact is among the most culturally variable nonverbal behaviours. Individuals from culturally diverse backgrounds may attribute other culturally based meanings to this behaviour.

The Arab population considers direct eye contact impolite and aggressive and may avert their own eyes when talking to a nurse. Additionally, prolonged eye contact by the female nurse with an Arab male may be misconstrued as a sexual advance. For Muslim Arab women, modesty is, in part, achieved by avoiding eye contact with males (except for one's husband) and keeping the eyes downcast when encountering the opposite sex in public. Females who smile and establish eye contact with men in public are considered to be prostitutes.

Eye contact was, therefore, an aspect of South African practice that the participants had to adjust. The fear of misinterpretation, and the consequences, was embedded within the participants' subconscious mind. The male participant was constantly aware that any nonverbal action on his behalf may be misinterpreted as inappropriate by the female Saudi population, be it patient, sitter or family. The consequence of this would lead to deportation.

“Professionally also the multicultural situation is a big thing that you need to cope with. The Muslim - Saudi kind of thing is that there are certain restrictions...especially between male and female...You do have to have a regard and respect and knowledge for the culture that you are moving into.”

Andrews and Boyle (1995:69) concurred that nonverbal behaviours are culturally very significant and failure to adhere to the cultural code (set of norms of behaviour used by a cultural group to guide their behaviour and to interpret situations) is viewed as a serious transgression.

Space, distance and intimacy

Both the patient's and nurse's senses of spatial distance are significant in cross-cultural communication, with the perception of appropriate distance zones varying widely among cultural groups. Although there are individual variations in spatial requirements, people of the same culture tend to act similarly. Because individuals are not usually consciously aware of their personal space requirements, they frequently have difficulty understanding a different cultural pattern. Sitting close, for example, may be perceived by one patient as an expression of warmth and friendliness but by another as a threatening invasion of personal space (Andrews & Boyle, 1995:65). According to literature, Arabs are amongst the nationalities that need the least personal space. However, due to the cultural restrictions imposed in Saudi Arabia, this was neither the perception nor the experience of the participants.

Al Krenawi and Graham (2000:14) state that Arab communication styles are formal, impersonal and restrained, rather than candid, personal and expressive. Furthermore, they say that it is also difficult for Arabs to display or divulge personal problems and feelings to someone outside of the family or community. Communicating such information would be seen as weak, disloyal or both. Difficulties, therefore, in communicating and deciphering the patients' verbal and nonverbal messages can lead to errant assessments, because of the existence of culture-bound symptoms.

“You need to learn that people who don't greet you don't necessarily mean harm, it's just because it is maybe part of their (Saudi) culture...In time I have learnt for example...that putting your hand out to actually

greet somebody...or touching somebody on the shoulder is not acceptable... but actually talking to people is okay.”

Andrews and Boyle (1995:65) further explain that interactions between nurse and patient are influenced by the degree of intimacy desired. This may range from very formal interactions to close personal relationships. Participants found that the interaction between Arabs was of an intimate nature, but from a personal perspective they experienced a distance between their patients and themselves due to cultural restrictions. Of special significance was the veiling of the Saudi women. This was seen to automatically create a distance within the nurse-patient/nurse-sitter interaction. As facial expressions could not be seen and persons could not be identified, interaction was hindered.

“Because here the women are basically just a pair of eyes walking around, most of the time the women are an absolutely faceless society because everything is closed...and the only thing that you see is a figure walking towards you that is clothed in black.”

Leninger (1995:77) states that cultural space is an important concept to understand in transcultural nursing in order to prevent cultural conflicts. She refers to cultural space as the variation of cultures in the use of body, visual, territorial and interpersonal distance to others. Additionally, she says that understanding cultural space brings awareness and enables the nurse to anticipate, recognise and respond to people in the space variations. Without such awareness, nurses will have difficulty with patients as they may violate another's space. This often leads to interpersonal stress, anger and communication problems.

Montgomery (year unknown: 5) states that practitioners should be aware that nonverbal communication varies among different cultures. In Native American cultures, for example, stares and silences are used to convey different messages. A firm look indicates seriousness and maintaining eye contact is a sign of disrespect. In Asian cultures,

silences are used to emphasize meaning and to show power. Eye contact is also viewed by African American cultures as a sign of disrespect. In white cultures, direct eye contact conveys trustworthiness, forthrightness and sincerity. There are also differences in the amount of touching within a culture. In African American cultures, handshaking, slapping of hands or hugging tend to be used for added expression. In white cultures, touching or closeness when speaking may be viewed as an invasion of space.

Participants' experiences in the professional environment

- **Orientation**

On entering the professional arena in Saudi Arabia, all participants attended a three (3) day hospital orientation and an extensive eight (8) day general nursing orientation (GNO) programme. Following this, the participants had an approximate ten (10) day unit orientation accompanied by their assigned preceptor. An evaluation was performed at the end of this period in order to assess if the participants were competent to take an assigned patient load on their own.

Anderson (1992:20): *As with hospitals throughout the world, KFSH&RC provides orientation for nurses to introduce policies and procedures. See Annexure E for relevant KFSH&RC Internal Policy and Procedure (IPP) regarding Orientation of new staff.*

"I still feel it is a very good experience for any professional to be in a system like this...being a JCIA (Joint Commission for International Accreditation) hospital you know...in South Africa we don't know about JCIA because we don't have that sort of accreditation there. I still feel it's very positive for any person professionally to be part of such a hospital."

The eleven (11) day nursing orientation was experienced very positively by the participants. Support systems and friendships were established among the multinational oriented groups. The tone was set and the expectations explained regarding mandatory competencies – generic and unit specific -

to be completed and courses and workshops to be attended within the three (3) month probationary period, as well as during their first year.

“Then while we were on orientation with you...we used to say "Oh, GNO is long...it's long...we want to get to the unit"...but actually it was the best time because you get all your support...you get support from you the GNO coordinator... you get support from your buddies in your group ...your own little peer group...the class in general and you find that everyone is supportive and welcoming.”

Participants had varied experiences regarding the unit orientation period. They did not experience the same degree of support in the units as they had done during the orientation programme; this gave rise to feelings of insecurity.

“Once you move out of GNO...you are left totally on your own...there is no support...I was very disappointed...and I think that for me wasn't good at all...I said to myself "If that was me I would never ever treat a brand new person coming into my department the way I was left"...or anybody else for that matter...because my buddy would phone and say "You know I'm left alone and I don't know what to do"... and whatever...and you feel totally isolated...you feel totally alone...and people responsible for the unit...the covering person at the time would come and say "Oh, how are you, I suppose you are fine" and was gone...lo and behold you are not fine.”

“Oh it was difficult...the first days...you know on the first day you get a preceptor and then she will work with you for 8 days...the problem is within those 8 days you don't learn everything...like some other things they are not there at the time...and then according to your time table you have to have other things but they are not there...so...eight days is finished and then maybe she is being off or whatever she is being difficult or whatever...and you ask the other people and they are ignoring you...so that was bad.”

Many participants had preceptors who were enthusiastic, knowledgeable, encouraging and patient – a positive experience. However, a few had preceptors who were unwelcoming, unhelpful, critical and whose accents could not be understood – a negative experience that did not lend itself to a conducive environment to learn and adapt. Feelings of frustration, isolation, worthlessness and inadequacy were experienced.

“She (preceptor) was fine...She was also South African...We did a lot of stuff together but the period was very short because she went on leave on my 9th day...Then I was all on my own...But it was OK.”

“My tweede preceptor was ‘n mens met ‘n goue hart...was ‘n mens wat weet hoe in stres situasies op te tree. Ek sê altyd ...sê vir my waar ek verkeerd geloop het ...maar ek sê altyd dis die manier hoe jy dit sê...moenie vergeet dat ons ook uit daardie posisie uit kom...waarin jy nou is nie...ons moet ook studente geleer het.” (‘My second preceptor was a person with a heart of gold ... a person who knew how to react in stressful situations. I always say...tell me where I did wrong... and I always say it is the way it is told...don’t forget that we were also in the position that you are in, we also had to teach students.’)

“The preceptor was too busy doing her own thing...too busy doing her work...too busy organising...and there was really no support...but I don’t know if I should blame her for that or not.”

“I was precepted by an Indian who was a lovely person but I couldn’t understand her accent ...I had to say “Excuse me...I beg your pardon”...you know 20 times a day...which made it stressful...but she had knowledge.”

- **Ensuring competence and level of knowledge**

Having to complete the mandatory core competencies, courses and workshops was stressful for all of the participants. The required pass standard of 80% to 84% was an added stressor. Although many

understood the rationale and saw the benefit of having to complete these requirements, it was apparent that they were angry with the agencies for not preparing them adequately. Participants verbalized that they felt like “first year students” and that they had come to Saudi Arabia to work and not to study. Feelings of resentment, anger and frustration were experienced. Additionally, having to work twelve hour shifts as well as study and attend workshops/courses during their off-duty time predisposed to feelings of exhaustion and added pressure.

“It has been very stressful... I wasn’t expecting this... and I wrote to my agent in South Africa and told her to be open with the staff who are coming over to Saudi...especially to this hospital...there is too much learning to do...it stressed me a lot...this ‘reading, reading, reading’...because when I went to the unit after completion of GNO I thought it was over and ‘let me just go and work and prove myself’ and whether I can fit in or not.”

“With me reading really...it is hell...I don’t like reading...so when I came here...you must read and write and pass a test 80% not less...Oh, why did I do this to myself. I become so frustrated... at the beginning I was so depressed about this reading...I was very miserable.”

“I feel like I’m a junior nurse coming for the first time for initiation in nursing.”

“So when I came here I thought I was coming to work...NOT to study again.”

“This is my own experience...I think that they (the South African nurses in Saudi Arabia) struggle with the technology...maybe different ways of doing things...different types of equipment...different clinical pathways and all the protocols and policies and so on. I don’t think they lack in competencies and skills... more or less, the South African nurses cope very well with the competencies and skills, once they have adapted to the different types of equipment and technology.”

Once the three month probationary period was completed, participants were more positive about the valuable educational opportunities made available at KFSH&RC. Most recognized that the educational programmes, regular seminars and symposia and in-service programmes served to enhance their professional development. Excitement and gratitude were expressed.

“You know I learnt a lot...they are so pro-education here and that is a positive thing. If you come from South Africa and you come from a private hospital...if someone walks in and they say... “Oh no, another one we have to teach”...we are very lazy in South Africa towards students...and here they don't mind ...you get so many people that just want to teach you.”

“So professionally, I think the very positive issues were that you could develop. I followed some computer courses. I also had the opportunity of attending some workshops...some seminars ...some symposiums...all the activities like grand rounds...it is all there free of charge...it is there for you to grow and use and develop yourself...so the opportunities professionally I have really enjoyed.”

Another aspect identified as enhancing the participants' professional and clinical development, was the disease entities with which they came in contact whilst nursing in the units. Many had only read about some of the diseases in textbooks and were excited at having this exposure.

“Some of the stuff I have read about in textbooks...in my student days or along the way...but actually coming and physically seeing it here...has been unbelievable...for instance one of the syndromes that sounds very South Africa...Cornelia de Lange syndrome...I always read about it in a textbook or we saw a photo in a text book...I've never physically seen a child...and I've not even been here 4 months and here comes a child with ALL the symptoms and signs or whatever.”

The main areas in which the participants identified deficient knowledge or skills were: pharmacology; computer literacy; basic physical assessment; Basic Cardiac Life Support (BCLS):

○ **Pharmacology knowledge:**

During the eight (8) day programme, the participants were required to do a pharmacology examination. All agreed that the agency had prepared them for this and all received a pharmacology review package prior to departure. The pending examination, as well as the difficulty experienced when doing the calculations, proved to be a source of stress for the participants. Many failed the examination on the first attempt as a pass rate of 80% was required. Participants were allowed to rewrite this examination three times. If unsuccessful, they would be dismissed and have to return home to South Africa.

Participants attributed this “struggle” regarding pharmacology to three things:

- A deficiency in their basic training.
- No mandatory pharmacological updates for registered nurses after completion of their basic training (this is a requirement in many countries throughout the world).
- The South African doctors working out doses for the nurses, for example drip rates.

“I think in our basic training, pharmacology is not adequately covered... I mean, a lot failed the exam in orientation...I mean, I can speak for myself...in my general training I did X amount of pharmacology... You do a lot of the nursing care aspects but not a lot of exposure to calculations on drugs, etc.”

“It (basic training) is not enough...because most of the things like calculations and some other things I have learnt here.”

“We tried to work out the calculations but we couldn’t get it right. We tried and tried and I thought “Oh my God...” ...You know, I was seeing myself in the flight back home because I wasn’t going to pass this (pharmacology), really... There were the three of us...We tried, man...oh really.”

“You see back home the doctor works it out and tells you “Give this and this”...so you don’t have to work it out...He says “Give five hundred in two hundred at that rate”...so you just follow instructions...Here you have to work it out... and calculate.”

See Annexure E for relevant KFSH&RC Internal Policy and Procedure (IPP) regarding ‘Orientation of new staff’.

- **Computer literacy**

On arrival in KFSH&RC the participants came to the realization that they were expected to have certain computer skills. Many did not have a computer and felt very inadequate as a result of this. Computer skills were included in the nursing orientation programme for which they were very grateful. Participants verbalized that this was another shortcoming in their basic nursing training; they also felt that the agencies had failed in omitting to inform them about this requirement. Computer classes were offered by an affiliated company on the KFSH&RC premises. This was viewed as an opportunity to develop by the participants.

“In SA we are very paper orientated...here just about everything is computerised...on the units we use computers to chart vital signs, patient assessments, laboratory results, doctors orders... for handover summaries, for medications called PYXIS...where you punch in details and out comes the vial of whatever you need.”

“At home I didn’t know how to use the computer...but during GNO they taught me how to use it...well, I think I was one of the only ones that didn’t know how to ...I had to go for extra lessons...they didn’t

mind...they used to say come early before other students...and then I used to come before...then sometimes I got left behind...and they were so patient...so I appreciate what they did.”

“I think South Africans lack all the computer skills. We have the basics but this hospital has the advantage of having all the computer courses and other courses on site so ...actually I could follow that free of charge...so I am much more empowered if you can say that with regard to computers than I was coming here.”

- **Basic physical assessment**

Since KFSH&RC is based on the American nursing system, the physical assessment of the patient has to be performed by the nurse within four hours (adults) and two hours (paediatrics) of coming on duty. Participants did not find this unrealistic, but many struggled with the extensiveness and depth of the assessment. Many participants had not been taught to perform an extensive physical assessment in their basic training – having to listen to the heart and respiratory sounds were particular areas with which they were unfamiliar. Participants who had done a post-basic course in which primary healthcare assessments on adults and children were included had more insight into the assessment. Participants attended the mandatory Basic Physical Assessment course and completed the accompanying competency check-off.

“I have done a physical examination...I have done the workshop and now am waiting for someone to come and stand and see I am checking the eyes and the mouth right. With my community that I did with UNISA we did that (physical assessment)...we had a chance to go and do paediatric and adult in the clinics.”

See Annexure E for relevant KFSH&RC Internal Policy and Procedure(IPP) “Paid Education time” regarding mandatory requirement for staff to attend Basic Physical Assessment Course.

- **Basic Cardiac Life support (BCLS)**

It was mandatory for participants to attend and be certified in BCLS within a month of commencing employment at KFSH&RC. For the participants in the critical care areas, certification in Advanced Cardiac Life Support (ACLS) and Paediatric Advanced Life Support (PALS) were additional mandatory requirements.

“We know about the pharmacology before we come but we don’t know about the BCLS...I’m telling you everybody hates BCLS...people really don’t like it.”

“And the BCLS...basic life support...the agency said that this only has to be done by people going to intensive care areas...but when we got here we had to buy a book to read and know what is going on...go for the test and be certified for the practical...and write another test... I was not aware I was going to have to do all this.”

“Some skills like ACLS and BCLS...we do not concentrate on that back home...we only train our emergency nurses in BCLS...so the other nurses are not really exposed to that.”

See Annexure E for relevant KFSH&RC Internal Policy and Procedures (IPP) “Paid Education time” and “Orientation of New Staff” regarding mandatory certification in Basic Cardiac Life Support.

Notable differences occur among cultural groups when it comes to epistemologies – the ways in which people come to know things. European cultures tend to consider information acquired through cognitive means, such as counting and measuring, more valid than other ways of coming to know things. In comparison, African cultures’ preference for effective ways of knowing include imagery and rhythm. Asian cultures’ epistemologies tend to emphasise the validity of knowledge gained through striving towards transcendence. The different approaches to knowing could affect the ways of analysing and finding solutions to resolve problems. Some may

want to do library research while others may prefer to approach people who have experienced similar challenges (Du Praw & Axner, 1997:4).

- **Nursing care experiences**

Whilst rendering nursing care to the Saudi population, the participants encountered positive and negative experiences.

- **Positive nursing experiences**

Positive aspects identified by the participants included:

- Being recognised as hard workers.
- Acceptance from the Saudi population and the caring work ethic.
- Availability of equipment.

Recognised as 'hard workers': Participants, and South African nurses in general, had the reputation of being “hard” and diligent workers. It was recognized that they could handle stressful situations and, because of this, were often allocated the heavier workloads. Even though they might have complained about the allocation at times, it was a morale boost to know that management had recognized their capabilities.

“You can see they rely on the South Africans, they give us the sicker patients. And if the workload is going to be high they give them to us, and its not only me...but we can take it, we might complain but we still complete the work...we can work under pressure.”

“Number one, our girls are used to working under pressure, they can take the fast pace and rapid turnover...we are used to that. Using initiative and taking the lead...very good... they are not hesitant to appear assertive and be advocates for their patients.”

Acceptance from the Saudi population and the caring work ethic: Participants were well received and accepted by patients and sitters; this was a rewarding experience. The caring aspect in nursing was seen as another of the South African nurses' strengths.

“And then of course the caring...the feeling of UBUNTU...which is very evident, especially in a paediatric set up.... and here it ...it is not so evident. So yes... some of the parents want a South African nurse because they feel that ubuntu.”

“I am a bedside nurse...and you know what I enjoy the most when the patients ask me "From where are you?" From Africa..."Good country...good country...good nurses"...and that tells you more about our South African nurses when they talk to their families they like brag... "Hah...South African nurse...good nurse"...you know you feel so good.”

Availability of equipment: Participants were delighted to have all the equipment needed to perform their routine nursing care efficiently. Many had come from hospitals in South Africa where equipment and linen were a scarce commodity. They expressed excitement and amazement at the abundance and availability of these commodities, but were horrified with all the waste and the throwing away of the “one time use” equipment such as bedpans and dressing scissors.

“I enjoy the satisfaction the most...that you have enough...ooh...there is no need to borrow something in the other ward or... now the other day we received 35 pumps...and you know that satisfaction that every patient has their own pump.”

○ **Negative nursing experiences**

In the KFSH&RC setting nurses are presented with a variety of practice challenges, and the potential for cultural conflict and stress is real (Luna 1998:8). Negative aspects identified by the participants included:

- “New bloke on the block” syndrome.
- Inability to adhere to a nursing routine.
- Nursing care given to males and females.
- Ethics.
- Transcribing.
- Holistic care.

“New bloke on the block” syndrome: Participants, once entering the clinical arena after orientation, experienced a “baptism of fire” or “new bloke on the block” syndrome from certain nationalities in their units. Participants felt that they had to prove their competence and worth. They were treated as if they knew nothing and any mistake made, no matter how insignificant, spread through the unit via the “grapevine”. Failure to acknowledge previous working experiences created feelings of worthlessness and anger. Additionally, some participants experienced a lack of support from management.

“There was just no support...and that is why, for example, X left who started with us...I mean one day she phoned and said "I have packed my bags since 4 o'clock this morning...I want to go"...and no matter what I said...she said "No, I am going home"...you know... so the support in the units are not enough.”

“I had to prove myself every moment of the day...every moment...in the meetings...wherever we went I had to prove myself...at times I became very cross and I actually told my colleagues that they misjudge my intelligence...I had that feeling at times that they would regard me as not being so intelligent...and that was humiliating, of course...so I actually became very cross about it...yes I had to prove myself and I still have to prove myself with every thing...every discussion...in every committee...with whatever...and you know what when I tried to share my experience with the rest of my colleagues that are less experienced...they didn't appreciate that. They regard their experience in a first world class hospital or a country as more important than my experience in South Africa.”

“I really don't know...I don't know what they call it ...punishment or whatever, but that first couple of months people are so, so horrible... but I think it's more an issue if they can see if you can do the work...you can handle a lot of the things...they begin to accept you and especially for me being the only male there...”

“It makes you feel very small...as if I’m nobody...with 25 years experience as a nurse, they don’t check your previous experience, you are treated as if you don’t know anything, you must do it the way they want you to do it...you must just do.”

Most participants experienced resistance and received negative responses when asking questions pertaining to the unit. Additionally, unfair patient assignments predisposed to conflict situations. The negative and critical attitudes displayed by colleagues in the units were unwelcoming and led to feelings of despondency; withdrawal and depression.

“You know they (staff) have to teach you the King Faisal way...but sometimes they make you feel so small...the way they talk to you...the way they gossip about you...then you hear what they are talking.”

“I’ve experienced wanting to go home more than ten times already...you know it’s just the feeling that everything gets too much and you get people at work which, you know you have done your best after the 11 or 12 hours, and then they come on duty and ask you... ‘Why isn’t this done ...why isn’t that done?’...And you go home and you just sit up packing things and you put it in your suitcases and you say to yourself “I’m going now...I don’t know how I’m getting there, but I’m going”. And you call home and you say “I’ll be home on Monday” or whatever and it’s just a feeling of really everything is just not working out.”

“Now coming to the colleagues...OK, the South Africans in the ward is OK but the Filipinos’...oooh...they have got a...I don’t know what is wrong with them...it’s like ...I don’t know...what can I say...they don’t treat you normal...especially when you are new...they treat you like a stranger...they don’t make you feel at home...some of them can be nice but most of them are horrible. For instance, with the scheduling, you will notice that they give you all the patients that need 100% nursing care and they give each other light patients...OK, that’s what I have noticed

and I asked the other South Africans in the ward and they say it is always like that....they do that.”

Inability to adhere to a nursing routine: Participants felt ineffective in performing their nursing duties because patients/sitters determined when duties should be executed. This, as well as the “no rush” attitude (Arabs utter the phrase “Enshallah” [as Allah wills]), was a source of frustration for the participants and was seen to be a waste of valuable time. Nonetheless, participants acknowledged that they had learnt the valuable lesson of patience, as well as to “slow down”.

“The fact that parents are very much...or I find them a very interfering nation...and that’s putting it very bluntly...if for arguments sake they, the parents decide that they don’t want the nurse in the room... then the nurse is sent out...if they don’t want to take medications on schedule then it just doesn’t get given... if they don’t feel the need to take the medication that has been transcribed... then they refuse the medication ...there is no medical backup for the nursing staff to say “Look your child’s condition is this, this is the medication that needs to be given...it has been prescribed”. The nurse is unfortunately the person who has to give it, so if they basically decide that they don’t want a procedure done, or they don’t want medications given, or they don’t want treatment rendered or they don’t want you in the room or they don’t want their observations done according to the schedule of the hospital or the unit then it just doesn’t get done. It is just very frustrating.”

“You as a nurse during the day, need to work with your patient, but the mother and child are sleeping and you cannot get your actual nursing care done...so you’ve got to now be at mom’s beck and call as to when you can come do this and when you can come do that... or you got a screaming child ...a child screaming at you because you come into the room and the door might have banged a bit or you touched the cot side and you disturbed their sleeping. So yes, you find that the stress levels are high.”

Time, to the Saudi Arabian, has little meaning except in business. 'Inshalla', or whenever it happens, is the norm. Social rituals continue, while appointments go by unattended (Geissler, 1994: 199).

Dunne (1994:25) advises that, when living in Saudi Arabia, you need to be tolerant and patient, as it will benefit you in the long run. Moreover, she writes that screaming and getting upset will lead to avoidance by the Saudi people and you will never get what you want.

Nursing care given to males and females: Andrews and Boyle (1995:69) state that violation of norms relating to appropriate male-female relationships among various cultures may jeopardize the nurses' therapeutic relationship with patients and their families. In Saudi Arabia, male nurses are not allowed to nurse female patients. The units (wards) in KFSH&RC contain a mixture of male and female patients. All rooms are private. A male cannot be a patient in a private room with a female in the next room. This means that there is a continual reassignment of rooms and patients. In paediatrics, a male may nurse a female child; adolescent girls, however, often prefer to be nursed, and certainly examined, by a female healthcare provider. Females cannot be examined by a male doctor or male nurse. Additionally, every time a male wants to enter a room where a female is present, he has to knock and then wait for the female to cover.

"The female nurses can look after males and females, but the male nurses cannot look after the females... and if the ward has more females than males ...then the male nurses must be allocated to another ward with more males for the day so that those female nurses can come to our ward...so there is a lot of swapping around... the male cannot go to a female ward and do a physical exam on a female."

"I am not that much exposed to the culture except in the unit...where the women have to cover themselves and the doctors come in and have got that restriction when it comes to do the physical exam and everything on

a woman... And you can't show the doctor the woman's back...if she has got anything at the back... you have to elaborate to the doctor what you are seeing...the vagina, the perineum is like that and that...it is very difficult."

The male participant experienced frustration as he was prohibited from completing his assigned workload due to his services often being rejected by female patients/sitters and being denied access into the rooms with female sitters. He experienced feelings of guilt as his nursing duties had to be re-assigned to the female nurses over and above their assignment.

"But then the thing about the knocking and the having to ask the mothers to come in and until now its getting everyday more and more worse. You can't enter a room if you are a male if the mother isn't covered... so first you have to knock and ask if you can come in and she will tell you to wait or whatever. And sometimes they just...in the mornings when I knocked to go and do my work they just say NO they don't want me there...like even this morning, too... I have been working there with this patient for two weeks already and now she says no she doesn't want me there... Evening duty is much worse."

"I've had to change with people to do day duty because it's not worthwhile doing nights...because I can't do my work... I haven't managed at all because I was on a week on night duty and this child was started on some medications which needed me to umm to do vitals every 2 hours...and the mother said NO...which meant that my workload became other people's workload, which is unfair to other people."

Ethics: In Saudi there is no governing code of ethics. A nursing act, medical act and child care act are non-existent. The Saudi Council for Health Professionals is in the infantile stage of development. In KFSH&RC, nurses sign and adhere to a code of professional conduct developed by the Gulf Cooperative Council (GCC) Health Ministers

Executive board, 2001. Participants were exposed to situations, especially pertaining to the preservation of life, where decisions were continually made by physicians that went against their (participants') ethical practice. Experiences were not pleasant, had a profound affect and resulted in an internal "turmoil" within each participant.

"And for the nurses it is very frustrating ...and the few episodes I have had on the ward, I couldn't believe it...it was terrible...you don't want to be a judge and you don't want to play God...but for me it was like... "How could they do this" because at the end of the day I didn't see it as a way of trying to...I mean I think in nursing you are taught to save life... but when I saw that child being resuscitated and end up going to the ICU and came back to the ward as a vegetable and eventually died on the ward...I thought but "What is the purpose of all of this?"

"For me I find it too restrictive in the sense that...they don't see the rationale behind what is being done...they just expect that if their child with this multiple syndrome, multiple problems, no prognosis suddenly starts aspirating or desaturates that you must give the oxygen and you must resuscitate...even if the child is dying or dead already. At the end of the day, all the stops are pulled out even if the doctor himself knows...he does it for the sake of the culture, the religion."

Bin Saeed (1999:51) researched the perception of physician and clinician perceptions on ethical issues in Saudi Arabia. His findings demonstrated that there were five attributes that had an influence on ethical issues in the Kingdom:

- Lack of committee to investigate ethical issues.
- Lack of technical follow-up to monitor physicians' medical practices.
- Hospital by-laws that do not emphasise a medical code of ethics.
- Patients' rights and duties are not specified in the hospital operating manual.
- Lack of punitive measures against those who do not abide by the accepted standards of medical practice.

“There is NO ethics in this place...they don't have an ethical committee... so you are going to see patients that is actually...they call it 'skin peeling' here...I call it 'rotting' ...they are lying on these beds...we are keeping them alive but I promise you...they are decomposing.”

“I see it from a CSICU point of view...even if a patient is on all the maximum inotropic support and they code...You still have to give them epinephrine...I said “Excuse me...she is on full resus all the time...she has a pacemaker...she is having all this...what are you calling it”...If you switch off you will see a straight line straight away...there is no two ways about it...I mean you turn this patient and the skin comes off...and I ask these doctors... and that's another thing we South Africans ... We have got firm beliefs...We say stop...let people mourn...but not here...they can't make up their mind.”

“I'm used to a very structured way of working...and together the multidisciplinary team takes a decision and we work towards something...Whereas here you get everybody going on their own leads and the patient is not the centre of the whole effort...and that for me is disturbing...They have all the resources, all the money, all the expertise at their disposal...why not somebody take the lead in the team and say “This is what we are doing for the patient.”

In order to address complex ethical issues characteristic of the healthcare environment, it is vital that the various members of the health team learn to cooperate with each other. Accordingly, various members of the healthcare team must enter into negotiations with each other when making ethical decisions. The issue at stake should be 'health care ethics' and not 'medical' or 'nursing' ethics. Notwithstanding, there are different perspectives that healthcare professionals may use when making ethical decisions, which may lead to conflict and insufficient cooperation between the members of the healthcare team (Botes, 2000:1077).

Transcribing: 'Transcribing' is the term used when the nurse rewrites a physician's medication order from the physicians' notes into the medication administration chart. Transcribe is defined in the Longman Dictionary of Contemporary English (1995:1536) as *to write an exact copy*. It is entrenched in South African nurses throughout their training that the transcribing of medication is forbidden. The consequence of violating this rule can lead to disciplinary action by the South African Nursing Council (SANC). The United States (USA) and Canada are the two countries where nurses are allowed to transcribe medication. KFSH&RC, following the USA model, requires all nurses to transcribe medications. Participants were not prepared for the moral dilemma in which they found themselves and experienced much anxiety and inner turmoil. The inclusion of a "Transcribing activity" in the GNO programme helped alleviate some of the anxiety but participants were never fully comfortable performing this activity.

"South Africans struggle because they are not used to transcribing...and that was something I even struggled with until now...it feels so wrong to be doing it because it is so ingrained in us that we cannot transcribe."

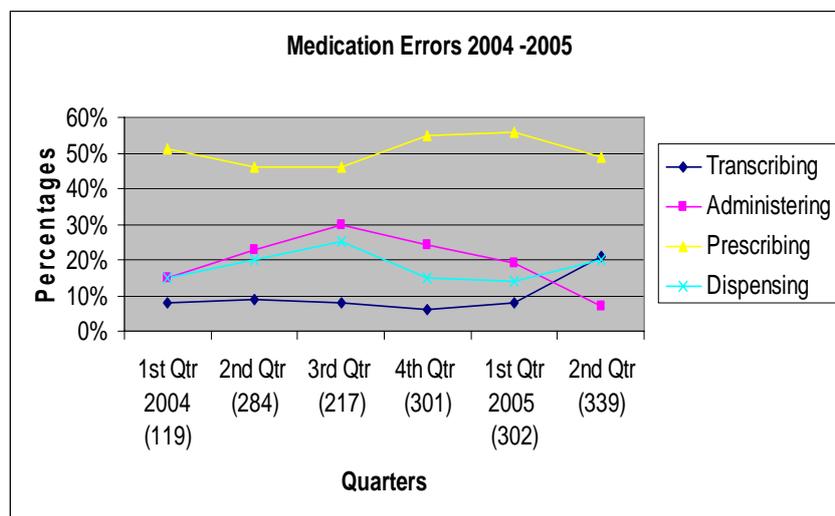


Figure 3.7 Graphical Representation Of Medication Errors 2004 – 2005

Figure 3.7 Shows medication errors at KFSH&RC for 2004 and the first two quarters of 2005. Transcription errors escalated from 8% to 21%. According to the nursing Quality Insurance manager, KFSH&RC, the

practice of transcribing is under review. It is predicted that transcribing by nurses will be stopped in the near future, as is no longer considered as best practice at KFSH&RC (personal conversation Daly, November 2005).

Holistic care: The term holistic, coined in 1926 by Jan Christian Smuts, defines an attitude or mode of perception in which the whole person is viewed in the context of the total environment (Andrews & Boyle 1995:27). Its Indo-European root word, *kailo*, means whole, intact or uninjured (Andrews & Boyle, 1995:27). The words whole, heal and health have come from this root. The essence of health and healing is the quality of wholeness we associate with healthy functioning and well being. Health is viewed as a positive process that encompasses more than the absence of signs and symptoms of the disease. It is not restricted to biological wellness but rather involves broader environmental, socio-cultural and behavioural determinants (Andrews & Boyle, 1995:27).

Holistic care has been the focus of nursing service delivery for many years. Florence Nightingale viewed the patient as a whole person and not simply a disease entity. Through continued research, education and practice, nurses have realised the importance of treating a person as a bio-psych-socio-spiritual being (McRoberts, Sato & Southwick, year unknown: 1).

Holistic nursing care principles are incorporated into the basic training of the South African registered nurses. This is stipulated in the South African nurse training institutions' Curriculum for the Diploma/Degree in Nursing Science (General, Psychiatry and Community) and Midwifery. It is, therefore, firmly engrained into their work ethic as they render quality nursing care to their patients. Absence of holistic care was the cause of another negative nursing experience for the participants as they continually encountered nurses and doctors who ignored or forgot the

importance of this principle, namely nursing the patient holistically (physical, spiritual, psycho-social aspects of care).

“Yes...they only see a big heart and pair of lungs in that bed...they see nothing else...everything else is separate...sometimes I am so frustrated...and say “Please leave the heart for a moment...you are depriving the kidneys”... but at the end of the day it is the doctor’s patient...”

“Cause sometimes I’m still passionate about it (holistic care)... but sometimes you get so frustrated that you think “It doesn’t matter what you do...here is the wall...and you just gonna walk against this wall over and over because this is the King Faisal way...”

“The one thing that does frustrate them (South Africans)...In South Africa you are multi-functional and multi-tasked... For instance you will give a nebuliser...You will take bloods...you will treat the patient holistically...whereas here you have to call the RT (Respiratory Therapist) or the Phlebotomist...This frustrates our South African girls because they know what total patient care is...and for them to wait for a RT to come and give a nebuliser can be agitating.”

Financial compensation for service

KFSH&RC employees are categorized into zones. The nationality (passport) of the employee will determine in which zone the employee is placed. The salary scale has 40 steps, with the entry level depending upon the zone in which one is. Accordingly, the salaries of nurses vary from zone to zone. Zones 1 and 2 (northern America) are the highest paid employees, closely followed by zone 4 (UK, some European countries, Australia and New Zealand). South Africans are in zone 8 and, therefore, earn thousands of riyals less than nurses from the aforementioned countries (but bear in mind that South African nurses still earn a better salary than the nurses from Middle Eastern and Asian countries). Participants found this to be an enormous bone of contention, as all staff on the same grades have the same job description

and are expected to, and indeed do, perform the same duties. Moreover, to add insult to injury, the South Africans had not received a pay increase in the past six years. The rationale given from executive management was that South Africans are an “easy to get” market. Participants felt that this was discriminatory and experienced feelings of anger and demotivation, especially as they had to sit back and accept other zones receiving regular increases.

“The unfairness of the system has disappointed me tremendously. As South Africans we know that there is discrimination here regarding the salaries ...but I don't think we know the extent until we are in the system. And I have signed for a certain amount of money in every month's salary, but I have definitely not signed for the gap to get bigger and not to get an increase when other people around me get increases. So it is very disappointing and actually sometimes humiliating, to be in a group to be paid maybe a third...maybe half of what the others are paid. And then whenever they would receive an increase...of course they would be very happy you know...but I was just left out.”

“One of the senior managers told me that you can offer anything to the South Africans and they will be comfortable and they will accept that. We are cheap labour...we are seen as cheap labour...we are appointed into the positions as the Westerners...we do the same job...we do it very well...we carry the same responsibilities, but we have to be happy with less. And it's because our market value is so low...the recruitment staff has this idea that they can go to South Africa...they can recruit hundreds and hundreds of nurses, if they wish to, because there are an enormous lot of nurses that are on the waiting lists still wanting to come to this country...and they can actually offer the nurses anything and they will accept it.”

“Also the discrepancies of the salaries play a major role at the hospital...It causes major dissatisfaction...You are a different nationality...I'm a different nationality...We are doing the same work...so because you earn more...I will work less...Why should I work hard if I earn less...that is the attitude...”

An added disappointment for the participants was that the recruitment agencies had not been fully honest with them regarding the salary discrimination, as well as the fluctuating exchange rate.

“The recruitment agencies do not inform the South African nurses...they only inform South African nurses regarding differences in salaries...they cannot give you numbers...they cannot say how big is the difference...and they do not inform the nurses about the increasing gap in salaries...and about increases and benefits that they will not get while others get it...so South Africans are not informed at all.”

Recruitment agencies

Participants experienced further disappointment in recruitment agencies for not fully orientating them to the realities of living and working in Saudi Arabia. The particular areas in which participants felt the agencies had not been completely ‘up front and honest’ with them were related to salaries and the impact of a fluctuating exchange rate. Other areas where participants felt that the agencies had not prepared them adequately were the general cultural environment and the extensive expectations regarding further education and competencies that were required during the orientation period. For some, disorganisation of travel arrangements was also an issue.

“Even with our agencies we come via...everything is not organised because I’ve met a couple of people now...the new people who are leaving even after 6 months or a year...because what the agency says how it is here and how it actually is here...is a worldwide of difference.”

“The recruitment agencies... currently they prepare the nurses very, very badly...the only important issue to the recruitment agency is to make money...to send nurses to Saudi Arabia ...to convince the nurses that they should stay for 3 months...ummm... and as you know the recruitment agency then gets a month’s salary of the nurse...so then they get their payment at least. It is not in their interest to prepare the nurse very well because then they will have less nurses coming to this country.”

“The agency must be honest... You know, when I went for my orientation day they painted a rosy picture...everything was good...I think there should be a balance...You know...Nothing is good all the time...there should be a honest balance...I’m not saying they should point out all the negatives but just get a balance...And say “this is what life is in Saudi” because even the slides that we saw...they were all ‘hunky dorey’...but it is not like that all the time...”

3.5 CONCLUSION

Nursing care of the Arab Muslim patient can be extremely challenging and it is, therefore, imperative that the nurse is knowledgeable about important aspects of the culture. Knowledge of the complex social structure, world view and cultural context features is critical in promoting a sense of care for the Arab patients. The centrality of religion and the family are closely interrelated and reflect many aspects of health care (Luna, 1989:22).

Data for this study were gathered by means of phenomenological unstructured interviews and personal journals written by each participant. Data obtained from the transcribed interviews and personal journals were analysed and themes and sub-themes were identified to describe the experiences of the South African registered nurses living and working in Saudi Arabia. An extensive literature search was done and the major theme and sub-themes were verified and placed within the context of the existing literature.

The following chapter will describe orientation guidelines that have been developed to optimize the support for future registered nurses migrating to Saudi Arabia. The identified themes, together with the data acquired from the registered nurses, served as a baseline for the formulation of these guidelines.

CHAPTER 4

GUIDELINES, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

The true goal is not to reach the uttermost limits, but to discover a completeness that knows no boundaries.
- Rabindranath Tagore (*Stray Birds*, 1916)

4.1 INTRODUCTION

In the introductory chapter, an overview of the research study was presented and the problem statement was described. Chapter two incorporated the research design and methodology. In chapter three, data were gathered during interviews with registered nurses and analyzed. Themes were identified reflecting South African registered nurses' experiences whilst living and working in Saudi Arabia. In this chapter, these experiences, as reflected in the themes and the transcribed interviews, form the baseline for the development of the orientation guidelines. The guidelines will be brought to the attention of professional bodies and agencies recruiting registered nurses to Saudi Arabia. In addition to the formulated orientation guidelines, this chapter includes the summary of findings, limitations, recommendations for nursing research, nursing education and nursing practice and the conclusion of the study.

4.2 OBJECTIVES

This research study had a primary and a secondary objective.

- The primary objective of this study was to explore and describe the lived experiences of South African nurses related to living and working in Saudi Arabia.
- The secondary objective of this study was to develop orientation guidelines to support South African nurses working and living in Saudi Arabia.

In order to attain the first objective, the researcher posed the following question:

"What are your experiences with regard to living and working in Saudi Arabia?"

In order to attain the second objective, the following question was formulated:

"How can a registered nurse be assisted to function effectively in Saudi Arabia?"

In the opinion of the researcher, the aforementioned objectives were reached on completion of this study.

4.3 SUMMARY OF RESEARCH FINDINGS

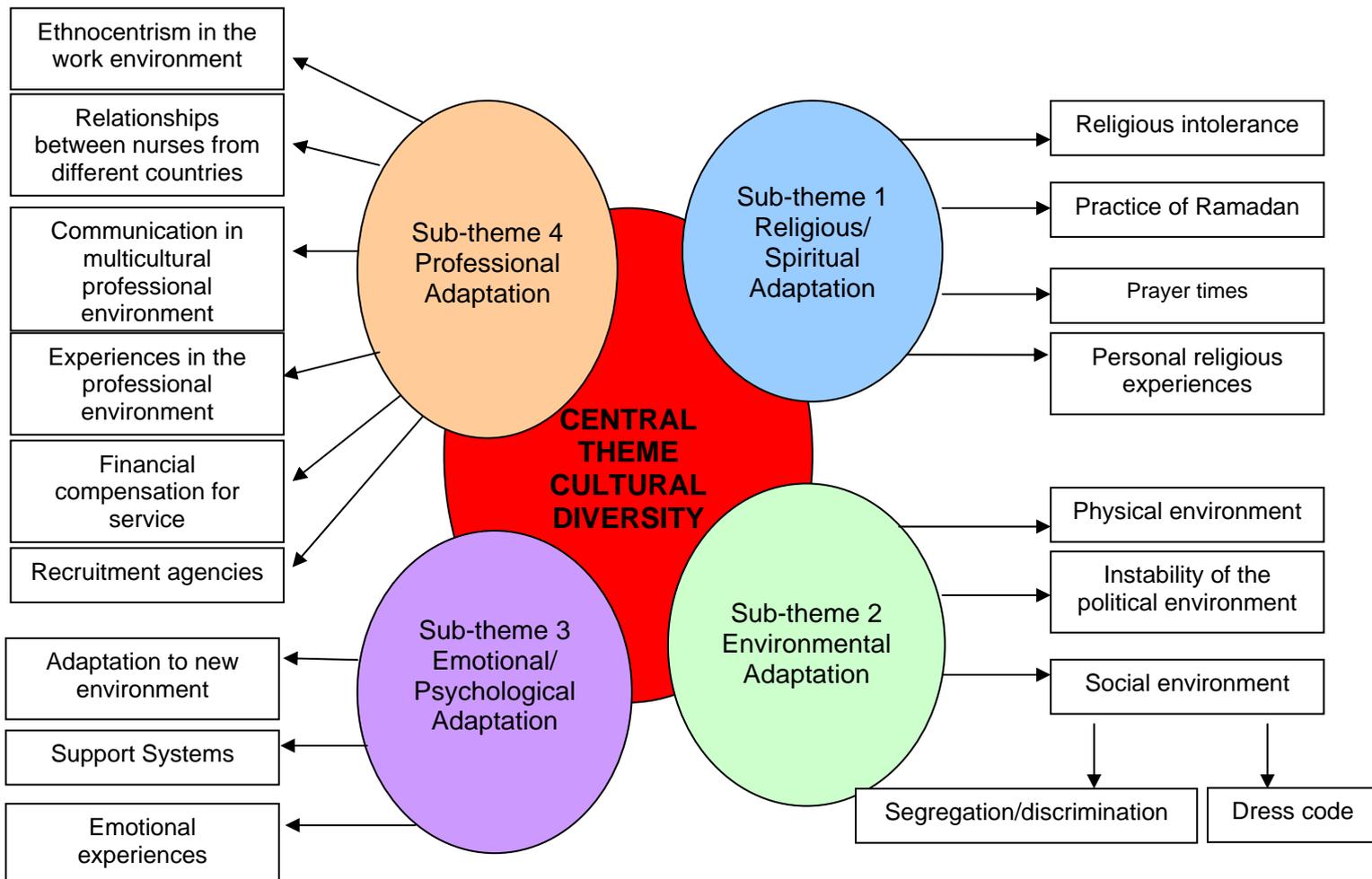


Figure 4.1: Expanded Diagrammatic Representation Of Central And Sub-themes

The study emanated from the researcher's own experience as a registered nurse living and working in Saudi Arabia. The researcher, as the General Nursing Orientation Co-coordinator and Clinical Instructor, noted apprehension, anxiety and lack of preparedness on the part of South African registered nurses working and living in Saudi Arabia.

During the research process, the South African registered nurses' who formed the sample population for this study were interviewed and verbalized their lived experiences to the researcher. Information-rich data were generated by the unstructured, in depth interviews. The data were analyzed and reported on under one central theme and associated sub-themes (see figure 4.1).

Although many experiences, both positive and negative, were shared with the researcher, one central theme emerged, namely: "Cultural diversity encountered in all aspects of the registered nurses lives while living and working in Saudi Arabia". It was the common thread that permeated the sub-themes, highlighting the diverseness between the South African and Saudi Arabian cultures. It was the experience of the researcher and the participants that the Islamic religion is so intertwined in the Saudi culture that it was difficult at times to decipher whether the practice encountered was part of the culture or as a result of the Islamic faith. The sub-themes highlighted the experiences and adaptations of the registered nurses to this diverse culture.

Sub-theme one covered the participants' religious and spiritual adaptation, highlighting the difficulties encountered in a country where Islam is the only religion practiced and all other religions are prohibited. To counteract the negative experiences, emotions and feelings resulting from religious intolerance and lack of freedom to practice their faith, the participants derived strength from spending time alone with their Maker. Spiritual support systems subsequently developed amongst friends and back home in South Africa. Ramadan and Prayer times were identified as two aspects of the Islamic faith that affected the living and working environment and required adaptation on the part of participants.

Sub-theme two covered the participants' adaptation to the physical, political and social environment. Adapting to the climatic conditions of the desert, especially the extreme heat, took its toll and manifested in clinical symptoms such as dehydration, exhaustion, headaches and skin ailments. A positive aspect of the physical environment for all participants' was the almost non-existent crime rate. The instability of the political environment proved to be a concern for both participants and their families. Adaptation to the social environment was, without a doubt, the most difficult for the participants'. Aspects highlighted were: segregation of males and females and discrimination against females, conforming to the dress codes and continually being policed by the Mattawan to ensure that the social mores were not violated.

Sub-theme three discussed participants' emotional and psychological adaptation. Every experience encountered by the participants had associated emotions and feelings filtering through, whether positive or negative. How the participants adapted and handled the roller coaster of emotions depended on their point of departure and their life experience. However, no matter how emotionally mature the participants were or how sound their coping mechanism were, migrating to Saudi Arabia was undoubtedly a very traumatic experience which evoked reactions and emotions that many participants had never experienced before. All participants agreed that, in order to survive living and working in Saudi Arabia, it was imperative that they adapt to and embrace the culture, have a positive attitude accompanied by sound coping mechanisms and establish solid support systems, namely friends, family and the Christian faith.

Sub-theme four discussed the participants' adaptation to the professional working environment. The 'working' aspect in Saudi Arabia demanded of the participants a flexibility, an open mind and a willingness to embrace and acknowledge the differences of the Saudi culture as well as the cultures and approaches to nursing by the multicultural and multinational workforce. General nursing orientation was perceived as positive and beneficial. The orientation to the unit, the attitude of the assigned preceptor and the

acceptance of the staff set the tone for either a positive or negative encounter. Participants who had a negative experience took that much longer to adapt to their work environment. Registered nurses encountered ethnocentrism, communication barriers (highlighting language and accents as the main problems) and interpersonal conflict between themselves and their colleagues. Positive and negative experiences were encountered in the actual nursing environment. Positive aspects included having the Saudi patients accept them as caring and competent nurses, having the reputation of being 'hard' workers and having the ability to handle stress. Negative aspects that were highlighted included: cultural and religious practices that hindered the nursing routine; communication barriers with the Saudi population; lack of holistic care; the moral dilemma of having to transcribe; ethical dilemmas regarding preservation of life and the worthlessness of the Saudi female, as manifested in lack/non-existence of decision-making regarding her treatment. With regard to educational expectations and competencies, participants found that they were completely unprepared for all the mandatory requirements that had to be completed in the probationary period. Although not the objective of the study, participants highlighted what they experienced to be deficiencies in their basic training with regard to pharmacological knowledge (especially regarding calculations), basic physical assessment skills and computer skills.

In the researcher's own experience, and as highlighted by the participants through the depicted central and sub-themes, certain issues/aspects related to the registered nurses' experiences are prevalent. The study was undertaken to reflect on and to understand the lived experiences of the South African registered nurses living and working in Saudi Arabia, as well as to determine how they can be assisted, in order to develop orientation guidelines.

4.4 ORIENTATION GUIDELINES

The main focus of the study has been on the registered nurses' 'life world' whilst living and working in Saudi Arabia. Accordingly, the proposed orientation guidelines are aimed at optimizing this 'life world'. Orientation

guidelines have been constructed from various sources, including registered nurses' experiences, inputs from various literatures, experience of the researcher, nursing colleagues living and working in Saudi Arabia and supervisors and experts in qualitative research, utilizing inductive reasoning. The purpose of the orientation guidelines is to assist and support registered nurses planning to migrate to Saudi Arabia in the future.

The two principle orientation guidelines that have been formulated are:

- Orientate South African nurses to highlighted cultural aspects of living and working in Saudi Arabia.
- Create an awareness of the emotional and psychological turmoil experienced by South African registered nurses when living and working in Saudi Arabia.
- Sub-guidelines with the rationale and implementation of these identified principle orientation guidelines are presented in tables 4.1 and 4.2.

Fountain with mosque in the background at main entrance to the hospital



4.4.1. Principle Orientation Guideline One: Orientate South African Nurses To Highlighted Cultural Aspects Of Living And Working In Saudi Arabia

Table 4.1 Principle Orientation Guideline One

Sub-guideline	Rationale	Implementation
<p>4.4.1.1 Create an awareness of the religious/spiritual environment/restrictions in Saudi Arabia</p>	<p>Registered nurses are exposed to:</p> <ul style="list-style-type: none"> - Religious intolerance to all religions other than Islam. Registered nurses' are not allowed to practice their own religion freely and openly. - Islamic evangelistic outreach in attempt to convert persons. <p>Rabat (2005:4) states that Religion can act as an isolating force or can offer a sense of belonging, but this depends on the approaches pursued by the host country. The creation of 'religious silos', in which migrants (that is the South African registered nurses) become isolated from a hostile and discriminatory environment, often arises from host societies' expectation that</p>	<p>The registered nurse needs to establish a spiritual support network:</p> <ul style="list-style-type: none"> - At home in South Africa. - A Christian communication network in Saudi Arabia. - By means of individual self reflection and affirmation of personal spiritual/religious beliefs so as to stand firm when faced with adversity and challenged regarding beliefs. <p>Rabat (2005:4) states that religious faith and religious organizations remain vital to many people today as transnational migration increasingly transcends spatial confines and requires a redefinition of identity and belonging for many individuals. He confirms that adequate spiritual support when trying to integrate into another country is essential. Lack of support could result in migrants feeling isolated and in need of reaffirming their identity. Furthermore, he says that migration has an impact on religious practices and identities themselves, as the new environment affects</p>

Sub-guideline	Rationale	Implementation
	<p>migrants become totally assimilated. This is evident in Saudi Arabia.</p>	<p>migrants' attachment to, understanding of and practice of their faiths. This sentiment confirms that registered nurses migrating to Saudi Arabia need to be grounded in their faith and belief system.</p> <p>The registered nurse needs to have information in this regard included in the orientation programme and information package presented by recruitment agencies.</p>
<p>4.4.1.2 Orientate South African registered nurses to the variations in the physical, political and social environment.</p>	<p>Registered nurses are exposed to:</p> <ul style="list-style-type: none"> - Desertous climatic conditions that impact on their physical being. - An unstable political environment that impacts on their psychosocial well being. - Discrimination and restrictions in the social environment due to cultural and religious influences. 	<p>Provide the registered nurse with information in the form of an orientation programme/package/video/CD on:</p> <ul style="list-style-type: none"> - Geographical topography of Saudi Arabia, including maps and information on cities/towns in which hospitals are situated. - Climatic conditions and the physical effects these may exert on individuals. - Instability of the political environment and the resultant restrictions and dangers of terrorist activity. - Enforced dress code for males and females. - Segregation of males and females. - Discrimination against females in all aspects of Saudi life. - Cultural restrictions (for example prohibition of alcohol and certain foodstuffs) and religious restrictions (for example

Sub-guideline	Rationale	Implementation
		<p>prohibition of the Bible and religious symbols such as crosses, etc).</p> <ul style="list-style-type: none"> - Censorship of, for example, magazines and music. <p>Provide the registered nurse with handouts/information/presentations on the following related topics:</p> <ul style="list-style-type: none"> - The Arabic/English language, conversation practice and expressions. - Available websites on Saudi Arabia and on the individual Saudi hospitals. - Saudi culture. - The nursing orientation programme of the individual hospitals in Saudi Arabia. <p>An underlying cause of negative reactions to another culture is the tendency to judge something that is different as inferior. It is important to be open toward the culture into which one is going, to try to discard stereotypes and to read as much as one can about the culture before departure. Educating oneself on the many aspects of the country in which one will be living provides for a better understanding and appreciation of the new surroundings much sooner. With this in mind, the</p>

Sub-guideline	Rationale	Implementation
		<p>registered nurse should do the following before departure:</p> <ul style="list-style-type: none"> - Learn about the country's history, natural resources, social customs, religions, art and political structures. - Find out the problems and current national issues. - Talk to others who have lived in the country to which one is migrating and learn about what problems may be encountered (Center for International Education, 2005:2).
<p>4.4.1.3 Inform South African registered nurses of the variations in the multinational/multicultural nursing/work environment.</p>	<p>Registered nurses working in Saudi Arabia encounter:</p> <ul style="list-style-type: none"> - Communication barriers when interacting with colleagues, patients and their families which lead to frustration, misunderstandings and hindrances to nursing care. <p>Communication is a vital part of nursing practice. Nurses who communicate effectively are better able to establish a trusting relationship with patients, families and colleagues, and prevent legal problems associated with nursing practice (Van Leuven, 2000:19).</p>	<p>The registered nurse needs to do the following to decrease communication barriers:</p> <ul style="list-style-type: none"> - Improve communication with the Arabic population by learning the language as quickly as possible. - Utilize the Arabic language handout in the recruitment package as an introduction to Arabic phrases, greetings and expressions as part of preparation before migrating. - Attend Arabic classes either prior to leaving South Africa or once in Saudi Arabia - Utilize the services of an interpreter, when available, in the hospitals in Saudi Arabia. - Research the differences in language approach and meaning between Arabs and Westerners to gain insight and understanding.

Sub-guideline	Rationale	Implementation
		<p>The above concurs with Van Leuven's (2000:19) statement that in some situations ordinary methods of communication are not sufficient, for example when dealing with persons/patients who speak a language that is foreign to your own. She states that there are many types of language barriers of which foreign language is one and stipulates certain guidelines to assist in communicating with the non-English speaking patient, including:</p> <ul style="list-style-type: none"> - Finding out whether the health care facility has a translation service. - Finding out if any staff members speak the language. - Not yelling at the patient; speaking loudly may only make the patient think you are angry; increasing the decibel level will not help. - Purchasing a phrase book, developing language skills and developing a resource binder containing frequently used (Arabic) terms if a particular language is commonly spoken at the facility (Arabic in this instance). - Enlisting, as a last resort, the help of a family member or friend who may be able to translate. (However, be considerate as translation can be very stressful for them.

Sub-guideline	Rationale	Implementation
	<p>- Interpersonal conflict in the workplace due to ethnocentrism, different cultural belief systems and work ethics which lead to unhappiness.</p> <p>One must be prepared to deal with personal rejection, prejudice and discrimination. Cultures are ethnocentric and their members typically view their own culture as superior (Winkelman, 2002:6).</p>	<p>Remember that they are the patient's support system, not the nurse's.)</p> <p>The registered nurse needs to do the following to decrease or alleviate interpersonal relationship turmoil:</p> <ul style="list-style-type: none"> - Display an open mind, positive attitude and teachable spirit to differing nursing practices as well as towards colleagues of different nationalities and from different cultures; a "know it all" attitude will lead to conflict and isolation. - Acknowledge the benefits of living in a different culture and have a positive attitude about the culture and learning experiences; one's attitude about the new culture and willingness to change are vital for adjustment (Winkelman, 2002:6). <p>Van Leuven (2000:24) confirms that in every country, nurses come into contact with people from cultures different from their own and some cultural issues require sensitivity and understanding. Examining your own attitudes towards different cultures, different races and ethnic groups is essential. Furthermore, she states that there are universal guidelines that can be of assistance when responding to</p>

Sub-guideline	Rationale	Implementation
	<ul style="list-style-type: none"> - Positive and negative experiences regarding nursing care. 	<p>persons from different cultures, including:</p> <ul style="list-style-type: none"> - Always treating the person with respect. - Acknowledging that different cultures may use different behaviours to denote respect or understanding; never assume you know the meaning of a specific behaviour. - Familiarizing yourself with the customs and beliefs of the cultural groups in your area (that is the Arabic population). - Learning how the persons (Arabic patient or colleagues from different cultures) view health, illness, grieving, and the health care system. - Trying to incorporate cultural symbols and practices into the care plan of the patient (that is culturally sensitive care to the Arabic population) where feasible; as this can be a comfort for the patient. <p>Provide information in the form of an orientation package/video/CD on:</p> <ul style="list-style-type: none"> - Cultural differences in the multinational work force encountered in nursing practice that is different approaches and attitudes to nursing care and different communication styles.

Sub-guideline	Rationale	Implementation
	<p>Education requirements and expectations of competence for which they were not prepared.</p> <p>- Discrimination regarding salaries.</p> <p>Inadequate information from recruitment agencies.</p>	<ul style="list-style-type: none"> - The effects that the enforcement of the Islamic faith has on nursing routines and practice such as prayer time, Ramadan, males not being allowed to nurse females, lack of autonomy of Arab female patients (example, decision making by male family members on behalf of female patients), and variation in work ethic and nursing ethics. - Educational expectations and requirements from different hospitals during the probationary period, for example, tests to be written (example pharmacology), competencies that have to be completed, workshops to be attended (example basic physical assessment), certifications to be acquired (example BCLS) and basic computer skills. - Differences in financial compensation between countries so as to minimize conflict between nationalities once in Saudi Arabia. <p>Recruitment agencies need to be urged to do the following:</p> <ul style="list-style-type: none"> - Be more balanced in the information given to registered nurses; both positive and negative aspects must be shared as this will enhance the trust relationship and reduce conflict between candidates and recruiters and enable

Sub-guideline	Rationale	Implementation
		<p>candidates to make a more informed decision.</p> <ul style="list-style-type: none"> - Update current information in the orientation programme by including the aforementioned in an attempt to better prepare candidates. - Review their existing orientation package and update it accordingly. - Develop a comprehensive orientation package should one not be available. - Request hospital recruitment departments to ensure that all information disseminated to the recruitment agencies is pertinent, relevant and updated.

4.4.2. Principle Orientation Guideline Two: Create An Awareness Of The Emotional And Psychological Turmoil Experienced By South African Registered Nurses When Living And Working In Saudi Arabia

Table 4.2 Principle Orientation Guideline Two

Sub-guideline	Rationale	Implementation
<p>4.4.2.1. Attempt to decrease/alleviate the intrapersonal relationship turmoil experienced by South African registered nurses.</p>	<p>The registered nurses experience a 'roller coaster' of emotions and feelings as they endeavour to adapt to:</p> <ul style="list-style-type: none"> - Being separated from loved ones. - The Saudi culture and way of life – socially and professionally. - “Outsider status” where psychological preparation for their status is essential, because most people immersed in a foreign culture will experience a negative evaluation of their differences and a rejection by members of the host culture (Winkelman, 2002:6). <p>When entering another country, environmental and cultural differences require adaptation of a person's</p>	<p>The registered nurse needs to utilize interventions that will decrease/alleviate intrapersonal relationship turmoil:</p> <ul style="list-style-type: none"> - The recruitment agency needs to conduct a self assessment using an applicable and available self assessment tool to establish a personality profile, including coping mechanisms, of the registered nurse to assess emotional maturity and establish suitability of candidate. This should be implemented early in the recruitment process. <p>Assessment regarding one's ability to adapt to a new culture is a good first step before even going to a new culture. Not all individuals are equally prepared to accept the rigors of culture shock and adaptation, nor are they disposed to change in ways necessary to acculturate effectively. One needs to be realistic about the necessary changes and aware of the problems inevitably encountered in living in a foreign country (Winkelman, 2002: 6).</p> <p>The registered nurse needs to establish supportive relationships by:</p> <ul style="list-style-type: none"> - Ensuring that family supports the decision to migrate and

Sub-guideline	Rationale	Implementation
	<p>behavioural norms and expectations. It is required that persons adapt to the new environment, establish new relationships and redefine themselves within a new context. This process can create intrapersonal and interpersonal difficulties (Fabrizio & Neill, 2003:1).</p>	<p>identifies with the reasons for migrating.</p> <ul style="list-style-type: none"> - Maintaining family support at home in South Africa via email, telephonically, etc. - Forming friendships (with persons with positive attitudes) and a support network in Saudi Arabia as soon as possible. <p>It would be useful if the Saudi Arabian hospitals established mentor support groups, comprising fellow countrymen who are already in Saudi Arabia, for new registered nurses to contact prior to departure and on arrival in the Kingdom. This will assist with adaptation and minimize initial feelings of fear and apprehension.</p> <p>Winkelman (2002:7) confirms that one needs to maintain or reestablish a network of primary relations - family and friends - who provide positive interpersonal relations for self esteem and for meeting personal and emotional needs. The adjustment of one's family is also essential to one's own well-being because effectiveness in work requires interpersonal harmony. Emotional life may be maintained through writing letters or keeping a personal diary of feelings and experiences. Furthermore, he states that social support may be found in <i>close ties</i> (family and friends) and in <i>weak</i></p>

Sub-guideline	Rationale	Implementation
	<p>Exposure to a new environment causes stress, potentially inducing a wide range of physiological and psychological reactions. These reactions can increase feelings of stress, anxiety, depression and uneasiness. Without achieving an adequate level of comfort and support, persons may have difficulty coping with their surroundings, interacting with others, and accomplishing tasks (Fabrizio & Neill, 2003:1).</p>	<p><i>ties</i> with those with whom one has secondary relationships. Adaptation requires friendships with locals in addition to fellow nationals, and international and multicultural individuals. Organizational support can also be very useful, for example social clubs, sports teams and theatrical productions, etc for developing social relations.</p> <p>The registered nurse needs to be disciplined about establishing a routine of active personal stress management strategies, for example:</p> <ul style="list-style-type: none"> - Performing sufficient physical exercise (many forms of sport are available, for example squash, HASH, tennis, gym, swimming, walking, running). - Being selective in eating a well-balanced, healthy, nutritional diet (including vitamin supplements if necessary). - Getting sufficient sleep. - Getting 'out and about': going on excursions and shopping trips, attending functions or social evenings when available and socializing with friends. <p>The aforementioned concurs with the following guidelines for coping with stress:</p>

Sub-guideline	Rationale	Implementation
		<p>Taking care of your body, mind and spirit can help reduce feelings of anxiety and frustration that often accompany stress. Therefore:</p> <ul style="list-style-type: none"> - Practice relaxation techniques such as controlling your breathing, clearing your mind and relaxing your muscles. - Get enough sleep. - Eat a nutritious breakfast and lunch. - Exercise, as this relieves tension and provides timeout from stressful situations. - Reduce or eliminate caffeine because it is a stimulant and can make you feel more anxious. - Get a massage to relieve tension. - Read a good book or watch an upbeat movie. <p>(Dumke, Hutman, Jaffee & Segal, 2005:3).</p>

4.5 LIMITATIONS

The following limitations were identified in this research study:

- Interviews were conducted with registered nurses who were employed by one hospital in Riyadh, Saudi Arabia. The study did not include the experiences of South African registered nurses employed by other government or private hospitals in Riyadh or in Saudi Arabia.
- Limited literature was available on the research topic due to lack of available data.
- A review of different recruitment packages available to confirm validity and assess preparedness was not conducted due to lack of accessibility.
- The population group in the study had only been in Saudi Arabia between three to six months.
- Lack of personal contact with the supervisors was extremely problematic at times. Electronic communication had to be relied upon due to the researcher living in Saudi Arabia whilst conducting the research.

4.6 RECOMMENDATIONS

Recommendations forthcoming from this research study will be discussed under the following headings:

4.6.1. Nursing Research

Recommendations for nursing research are as follows:

- Further study could be initiated on how and if the family who are left behind cope - more specifically the children when a spouse/parent migrates to Saudi Arabia.
- Further study could be initiated on the registered nurses who have lived and worked in Saudi Arabia for longer than 6 months.
- Research could be initiated on the personality profile of nurses who are/are not successful in adapting to living and working in Saudi Arabia.
- A comparative study could be initiated on registered nurses working and living in other hospitals throughout Saudi Arabia to obtain a broader perspective.

- Further study could be conducted to determine the relevance and value of the aforementioned orientation guidelines once implemented.

4.6.2. Nursing Education

Recommendations for nursing education include the following aspects:

- **Pharmacological knowledge**

- Developing workshops/courses to update registered nurses pharmacological knowledge, specifically with regard to calculations.
- Reviewing of the pharmacology component in the basic diploma and degree courses in nursing to incorporate a bigger component on various pharmacology calculations.
- Instituting regular mandatory pharmacological updates post basic nursing training for all registered nurses.

- **Physical assessment**

- Reviewing the physical assessment component in the basic diploma and degree courses in nursing.
- Developing workshops/courses to master the technique of physical assessment post basic training.

- **Computer skills**

- Developing workshops/courses on basic computer skills and including these in basic nursing training.

- **Transcultural nursing**

- Developing workshops on transcultural nursing for registered nurses in order for them to gain insight into working with multinational professionals.

- **South African Nursing Council (SANC):**

- Requesting SANC, as the Education and Training Quality Authority (ETQA) appointed for nursing, to inform the South African Qualifications Authority (SAQA) of the shortcomings in education identified by the South African registered nurses in Saudi Arabia and suggesting that international benchmarking be used for curriculum planning.
- Encouraging SANC to hasten the process and consider the information gleaned from this study when determining criteria for Continuous

Education Units (CEU) and requirements for licensing and continuous professional development.

- **Saudi Council for Health Professionals (SCHP)**

- Recommending to the Saudi Council for Health Professionals that requirements be stipulated and completed before licensing expatriate nurses to work in the Kingdom.

4.6.3. Nursing Practice

Recommendations for nursing practice are as follows:

- **Orientation guidelines**

- Should be available to all registered nurses planning to migrate to Saudi Arabia.
- Should be integrated into the orientation programmes presented by the various agencies who are recruiting registered nurses to Saudi Arabia.
- Should be made available to recruitment agencies throughout the world.

- **Self assessment tool**

- A self assessment tool focusing on psychological profile should be developed for registered nurses to complete prior to migrating to Saudi Arabia.

- **Publishing of experiences**

- Suggestions could be made to DENOSA to encourage registered nurses to publish reviews on their international experiences.

- **Website**

- Development of an accessible website where registered nurses who have returned to South Africa after living and working in Saudi Arabia could share their experiences.

4.7 CONCLUSION

“Take time to gather up the past so that you will be able to draw from your experiences and invest them in your future”

(anon)

This research study, through the reflections of the registered nurses living and working in Saudi Arabia, has exposed the unique situation and circumstances that South African registered nurses encountered, when migrating to Saudi Arabia. The researcher realized that South African registered nurses have had to endure various unique experiences related to adapting to a new cultural, religious, physical, emotional and professional environment. Successful adaptation depended on the registered nurses' ability and willingness to embrace the Saudi culture, embrace personal development and embrace and engage in learning and change, thus gleaning from the challenges encountered and enriching their lives through their experiences. The researcher constructed guidelines in an attempt to assist and prepare registered nurses migrating to Saudi Arabia. The researcher and the participants agreed that the guidelines would be a very useful tool to assist registered nurses in adapting to living and working conditions in Saudi Arabia. However, as a consequence of the perceived uniqueness of the Saudi Arabian culture, Saudi enforcement of the Islamic faith and the lack of exposure of the outside world to this 'closed' country, the participants aptly concluded that nobody could be fully prepared for what awaited them in Saudi Arabia.

To the South African registered nurses planning to migrate to Saudi Arabia

“Who you are, where you are, what you know gives you value. It either makes your life important or discounts the importance of your life. How much you believe in who you are, serve where you are and use what you know can make a big difference in who you become, where you go and what you do when you get to the next place.”

Iyanla Vanzant (Until Today, 2000)



Sunset in the Saudi Arabian desert

BIBLIOGRAPHY

AFFARA, FA & STYLES, MM 1997: Nursing Regulation: From Principle to Power. Geneva: International Council for Nurses.

AL EQTISADIAH 2005: Women Demand More Private Sector Jobs. Arab News, Monday 5 September 2005.

AL KRENAWI, A & GRAHAM, JR 2000: Culturally sensitive social work practice with the Arab Clients in Mental Health Settings. Journal Health And Social Work, 25(1): 9.

AL THANI, J 1980: The status of women in Islam. April 1980.
<http://www.iad.org/books/S-women.html>

ANDERSON, R 1992: Saudi Arabian Culture. Nursing Administration Quarterly, 16(2), Winter 1992:20-22.

ANDREWS, M & BOYLE, J 1995: Transcultural Concepts in Nursing Care. Philadelphia: Lippincott Company.

ANON, 2004: Chronology of attacks on Westerners in Saudi Arabia. 6 December 2004, Posted: 5:46 AM EST (1046 GMT).

ANON 2005: Holistic Care. Retrieved from Google 30 October 2005. <http://forestvillevet.com/HolisticCare.php>

ANON 2005: Islamic New Year: What is the Hijrah Calendar? Retrieved Google 25 November 2005. http://islam.about.com/cs/calendar/a/hijrah_calendar.htm

ANON 2005: Saudi Arabia. Wikipedia, the free encyclopedia. Retrieved Google. 12th November 2005. http://en.wikipedia.org/wiki/Saudi_Arabia

ATKINSON, RL; ATKINSON, RC; SMITH, EE; BEM, DJ & HOEKSEMA, SN 1996: Hilgard's Introduction to Psychology. Orlando, Florida: Harcourt Brace College Publishers.

BABBIE, E & MOUTON, J 2001: The Practice of Social Research. Cape Town: Oxford University Press.

BIN SAEED, KS 1999: How physician executives and clinicians perceive ethical issues in Saudi Arabian Hospitals. Journal of Medical Ethics, 25: 51-56.

BOTES, A 2000: An integrated approach to ethical decision-making in the health team. Journal of Advanced Nursing, 32(5): 1076-1082.

BOTES, AC 2000: A Model for Research in Nursing. Rand Afrikaans University (Ed). Department of Nursing Paradigm: Vision and Mission Statement, Theory of Health Promoting in Nursing, Research Model in Nursing. Johannesburg: Rand Afrikaans University.

BRAMMER, LM; SHOSTRAM, EL & ABREGO, PJ 1993: Therapeutic Psychology: Fundamentals of Counseling and Psychotherapy. 6th Edition. New Jersey: Prentice Hall Incorporated.

BRINK, H.1996: Fundamentals of Research Methodology for Health Care Professionals. Kenwyn: Juta.

BROUGHTON, T; KNOWLER, W & LEEMAN, P 2002: Why the lamp is being snuffed out. Sunday Tribune, 28 July: 1.

BURNS, N & GROVE, SK 1993: The Practice of Nursing Research, Conduct, Critique & Utilization. 2nd Edition. Philadelphia: WB Saunders Company.

BURNS, N & GROVE, SK 1997: The Practice of Nursing Research, Conduct, Critique & Utilization. 3rd Edition. Philadelphia: WB Saunders Company.

BUTLER, M 2005: The Development, Implementation, Validation and Evaluation of a Continuing Professional Development Learning Programme for Nurses Working in Saudi Arabia. Unpublished doctoral dissertation. University of Stellenbosch, South Africa.

CENTER FOR INTERNATIONAL EDUCATION 2005: Cultural Adjustment. University of California. Retrieved from Google 12 December 2005. <http://.cie.uci.edu/world/shock.html>

COLLINS GEM ENGLISH DICTIONARY 2003: 11th Edition. Great Britain: Harper Collins Publishers.

COLLINS PAPERBACK ENGLISH DICTIONARY. 1986. London: William Collins Sons & Co.

CRABTREE, BF & MILLER, WL 1999: Doing Qualitative Research. 2nd Edition. California: Sage Publications Incorporated.

CONSULAR CIRCULAR TO ALL SOUTH AFRICAN EXPATRIATES IN THE KINGDOM OF SAUDI ARABIA October 30, 2004. www.southafrica.com.sa

CRESWELL, JW 1994: Research Design. Qualitative and Quantitative Approaches. California: Sage Publications Incorporated.

CRESWELL, JW 1998: Qualitative Inquiry and Research Design, Choosing Among Five Traditions. Thousand Oaks: Sage Publications Incorporated.

CRESWELL, JW 2003: Research Design. Qualitative and Quantitative and Mixed Methods Approaches. 2nd Edition. Thousand Oakes: Sage Publications Incorporated.

CROOKES, PA & DAVIES, S 2004: Research into Practice: Essential skills for Reading and Applying Research in Nursing and Health Care. 2nd Edition. London: Balliere Tindall.

DALY, M 2005: Personal Conversation: Medication errors at King Faisal Specialist Hospital and Research Centre. November 2005.

DAVIS, CF 1992: Culturally Responsive Nursing. Nursing Administration Quarterly, 16(2), Winter 1992: 36-39.

DE POY, E & GITLIN, LN 1998: Introduction to Research: Understanding and Applying Multiple Strategies. 2nd Edition. United States of America: Mosby Incorporated.

DE VOS, AS 1998: Research at Grass Roots. Pretoria: Van Schaik Publishers.

DENOSA 1998: Position Papers: Ethical Standards for Nurse Researchers.

Denosa: Pretoria.

DICKSON, P 2002: South Africa's best brains leave country. Pretoria News, 16 Oct:1.

DUMKE, LF; HUTMAN, S; JAFFE, J & SEGAL, J 2005: Coping with Stress: Management and Reduction Techniques. Retrieved from Google 12 December 2005. http://www.helpguide.org/mental/stress_management_relief_coping.htm

DU PRAW, E & AXNER, M 1997: Working on common Cross-Cultural Communication Challenges. www.wgcd.org/action/ampu/crosscult/html

DUNNE, T 1994: Unveiling Saudi Arabia. Australian Nursing Journal, 2(4) October 1994.

ELY, M; ANZUL, M; FRIEDMAN, T; GARNER, D & MC CORMACK STEINMETZ, A 1991: Doing qualitative research: Circles within circles. London: Falmer Press.

FABRIZIO, SM & NEILL, JT 2003: Cultural adaptation in Outdoor programming. University of New Hampshire. Retrieved from Google 13 December 2005. <http://www.wilderdom.com/html/FabrizioNeill2003CulturalAdaptationOutdoorProgram.html>

FARNSWORTH, E 2002: Online news hour: Inside the Kingdom: Turki Al-Faisal. Retrieved from Google 21 January 2002. http://www.pbs.org/newshour/bb/middle_east/saudi_arabia/saudi_faisal.html

GEISLER, EM 1994: Pocket guide to Cultural Assessment-Saudi Arabia. Map page 262. Louis Missouri: Mosby.

HAM, A 2004: Saudi Arabia. 1st Edition. Australia: Lonely Planet Publications Pty Ltd.

HANCOCK, C 2001: Inaugural Address: International Council for Nurses Congress. 14 June. Denmark: ICN.

HASSAN, J 2004: Saudization Fails to Stem the Tide of Foreign workers. Arab News, Tuesday 23 March 2004.

HASSAN, R (year unknown): Members, one of another: Gender Equality and Justice in Islam. Department of Religious Studies, University of Louisville, Kentucky.

HOLLOWAY, I & WHEELER, S 1998: Qualitative Research for Nurses. Oxford: Blackwell Science Ltd.

INTERNATIONAL COUNCIL FOR NURSES 2001a: Position statement: Career Development in Nursing. Geneva.

INTERNATIONAL COUNCIL FOR NURSES 2001b: Position statement: Ethical Nurse Recruitment. Geneva.

INTERNATIONAL COUNCIL FOR NURSES 2002: Career Moves and Migration: Critical Questions. Geneva.

INTERNATIONAL COUNCIL FOR NURSES 2003: International Perspectives. International Nursing Review, 50:132-137.

ITANO, N 2002: South Africa sees health care crisis. Washington Times, 11July: 1.

KAPLAN, D; BROWN, M & MEYER, BP 1999: Brain Drain: New Data, New Options. 06-06-2004 @ 4:00 pm. <http://www@uct.ac.za/org/sansa>

KEMBER, D 2001: Reflective Teaching and Learning in the Health Professions. Oxford: Blackwell Science Ltd.

KIRK, J & MILLER, ML 1986: Reliability and Validity in Qualitative Research. Newbury Park: Sage Publications Inc.

KOTZÉ, WJ 1998: An Anthropological Nursing Science, Nursing Accompaniment Theory. Health SA, 3(2): 3-14.

KREFTING, L 1991: Rigor in Qualitative Research: The Assessment of Trustworthiness. American Journal of Occupational Therapy, 45(3): 214-222.

KVALE, S 1996: Interviews: An Introduction to Qualitative Research Interviewing. Thousand Oakes: Sage Publications.

LAW, B 2005: BBC News: Saudi Stories: The Booklet. Retrieved from Google 18 July 2005.

http://news.bbc.co.uk/go/pr/fr/-/2/hi/middle_east/4692613.stm

LEE, B 2003: Personal conversation: Migration of South African Registered nurses to Saudi Arabia. December 2003.

LENINGER, M 1995: Transcultural Nursing, Concepts, Theories, Research & Practices. 2nd Edition. USA: Book-mart press.

LONGMAN DICTIONARY OF CONTEMPORARY ENGLISH 1995: Great Britain: Clays Limited.

LUNA, L 1989: Transcultural nursing care of Arab Muslims. Journal of Transcultural Nursing, 1(1), Summer 1989: 22-23.

LUNA, L 1998: Culturally competent Health Care: A challenge for nurses in Saudi Arabia. Journal of Transcultural Nursing, 9(2) Jan to June: 8-14.

MAFALO, E 2003: Shortage of nurses in SA: An Impact to the Health Service and Nursing Profession. Nursing Update, Dec/Jan, 26(5): 38-41.

MELOY, JM 1994: Writing the Qualitative Dissertation. New Jersey: Lawrence Erlbaum Associates Publishers.

METZ, H C 1993: Saudi Arabia-Religion Tenets of Sunni Islam. August 23.

MC ROBERTS, JM; SATO, A & SOUTHWICK, WE (year unknown): Spiritual Care: A Study on the views and practices of Psychiatric Nurses. Graduate Research On-line Journals- Research for Nursing Practice. Retrieved from Google 30 October 2005. <http://www.graduateresearch.com/mcroberts.htm>

MONTGOMMERY, M (year unknown): Multicultural Awareness: Developing Cultural understanding in the Juvenile Justice System. <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>

NAIDOO, N 2000: SA losing hundreds of nurses each year. Natal Witness, 24 May: 24.

OKUN, BK 1992: Effective Helping: Interviewing and Counseling Techniques. 4th Edition. New York: Appleton and Longa.

PARAHOO, K 1997: Nursing Research: Principles, Processes and Issues. Great Britain: Palgrave Mac Millian.

PEER, N 2002; Improve conditions to keep medical skills here, government told. Cape Times, 30 Aug: 1.

POLIT, DF & HUNGLER, BP 1997: Essentials of Nursing Research: Methods, Appraisal and Utilization. 4th Edition. Philadelphia: Lippincott Company.

PRIESTLY, L 2000: Nursing in a Foreign Country. Australian Nursing Journal, North Fitzroy, June 2000, 7(11): 18-19.

PASCOE, R 2005: Support proves a lifeline in Shanghai. 3 May 2005. <http://telegraph.co.uk/global/main.jhtml>

RABAT, MV 2005: Migration and Religion in a Globalized World. December 5-6. <http://www.iom.int> ; www.marocainsdumonde.gov.ma

RITCHIE, JE 1999: Using Qualitative Research to Enhance the Evidence Based Practice of Health Care Providers. Australian Journal of Physiotherapy, 45: 251-256.

ROSSER-MILLER, K 2005: The Evolution of Nursing in Saudi Arabia: A Historiography. Unpublished PhD Thesis. Monash University, Melbourne, Australia.

SACHEDINA, A (year unknown): Woman Half-the-Man? Crisis of Male Epistemology in Islamic Jurisprudence.
<http://www.people.virginia.edu/aas/article/article1.htm>

SHEVEL, A 2003: Hospitals offer incentives in bid to keep their staff. Business Times, 2 Feb: 3.

SMETHERHAM, J & LAURENCE, J 2003: UK poaching of South African nurses carries on despite ban. The Cape Times, 13 May: 2.

SOUTH AFRICA (REPUBLIC) 1978: The Nursing Act (Act 50 of 1978 as amended). Pretoria: Government Printer.

SOUTH AFRICA (REPUBLIC) 2005: Provincial Government, Western Cape, RSA. Department of Health. Annexure E to DPSA Circular 3 of 2005.

STUART, GW & SUNDEEN, SJ 1991: Principles and Practices of Psychiatric Nursing. 4th Edition. New York: Mosby.

SULLIVAN, SN 1993: The Patient Behind The Veil: Medical Culture Shock in Saudi Arabia. Canadian Medical Association Journal, February 1993, 148(3): 444.

STAHL, L 2003: Nursing shortage in critical stage. 60minutes. CBS news.com Retrieved Google, 8th April 2003.
www.cbsnews.com/stories/2003/01/17/60minutes/main536999.shtml.

TABER'S CYCLOPEDIA MEDICAL DICTIONARY 1993: 17th Edition. Philadelphia: F A Davis Company.

THE CONCISE OXFORD DICTIONARY 1990: 8th Edition. Oxford: Oxford University Press.

THE COUNCIL FOR INTERNATIONAL EDUCATION (UKOSA) 2003: International students and culture shock (form 810-16:1-4). London.

THERON, R 2003: Adapting to a new culture-When you find yourself in Rome. September 2003.

<http://www.newscomersnetwork.com/mel/yoursay/yourstories/viewstories/ray03.php>

THOMPSON, A 2003: Where have all the nurses gone. Saturday Star, 22 Feb:1.

TUMULTY, G 2001: Professional Development of Nursing in Saudi Arabia. Journal of Nursing Scholarship, 33(3) Third quarter: 285-290.

UYS, HHM & BASSON, AA 1996: Research Methodology in Nursing. Pretoria: Kagiso.

UNITED STATES DEPARTMENT OF STATE BUREAU OF CONSULAR AFFAIRS, WASHINGTON DC 20520 May 17, 2005: Travel warning Saudi Arabia. http://travel.state.gov/cis_pa_tw/tw/tw_932.html

UNITED STATES DEPARTMENT OF STATE BUREAU OF CONSULAR AFFAIRS, WASHINGTON DC 20520 August 10, 2005: Consular Information Sheet. Saudi Arabia. http://travel.state.gov/cis_pa_tw/cis/cis_1012.html

VAN DER MERWE, TD 2003: Nursing Saudisation Professional Development. Working document 2003. Riyadh: King Faisal Specialist Hospital & Research Centre.

VAN DER MERWE, TD 2003: The practice environment as an indicator of quality. Paper presented at an International Symposium: March 2003, Riyadh: Saudi German Hospital.

VAN LEUVEN, K 2000: Clinical Companion: Fundamentals of Nursing: Concepts, Process, and Practice. 6th Edition. New Jersey: Prentice-Hall, Inc.

VAN MANNEN, M 1990: Researching Lived Experience: Human Science for an action sensitive pedagogy. New York: State University of New York Press.

WILSON, HS 1989: Research in Nursing. 2nd Edition. Redwood City: Addison-Wesley.

WINKELMAN, M 2002: Culture Shock and Adaptation. Arizona State University. Retrieved from Google 12 December 2005.

<http://www.asu.edu/clas/anthropology/bajaethnography/shock.htm>

WORLD BOOK MILLENNIUM: VOLUME A-K 2000: Chicago: World Book Incorporated.

YIN, RK 1994: Case study research methods. Applied social research method series. 2nd Edition. Volume 5. Thousand Oaks: Sage.

YOUNGE, D; MOREAU, P; EZZAT, A & GRAY, A 1997: Communicating with cancer patients in Saudi Arabia. Academic Science, 20(809) Feb1997: 309-310.

ZAHARNA, RS 1995: Bridging Cultural Differences: American Public Relations Practices & Arabic Communication Patterns. Public Relations Review, 21(155-241).

4x4 reports .2002. (BBC1) 9 December: 16h48.

Annexure A



Telephone:
23070

NURSING AFFAIRS
Nursing Education & Research - MBC 63
Memorandum

Fax: 23075

TO: *Mohamed M. Al-Turki, CCRP*
Co-Director
Office of Research Affairs

DATE 06 RAM 1425
(19 December, 2005)

THRU: **Heather Byrne**
Head of Service
Nursing Education & Research

FROM: *Colette Telford Smith*

NSE&R-

Clinical Instructor
Nursing Education & Research

SUBJECT: *Request for review of Research Project*

Please find attached a research proposal for my Masters Degree (MCUR)
The project is a study of The Reflections of South African Nurses living and working in the Kingdom of Saudi Arabia.

As there is no experimentation or intervention in any form, I have included a request to modify the consent form. The modified form is attached to the proposal.

There will be no costs in conducting this project.

I would like to seek your support in an expedited review for this project.

Thank you for your help in this matter.

Telephone:
23070

NURSING AFFAIRS

Nursing Education & Research - MBC 63
Memorandum

Fax: 23075

TO: *Abdullah Al Dalaan*
Executive Director
Academic & Training Affairs

DATE 06 RAM 1425
(19 December, 2005)

THRU: *Heather Byrne*
Head of Service
Nursing Education & Research

REF: NSE&R-354-1425

FROM: **Colette Telford-Smith**
Clinical Instructor
Nursing Education & Research

SUBJECT: *Research Proposal Clearance*

Please find attached a proposal for a research project that represents a small segment of my Masters degree. This research Masters is through the University of Port Elizabeth, South Africa

Briefly, the aspect of the project for which I am requesting clearance is a study of the 'Reflections of South African Registered Nurses living and working in the Kingdom of Saudi Arabia'. As can be seen from the proposal, it is a qualitative study with data collected from participants. As such, it does not require bio-statistical, epidemiological or computing assistance.

There will be no costs in conducting this project, as it is self funded, and will be conducted out of work hours.

I would like to seek your support in clearance for this proposal as it has 'academic application'.

Thank you for your help in this matter.

c.c. NE&R Chrono file
Employee file
NE&R Chrono file

KINGDOM OF SAUDI ARABIA

KING FAISAL SPECIALIST HOSPITAL
AND RESEARCH CENTRE

(General Organization)



المملكة العربية السعودية
مستشفى الملك فيصل التخصصي
ومركز الأبحاث
(مؤسسة عامة)

Telephone: 23070

NURSING AFFAIRS
Nursing Education & Research - MBC 63
Memorandum

Fax: 23075

TO: Colette Telford-Smith
Clinical Instructor
Nursing Education & Research

DATE: 19 DAH 1425
(30 January 2005)

FROM: Heather Byrne
Chairperson
Nursing Education & Research Committee

REF: NSE&R-262-1426

SUBJECT: RESEARCH APPROVAL NERC #001

Please be advised that as stated in your letter from ORA your research does not require ORA approval however, it does require tracking within Nursing Affairs.

Therefore, I am pleased to inform you that the Nursing Affairs Nursing Education & Research Committee reviewed your research and approved it for twelve (12) months. Please submit a brief final report within one (1) month of completion of project or within twelve (12) months of the date of this letter.

It is noted that you have received ethics clearance from the Nelson Mandela Metropolitan University – South Africa and it is a requirement that you comply with all aspects of that approval.

Please supply the NE&RC with the copy of that ethics approval document.

Thank you.

Annexure B



Ms C Telford-Smith
PO Box 59
Ridge Terrace
PORT ELIZABETH
2168

19 November 2004

Enquiries: Mrs G Ehbel

Telephone: 041 5042121

Our ref: 203060911

Dear Ms Telford-Smith

FINAL RESEARCH PROPOSAL: 2004

Please be advised that your final research proposal has been approved by Faculty Management subject to the following amendments/suggestions/recommendations being made to the satisfaction of your Supervisor/Promoter.

- (i) That it was suggested that the title be amended as follows:
SOUTH AFRICAN NURSES' EXPERIENCES WORKING IN THE KINGDOM OF SAUDI ARABIA: A FRAMEWORK FOR SUPPORT;
- (ii) that the title page be amended and in accordance with the detail as indicated in the 2004 University calendar, page 94;
- (iii) that language editing be done throughout the study;
- (iv) that concerns were raised about the amount of personal experience mentioned in the Problem Statement;
- (v) that the Linguist Fee and Independent Coding budget seemed unrealistically low;
- (vi) that the conclusion section be removed.

Yours sincerely

**OFFICE OF THE DEAN
FACULTY OF HEALTH SCIENCES**

GE/rj/C:\mydocumetns\rachael\letters\finalresearch\nov

Copies to: Prof RM van Rooyen
Prof J Strümpher
Mrs G Ehbel



DEPARTMENT OF PSYCHOLOGY
DEPARTEMENT PSIGOLOGIE
ISEBE LASAYIKHOLOJI

HUMAN ETHICS COMMITTEE

Dr R M van Rooyen
Dept of Nursing Science
MB 9th Floor
UPE

Dear Dr Van Rooyen

RESEARCH PROPOSAL FOR ETHICS APPROVAL : C. TELFORD-SMITH

The proposal entitled *Reflections of South African nurses migrating to the Kingdom of Saudi Arabia. A framework for support* was submitted for approval in October 2004.

The Committee accepted the proposal.

Please inform the candidate of the outcome and we wish you well with the project.

Sincerely

PROF B POTGIETER
ACTING CHAIRPERSON

Cc: Members of the Human Ethics Committee
Research Administration Office, UPE
Faculty Officer, Faculty of Health Sciences, UPE



Annexure C



Example of:

INFORMATION AND INFORMED CONSENT FORM

TITLE OF THE RESEARCH PROJECT:.....

.....

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR:

ADDRESS:

CONTACT TELEPHONE NO.:

<p>DECLARATION BY OR ON BEHALF OF PATIENT / PARTICIPANT:</p> <p>I, THE UNDERSIGNED,.....(name)</p> <p>[I.D. No:.....] the patient/participant in my capacity asof the patient/participant [I.D.....] of</p> <p>.....(address).</p> <p>A. HEREBY CONFIRM AS FOLLOWS:</p> <p>1. I/The patient/participant was invited to participate in the abovementioned research project which is being undertaken by (name)..... of the Department of in the Faculty of University of Port Elizabeth.</p>	Initial
<p>2. The following aspects have been explained to me/ the patient/ participant:</p> <p>2.1 Aim: The investigators are studying:.....</p> <p>The information will be used to/for</p>	Initial
<p>2.2 Procedures: I understand that</p> <p>.....</p>	Initial

2.3 Risks:	Initial
Possible benefits: As a result of my participation in this study	<u>Initial</u>
Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.	<u>Initial</u>
Access to findings: Any new information / or benefit that develop during the course of the study will be shared with me.	<u>Initial</u>
Voluntary participation / refusal / discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect my present or future medical care/ employment / lifestyle.	<u>Initial</u>
3. The information above was explained to me / the participant by (name of relevant person) In Afrikaans / English / Xhosa / Other And I am in command of this language / it was satisfactorily translated to me by(name of translator) I was given the opportunity to ask questions and all these questions were answered satisfactorily.	<u>Initial</u>
4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization.	<u>Initial</u>
5. Participation in this study will not result in any additional cost to myself.	<u>Initial</u>
<p style="text-align: center;">B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVEMENTIONED PROJECT.</p> <p>Signed / confirmed at on 20...</p> <p style="text-align: center;">(place) (date)</p> <p>.....</p> <p>Signature or right thumb print of participant Signature of witness</p>	

**IMPORTANT MESSAGE TO PATIENT / REPRESENTATIVE
OF PATIENT / PARTICIPANT:**

Dear patient/representative of the patient/participant,

Thank you for your/the patient's participation in this study. Should, at any time during the study,

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

.....

..... (indicate any circumstances which should be reported to the investigator) kindly contact (name) at telephone number

(it must be a number where help will be available on a 24 hour basis).

Annexure D



C.TELFORD-SMITH

INTERVIEW 6
DURATION: 60 MINUTES

TRANSCRIPT

R= RESEARCHER

I= INTERVIEWEE

SPEAKER	DIALOGUE	NONVERBAL
R	Interview number 6 for my Masters degree - Reflections of the South African nurses living and working in Saudi Arabia. J I thank you for coming...I really appreciate it...especially at this hour of night. And again I promise your anonymity and confidentiality will be maintained at all times. So you can quite happily be very open and frank in what you have to say. Now you have been here for just over 3 months. What I am going to do is ask you two main questions and I should imagine the interview should probably take about forty-five to sixty minutes. The first question I would like to ask you is as follows "What have your experiences been since coming to Saudi Arabia as far as living and working in Saudi Arabia?"	Both laugh
I	Ok...ummm...let me start with the living. To me the living with the Muslim culture is fine because I come from Cape Town and was brought up in a small Muslim environment...ummm... but here it was like a shock...	emphasises
R	Why?	
I	Aah... an example is...you feel like dressing up...you feel like really looking smart and then it hits you and you think, "oh my goodness now I have to wear a black 'frock' over my smart clothes...but ok, ok I still 'try' to feel good..."	
R	So that has been a hindrance to you?	
I	Yes, yes...and the other day we wanted to go somewhere and my flatmate said to me "it doesn't matter what you wear under that abaya...you can wear your pyjamas...nobody would know...nobody will care"...	
R	Ya...	
I	So I think that played a major role because I for example was not sure what to wear or even how to wear it...because I was stopped after a month and the girl said to me "you are new here"...and I and "does it show"...and she said "I can see exactly by the you are dressed"...	laughs
R	Mmm...	

SPEAKER	DIALOGUE	NONVERBAL
I	So that I found a hindrance and also a typical example is ummm...not that I really mind, but there is no sort of personal contact with people ... because people are all covered...ummm...you look at the person and the person looks at you in acknowledgement and you can see the eyes are smiling but you don't know who the heck it is...	emphasises
R	Who it is...sure...	
I	And now you are uncertain and sort of smile and nod but there the person goes... ummm... but it could be a person who I have spoken to often before but I don't know that...	
R	Ya...	
I	And also what I find a hindrance ...the good Lord must forgive me , but... its not the prayer times as such but it is the shopping ...and then suddenly you find yourself...voop...the shops are closed and you find yourself waiting outside or inside for one and a half hours...and I find that a major waste of time ...	emphasises
R	Sure...	pause
I	You know I respect peoples religion or prayers or whatever but just its...ummm... you either have to shop very, very quickly or you just have to be prepared to wait ... and I think because of that what I have personally experienced was just to be patient ...	emphasises
R	Ok...	
I	This afternoon I went to the shop and I asked one of the shop keepers "when is prayer time and how long will it be?" and he said 10 minutes so I thought ok ill wait but then an hour later there was another prayer time and the shop closed again...	
R	Whew...	
I	So you just ...I think because of that I developed patience...	
R	Ok...	
I	And also what I found about Saudi itself... that helped me...that made the difference between well...the western world and Saudi...is that I have lots of time to myself...you know previously back home I would rush around like crazy going from shop to shop... it was just one big rush ...	emphasises
R	Ya...	
I	And here I find that I am more in touch with myself...more in touch with my feelings...ummm...there is no need to rush for anything...	
R	And what have your feelings been since you got here...what emotions have you experienced?	
I	I've gone through a lot of emotions...a lot of emotions... I've gone through ummm... total panic...total panic	emphasises

SPEAKER	DIALOGUE	NONVERBAL
	ummm..."what am I doing here...what did I get involved in?"...sort of questioning "why did I eventually come?"...you know it was total panic and then extreme anxiety ...I had so much anxiety and emotional exhaustion to the point that...I had lots of physical complaints because of that ...you know... lots of headaches, I had a stiff neck, lower back pain...knees ached...you name it...and even one girl said "you know to be physically tired is fine but to be emotionally tired is bad and you look terrible "...so I think the emotional tiredness ummm...was painful ...	Holds face in her hands Wipes forehead
R	What was the cause of your emotional tiredness?	
I	The emotional tiredness was work related and also a feeling of being terribly isolated ...	emphasises
R	Mmm...ok...	pause
I	Ok let me go back to work...with the work it would be the expectations that...most times I felt like a total idiot ...you know like the doctor would say to remove sutures...and I would think... "ya, I can remove sutures"...and I would ask where the stitch cutters were...and they would look at me and ask "what are stitch cutters...what you want them for?" and I say " I want to remove sutures"...and they say "no we use scissors here"...and I think, "oh my gosh I haven't removed sutures with scissors in my life before..."	emphasises Hangs head
R	Shame...	
I	And you know its simple procedures that I did at home that I find I cannot do here... and its things that they would use different words...different terminology for...	
R	Mmm...	
I	And the accents ... the biggest problem ...answering the phone... I hated to answer the phone ...I actually ran away when the phone rang...went around the corner...because I couldn't understand what the person was saying...even the doctors ...I would look at the doctor and think..."what the heck is he saying now?"...and he would look at me and I could see that he was thinking that I was a total idiot...and it would be a simple command or order and I just couldn't understand what he was saying ... and I would run out and call an Arabic speaking nurse to come and see what he was saying...and then I would feel so stupid ...and that was an extremely painful process ...	emphasises Wipes forehead
R	Sure...	pause
I	And also the difference between myself and the nurses working in the clinic...it is easier for an Arabic speaking nurse to work there because when the doctor speaks Arabic to the patient the doctor doesn't really still have to give orders to the nurse because she hears and	

SPEAKER	DIALOGUE	NONVERBAL
	understands what he is saying...whereas when I am there I have to ask...or sometimes the doctor just walks out and I have to ask the patient...you know... ummm..."what did doctor actually tell you?"...	
R	Ya...	
I	And one instance the doctor told me I did the wrong thing...he said "didn't someone orientate you...who was you preceptor?"... you know it was along story and the doctor didn't tell me what he had said...and eventually when I questioned the patient they said the doctor said that ...and I said "yes that is what I understood"... and when he came to do the round he gave different story...you know and I think those things are very upsetting...	emphasises upset
R	mmm...	pause
I	The other issue is the computer...I have found that aah...because we are not used to working or placing orders in the computer...normally what we do is manuscripts and letters and things like that... here everything is computerized...	emphasises
R	So is that a strain on you?	
I	Ummm...I find it is, hey...ok now the doctor refers the patient to a different departmentsay gynae and he doesn't write the other doctor's name...ummm..."what do I do now?"...I'm always asking someone or going to the appointment clerks...those guys are exceptionally helpful...	
R	Have you generally found that people are helpful?	
I	Most people are helpful...I can see some are irritated by me asking and not knowing...ummm...and that was also painful...because I mean I am a registered nurse I am supposed to know what I am doing...but I found that the people who really make me feel at home is the appointment clerks...	
R	The Arabic appointment clerks?	
I	Yes yes...they were great.	
R	Good...good... You are working in the surgical clinic?	
I	ENT clinic...and you find that people like the audiologists walk by day after day and never greet you...you know...not acknowledging you at all...I think that that is also very painful situation...and I'm working with them all day and now I am not sure if I must greet them or leave them or...	
R	Mmm... and the staff in the clinic...how have they responded towards you?	
I	Ummm...the staff...most of the staff are fine ...it is just that we were very short staffed at the time that I started...so almost everyday we had a new relief staff	

SPEAKER	DIALOGUE	NONVERBAL
	member...so it was teaching that staff member as well as me... but from mid October is the first time we have had our full staff.	
R	Ok...so you came at a bad time...	
I	Yes...and there was one time ... I am not a person to cry...I am not a tearful person but I am telling you here...I cried ...one day I got to the unit and I started on the phone and somebody just said something and I just burst out crying ...I thought "oh my goodness, what is happening to me?"... And they wanted to send me to my room and I said no...but when I got back home eventually... I just cried and cried ...	emphasises shakes head and looks away
R	Shame...who is your flatmate?	
I	I'm sharing with a fellow South African...she is a x-ray technician and we try and share experiences but it is sort of difficult to share... a nurse will probably be easier... as she doesn't really understand what I am trying to tell her what is happening in the unit...ummm...any other nurse will understand...ummm...but the two of us get on fantastically well.	
R	So your home situation is fine...no problems?	
I	No it is fine, fine...we spent the whole afternoon shopping together...	
R	You arrived together didn't you?	
I	Yes cause when you fetched us... you still told us that we were staying together...no... we had to get used to each other but no problems...none whatsoever...	
R	Ya...good...	
I	Ummm... and also you sort of want something familiar...and there is NOTHING familiar around you ...especially when the loneliness sets in ...and ,and there is lots of times I used to withdraw completely...not even speak to my flatmate...just withdraw and sleep and get up the next morning and so on...	emphasises
R	Mmm...	
I	And I think then one day Ann got hold of me...Ann is now our new head nurse, she is a South African...and she said "don't destroy yourself ...it is not worth it"... and I thought "what is she talking about?" and then she said "pull yourself together"...ummm... and I thought about it for a very, very long time...a good few days...and I said "ok...its not working so I must change my attitude...go to work and think positively "... and that is what I did one morning... when I got to work...I told myself "today will be a good day...I will enjoy the day and nothing wrong is going to happen"...and the day was actually better... because every morning was a burden going to work...it was a burden getting out of bed ...and it lasted for many weeks..."must I really go to that place?"	emphasises

SPEAKER	DIALOGUE	NONVERBAL
	I would say... ...and then people could sense at home also by the way I wrote emails...and yet I tried not to write negative words... ummm "I am getting the impression that you are sad"...they would write... and I thought no, no now this must stop...	
R	Ok so lets just talk about that... it sounds like you had an attitude change... are you saying that attitude is a very important thing?	
I	Yes, yes...once I tried... tried to be positive ...I really tried... it does help but it is not easy...especially when the doctors throw instruments and shout..."why isn't this working"...how the heck must I know why a thing isn't working...I mean I just got there... or I must push this heavy machine...and I think ok...just keep cool and don't even bother to back chat... because I was warned ...certain doctors...don't even try ...because the doctor will get you sent home...so now I just call the team leader to sort it out ...so I would try to psych myself up and say "just think positively...just ignore what he is saying...call the team leader...she can sort out the problem"...	emphasises
R	So are you still in that frame of mind?	
I	Well there are a few dips but it is not as bad...not as bad as it was before...	
R	Ok ... now you spoke about your people back home...lets just zoom in on that a bit...who have you left back home?	
I	I have left an ex husband who is looking after my house...we get on very, very well...initially he didn't respond to my emails but after a month he started writing and has phoned once on my birthday...	
R	Do you have parents?	
I	No both parents are deceased but I have a niece and nephew who I am very close to and I am very, very close to my sister in law... and ummm...then a sort of a boyfriend I would say...	
R	So how has it been leaving them behind?	
I	The impression they have is ...wow J is in Saudi and she is having a ball of a time...and she is going places and it is great and she is having fun...they think it is 5 star and its close to heaven...	
R	So they seem to be ok with you leaving... how do you feel?	
I	You know Colette it happened so fast...my leaving really happened very quickly...the day that I received the phone call was the 1 st of June and the agency told me to resign on the 2nd June...to hand in my resignation the very next day...I had to tell the staff and then I had to	

SPEAKER	DIALOGUE	NONVERBAL
	leave work the end of June and leave mid July...and then this contract came through...the other contract was for Tabuk. So it was all a rush...I didn't have time to think...you know...I just had time to get myself organised ...to get things running smooth...to get my house sorted...and just to go about telling family and friends that I was leaving...ummm...I think initially for me I was extremely anxious...even at the airport...I thought "what is wrong with you?"...I was just feeling so anxious...I had no tears but they were crying at the airport...my friends ,my niece, sister in law was crying and the ex husband cried at home...but I was just very anxious...	
R	Are you an anxious sort of person?	
I	Ummm...not normally...ummm...	pause
R	So that anxiety you have experienced here, because you mentioned you were very anxious, is it abnormal for you?	
I	It is abnormal for me ... absolutely abnormal ... as I said I am not a person to cry...but here my emotions are abnormal for me...	emphasises wipes head
R	Ok...	
I	And one day my friend phoned and just cried and said "I am not good for you...I didn't want you to leave"...	
R	Ya...so it is not easy, is it?	
I	No its not...I think it is getting easier...	
R	Mmm...	
I	You know what got me the first day I was here...was the hours... I am not used to working such long hours ...I mean from 8 to 6...no tea break in the morning...no afternoon tea break... the first few days was basically lunch on the run...it was "oh take lunch quickly the next session is starting at 1.30..." and you sort of leave just before one...and I thought back home ...where is my union...where is the labour law...you know 5 hours without a decent break... it is not on ...	gestures with her hands emphasises
R	So you miss that...	
I	Yes... I thought "but this is unfair...no person can work from 8 o'clock right through to 1 " and don't even get a decent lunch...my colleague and I were new... our feet were aching...we were exhausted...we were really exhausted ...	emphasises
R	So you had the physical and the emotional all in one...	
I	Ya, ya ...so when the new head nurse came on the 1 st November I said no...look lunch times must definitely be ...I said "anywhere tea time is a privilege"...even back home I realise that tea time... so when I get a cup of tea I know it is a privilege...but I mean lunch time...really...I deserve my lunch...ummm...	
R	What other experiences have you had as far as the culture goes?	

SPEAKER	DIALOGUE	NONVERBAL
I	<p>Well the patients themselves I my department are very friendly...the hindrance I find for me...the major barrier is the language...because 95% of them speak Arabic...ummm...while I'm learning Arabic as fast as I can...I promised myself 2 to 3 new words every day...I'm getting there...</p> <p>What I also find strange is that ...you know...a husband and wife in the same room...the husband does all the talking ...the husband does all the talking for the wife...or ...the doctor will look at the male partner and talk to the male partner about the woman and ignores the woman...and then only afterwards if there is a direct examination he will then address the female patient. The husband also gives consent... not the woman...so even if she doesn't want a procedure... if the male consents it gets done.</p> <p>Also what I didn't know that if a male doctor examines a female patient ...I am not allowed to leave the room...</p>	emphasises
R	So in your clinic they are allowed to examine a female patient unless you are present?	
I	If the male is present I don't have to be there but it is only a male doctor alone with the female patient then I have to be there...	
R	And that is any part of their body that they can examine?	
I	Well we just do ENT...so even if she just shows her ear ...I have to be there...	
R	Ok...	pause
I	<p>Ummm... what I find here too...the male plays 'the' major role... because females can't drive for instance...so that means that any man has to take a woman wherever she wants to go...I was also looking at a female colleague of mine who's child fell ill and she had to phone the husband to go to school and fetch and go to the doctor and so on...</p>	
R	And how do you feel about not being able to drive?	
I	<p>Ummm... not being able to drive I find sort of ok cause I find driving tedious...but...it also takes away my independence and that is what I don't want to lose...you know being dependant on limo's...and the drivers here are lousy in any case...wow...they are terrible drivers...no road sense...and then you get 12year olds driving too...</p> <p>And even the female Saudis...one or two have said to me..."You know I would really love to drive"</p>	emphasises
R	So they actually verbalised it?	
I	Aah ...because this one girl explicitly said..."you know I am not independent here...but this is my country and there is nothing I can do about it"...she has been abroad so she knows the other side...	

SPEAKER	DIALOGUE	NONVERBAL
R	What other things have you experienced regarding the disparity between male and female?	
I	Well there are two major things for me...the one is the intermarriages and the other one is the lack of closeness, tactile contact and affection between male and female...in the park it is strange to see a couple holding hands...but the other strange thing is that men are affectionate to one another...they kiss and hold hands and no one blinks or gives it a second thought...but if it happens in my country ...you know..."wow what is happening here?" But the heterosexual couples don't show affection...so that I find a major difference...	
R	Have you experienced any restrictions as far as interacting with men?	
I	I am too scared to interact ...I am not sure what I must and mustn't do... I'm not sure if I can shake their hand or what...because I went on a trip about a month ago and two guys wanted to swap photos... so I arranged to meet them in an area where we can talk to males... and when they came I wasn't sure what to do ...I wasn't sure whether I should greet them by hand or do what...so I just stood and said "hello how are you" and I felt like an idiot ...because normally I would hug a person...just a friendly hug and that is nothing to me ...but here I am even to scared to stand too close to a guy...ummm so that I find a bit strange ...and sometimes I really feel 'naked' ...I feel as if I'm...it doesn't matter what I am wearing...if a member of the opposite sex looks at me for too long I feel naked...	emphasises laughs
R	And do you find that this happens quite often?	
I	Yes...and back home they don't even look at you but the Saudi men here...stare...	gestures with hands
R	Ya...	pause
I	And what is also strange here is that in the shops all the assistants are males...all males...so when you fit on things you feel awkward doing it over your abaya... and like I said I haven't even bought myself anything decent...you cant try on the size ...especially pants...	
R	Cause you are not allowed to fit on in the shops?	
I	Yes I attempted that and they shouted stop, stop, stop... I don't know why they don't employ females in female stores that... you know...so that you can feel ok...	laughs
R	So that and has made you feel uncomfortable...is that what you are saying?	
I	Terribly uncomfortable... And I also feel it is a very unfair...there is not a balance...	
R	Between male and female?	
I	Between male and female...especially as far as	

SPEAKER	DIALOGUE	NONVERBAL
	employment is concerned...ummm...the men run the show...	
R	You mentioned that your family are under the impression that you are going out and having a good time...what has your social life been like?	
I	Well I've tried to go out...I went on a trip for a weekend...	
R	With the social club?	
I	Not with this social club because they are always cancelling...I went with another hospitals social club... And lots of people have said please don't sit in your room...get out...so I have tried...but that is the only place I have been to.	
R	What else have you been doing?	
I	I go out for walks in the desert on the weekend with the HASH...I must still get the Friday HASH's number from you...I have also gone to the opera society on a Sunday ...	
R	Is there a lot to do out there?	
I	Ag it's not too bad...you can actually meet people...ummm...I think most of the time people go shopping and dining...	
R	How do you feel going out...do you go out on your own?	
I	I can't wait on anybody...so I go shopping by myself ...I get into a limo and I do my thing...initially I was a bit nervous about it because not knowing the area and the streets...I also heard rumours that ..."be careful and don't go out by yourself"...that the limo drivers can drive you into the desert... but I thought "oh my gosh if I am going to wait I'm not going to get anywhere"...and now I just go...I don't wait for anybody...	
R	Ok... and as far as the political situation...how do you feel about that?	
I	Ummm...people at home this passed week have been asking me and telling me "please look after yourself...please take care I hear there is bombings going on...there is this going on..." ummm... we are relatively unaffected...ummm... for me the political situation is ok because I have been through a lot worse at home...and that is what I tell them...it is fine for now... Ummm...the sporadic shootings doesn't make me that nervous...it is just the fact that I ...my roommate wore a bandanna and I said "oh yes I also have one"...and I took it out and she looked at it and shook her head and said..."not a good idea...stars and stripes" and ...	
R	The American flag on your head...	Laughs heartily
I	And I said with my dread locks...not good...not good...	Laughs Pulls her hair
R	Definitely not...	Mumbles

SPEAKER	DIALOGUE	NONVERBAL
		under her breathe
I	But with the political situation I am not fearful...if things really get bad I will reassess the situation and see how it goes...and then decide what to do then... I mean back home there was a lot of violence...	
R	Now what has your reason been for coming?	
I	Twofold... I was 'gatvol' of my job ...there is no other word to describe it...and there was no way out...	emphasises
R	Where were you working?	
I	I was working in community clinics...and it doesn't matter which district I went to, it would all just be the same mess... there were a lot of changes but even with all the changes I started to stagnate...ummm...and I told myself..."just get out"...and my managers knew that I tried for a long time for better positions but nothing happened...ummm I was just tired and I didn't know what else to do then... ...and ...secondly ...the money that I earned wasn't enough to travel...and I would really love to travel...and I was telling my friends...one months salary here will take me to wherever I want to be...for example I went to Kilimanjaro last year...it took me two years to save to get all my gear and to save for the air fare... I mean two years ...	emphasises
R	Ya...	
I	And in February inshallah...I will be going to Hawaii and the USA... and I just started in August ...	emphasises
R	So the financial aspect has lived up to your expectations, has it?	
I	Ummm...yes and no...with the past 'Bush election' the rand is not doing so well...no, no... the rand is doing too well, too well ...	emphasises
R	Absolutely...	smiles
I	Or rather that the dollar is doing badly...rather look at it that way...ummm...that when you send money home...you say "oh well it is not even worth sending money home"...but what I get out is still a lot more...still a lot more ...	smiles emphasises
R	So do you think you are going to achieve your objectives?	
I	Yes...definitely...it is still a lot more...I don't have major commitments back home...just the bond ...and that I am going to pay off very quickly...and other than that it is just to travel...	
R	All right...is there anything else you would like to share before I go on to my next question?	laughs
I	There was something but it has slipped my mind...	
R	Its ok it will come back to you I'm sure...	

SPEAKER	DIALOGUE	NONVERBAL
I	Ok go on...	
R	Ummm...my next question is this "How do you think we can assist future South African nurses coming to Saudi Arabia?"	
I	I think that is not an easy question...the first was easier...	laughs
R	Easier ...Yes...but do you have any suggestions?	laughs
I	Ummm...I think computer literacy...you have to be computer literate ... ummm... I am reasonably computer literate...you know punching in ,working with the mouse was fine...but I find...back home...ummm...back home I was a head nurse ...I had to work with the computer but for example the person who was next in charge couldn't work the computer at all...and I really felt sorry for her...	emphasises
R	How does it feel to be an SN1 and not a head nurse now?	
I	Wonderful...it is nice to be a 'follower' for a change...	
R	Ok so that is computer literacy...it would be a big pro for them to come equipped with...	
I	Also what I find is...it is very difficult to prepare someone for a country like Saudi Arabia...unless the person... ..doesn't matter what I tell the person really...	Pause thinking
R	Mmhmmm	
I	Ummm...a South African will have to experience this country for themselves...so if I say look you won't be able to drive...or ummm...if you talk about the pluses for example...the money is good...ummm...sort of warning them of being careful of what they buy...don't over spend...don't go crazy...cause I mean there are lots of beautiful shops...be goal orientated and remember why you came here or what you came for...ummm...	
R	Those are good points...	
I	Ummm...have a positive attitude ummm...learn Arabic as fast as you can...ummm...the other thing is with the agency...they must be totally honest...I don't think they are honest enough...	
R	Just elaborate on that ...	
I	I mean about the leave...we were told we could get a hospital ticket home after 9 months but now I find out it is not true and now it is only after your first contract is signed...you know I was terribly upset and Ann my head nurse said not to let it upset me because there was nothing I could do...but ...I said the reason why I was upset is because they weren't honest about it...and this raises expectations and you plan your time ,you plan your leave and you plan your going away... So I think they must be very clear because in my contract it states 6 months...so whoever draws up the contract must change it or delete what is not applicable	

SPEAKER	DIALOGUE	NONVERBAL
	anymore...because it is a horrible feeling because everybody want to go home...ummm so another thing is that the nurses must know what is in the contract and not just sign...	
R	Is there anything else...?	
I	The package they gave us was ok... the pharmacology...was tricky...and that is another thing...tell them that they must really go over the pharmacology before they get here...then there won't have the panic...	
R	Why do you say it was tricky?	
I	Ummm... I asked one of the Australians...there is a continuous evaluation on pharmacology in their country...whereas with us there is not...once you have done your pharmacology that is it...	
R	Are you talking about your basic training?	
I	I'm talking about our basic training...once you have finished with it you have finished with it...	
R	And do you think your basic training was adequate?	
I	Not for pharmacology ...no...we learnt the side effects of this and that and nursing but not calculations...so it would be good to bring in calculations in our training and to make it a part of the in-service education in the hospitals...soo...ummm that it is why we find it tricky when we do it here...so they must practice before they come...	
R	Ok...	
I	And also they must be warned about all the procedures and competencies and education you have to do...ok...we know about the pharmacology before we come but we don't know about the BLS...I'm telling you everybody hates BLS...people really don't like it...ummm...then there are all the things you have to be checked off on your unit...ticked off for this and ticked off for that...	
R	How did that make you feel?	
I	The physical assessment was fine because that is my forte coming from community ...ummm ...others I had to recall from my student days but it was ok...it was probably just the BLS and the number of competencies we had to do...and the in-patient ward nurses have to do a lot more than we did...so I think I am fortunate working in clinics...	emphasises
R	Mmm...	
I	Then while we were on orientation with you...we used to say "Oh GNO is long...its long...we want to get to the unit"...but actually it was the best time because you get all your support...you get support from you the GNO coordinator... you get support from your buddies in your	

SPEAKER	DIALOGUE	NONVERBAL
	<p>group...ummm...your own little peer group...the class in general and you find that everyone is supportive and welcoming...</p> <p>Once you move out of GNO...you are left totally on your own...there is no support...I was very disappointed...and I think that for me wasn't good at all...I said to myself "if that was me I would never ever treat a brand new person coming into my department the way I was left"...or anybody else for that matter...because my buddy would phone and say "you know I'm left alone and I don't know what to do"... and whatever...and you feel totally isolated...you feel totally alone...and people responsible for the unit...the covering person at the time would come and say "oh how are you I suppose you are fine" and was gone...low and behold you are not fine...</p>	emphasises
R	What support did you get from your preceptor?	
I	The preceptor was too busy doing her own thing...too busy doing her work...too busy organising...and there was really no support...but I don't know if I should blame her for that or not...	
R	So you really struggled...	
I	There was just no support...and that is why for example X left who started with us...I mean one day she phoned and said "I have packed my bags since 4 o'clock this morning...I want to go"...and no matter what I said...she said "No, I am going home"...you know... so the support in the units are not enough...	
R	Mmm...	
I	<p>And another thing...I am fortunate I am in a unit where there are 6 of us and we are all different nationalities...it is only now that the head nurse who came is South African...but once you find that there are 2 or 3 of the same you find the 'clicking' ...</p> <p>and also the discrepancies of the salaries play a major role here at the hospital...it causes major dissatisfaction ummm...you are a different nationality...I'm a different nationality ...we are doing the same work...so because you earn more...I will work less...why should I work hard if I earn less...that is the attitude...</p>	
R	Have you found that in your unit?	
I	Fortunately in my unit we can talk about it..especially the one Saudi nurse...because especially where I came from I can sort of empathise and say that it is unfair and I do realise it is unfair...ummm...there is nothing I can do about it but...you go and talk...aah because that system I find terribly unfair...	
R	Ya sure...sure... All right lets get back then to your suggestions...you have said...computer literacy...learn	

SPEAKER	DIALOGUE	NONVERBAL
	Arabic as quickly as you can...	
I	...read the package and contract...do the pharmacology at home...	
R	Ya those are valid points...	
I	And then the agency to be honest...you know when I went for my orientation day...they painted a rosy picture...everything was good...I think there should be a balance...you know...nothing is good all the time...there should be a honest balance...I'm not saying they should point out all the negatives but just get a balance...and say "this is what life is in Saudi" because even the slides that we saw...they were all 'hunky dory'...but it is not like that all the time...	
R	Ok...and then the last thing you said is that they will be doing a lot of education and must be prepared...	
I	Education...yes...especially those on the wards...they mustn't think they are just going to walk in and just work... no way ...and we are not told that...	
R	Mmm...Is there anything else?	
I	No...I think that is all...	
R	It sounds like You have been through a lot of emotions and you have been through a tough time on the unit...so have you established a support system outside of work?	
I	Yes I am doing ok...I can phone people every now and again...fortunately I have a friend outside at another hospital so we always comparing and we are able to support each other...	
R	And how do we compare?	
I	They are far more relaxed and the one person said to me the last time I was there..." do you know that we look up to you at Faisal"...and ... ummm...my friend said..."Gee...you work so hard there...and here we are all laid back"...so laid back that she in fact was going to resign because she was bored...she is a head nurse there...	
R	Ok, so they are relaxed and not so pressurised...	
I	But our salary is higher...even the limo drivers know that the Faisal people get the bucks...	laughs
R	Well it sounds like we work for it....	laughs
I	Oh yes ...the other positive thing is about the South Africans here...you know for the first time when I look at people...I can see that everybody says "I am proudly South African"...not one will say a negative thing about South Africa... and it really gladdens my heart...because it is un like being at home where you have negativity towards the country as a whole...but I mean once they are here it is totally different and I find that the South Africans are so great...as soon as they hear your accent...like one heard me in the tearoom and said "Oh	I

SPEAKER	DIALOGUE	NONVERBAL
	welcome you from South Africa...welcome...and chatted away...	
R	Mmm...so there is a positive out there...	
I	Yes, yes and the other thing is the crime...I can walk around with my bag without looking over my shoulder...I mean that is a big plus...	
R	Ya sure...so even though you are restricted as a woman...you still have freedom within that...	
I	Ya it's a different type of freedom...it's a sense of being free whereby you don't need to look over your shoulder because the crime is so minimal ...	
R	Well thank you very much for your time, J...I appreciate your honesty and valuable comments...I am just sad that you have had such a tough time...be strong and be positive and if you ever need a shoulder...you know where to find me...	

Annexure E



**KING FAISAL SPECIALIST HOSPITAL
AND RESEARCH CENTRE**

INTERNAL POLICIES AND/OR PROCEDURE (IPP)

TITLE/DESCRIPTION: ORIENTATION OF NEW STAFF			INDEX NUMBER: MCO-NA-NAA-01-003
EFFECTIVE DATE: 26 July 2005 (20 Jumada Al Thani 1426)	REPLACES NUMBER: NSG-02-07-01 NSG-02-03-03 (MUH 1421/April 2000)	APPLIES TO: Nursing Affairs	APPROVED BY: <i>(signature on file)</i> Chief of Nursing Affairs

PURPOSE

To familiarize new employees with the work environment, job responsibilities, standards of care, hospital and Nursing Division policies and procedures, and competency requirements.

REFERENCES:

Joint Commission International Accreditation Standards, 2nd Edition (2002). Joint Commission on the Accreditation of Healthcare Organizations, International.

Nursing Affairs Paid Education Time Policy MCO-NA-NAA01-012

Management of Human Resources in Hospitals: Examples of Compliance (1997). Joint Commission on the Accreditation of Healthcare Organizations.

Preceptor Program MCO-NA-NAA01-013

COMMENTS:

1. Every employee will participate in an orientation program with content and duration determined by the needs of the Nursing Division, the Nursing Department, the specific unit, the job responsibilities, and the individual's knowledge and skill level.
2. Every employee will work with a designated unit preceptor to guide, mentor, and evaluate the new employee during the orientation period.
3. Rehires: General Nursing Orientation attendance and testing requirements for nurses returning within one-year of termination will be at the discretion of the Program Director / Head of Service / Head Nurse.
4. New nursing staff reporting for work at times which do not correspond to the time of the monthly orientation will be scheduled by their Head Nurse/Supervisor to attend the next scheduled Hospital and General Nursing Orientation.
5. **NE&R** will be responsible for administering written tests during GNO. NE&R will provide assistance to any orientee who, on the second attempt, fails to satisfactorily pass any written test (limited to 3 attempts). NE&R will forward a report including all test results to the orientee's Head Nurse/Supervisor immediately following the General Nursing Orientation.
6. **Orientee** will be responsible for re-scheduling tests within a time frame that is agreeable to the Head Nurse, the Clinical Instructor, and/or Life Support Training Center.

POLICY:

1. Hospital Orientation Program

- 1.1. All Nursing Division staff will attend the three-day KFSH & RC Hospital Orientation.
Exception: Rehires returning within one year of termination or locums.

2. General Nursing Orientation (GNO)

All New Nursing Department Staff will:

- 2.1 Attend the full Nursing Education and Research (NE&R) General Nursing Orientation (GNO) which shall be conducted monthly and will include the following:

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- GNO Program (approx. 8 days)
- GNO Clinical Lab. Incorporating core generic competencies (approx. 3-4 days)
- Approximately 10 day unit Orientation

- 2.2 Pass all required written tests with a minimum score of 80% limited to 3 attempts. The Head Nurse will be notified of the outcome and records will be kept by NE&R.
- 2.3 Complete BLS Certification within first 12 weeks
- 2.4 Complete designated competency-based orientation check-offs within the probationary period with 100% accuracy.
- 2.5 Receive a probationary performance evaluation within the first 90 days from his/her Head Nurse / Supervisor / Administrator.

3. Unit Orientation for Nursing Staff and Support Staff

- 3.1 The **Head Nurse/Program Director/Head of Service/Assistant Chief** will be responsible for ensuring that each new employee is provided with a **competency-based unit orientation** from 2 to 4 weeks, depending on the requirements of the unit and the needs of the individual employee. A modified orientation plan will be provided for rehire employees and for employees who transfer from other hospital departments/units to another.
- 3.2 **Head Nurse/Program Director/Head of Service/Assistant Chief** will be responsible for assigning a preceptor for each new employee.
- 3.3 **NE&R** in collaboration with the Head Nurse will develop orientation materials consisting of:
 - 3.3.1 Unit orientation manuals consisting of a continuation of competencies and performance criteria received in the GNO, probationary evaluation criteria, and other materials to be used during the orientation period.
 - 3.3.2 An orientation calendar and sequencing of the orientation period specifying topics and assignments to be given to each orientee.
 - 3.3.3 Preceptor packet with written materials to assist the preceptor, including competency check-offs and other materials to be used during the orientation period.
- 3.4 **Orientee**, in collaboration with the **Preceptor** will be responsible for completing all required aspects of the GNO and all Unit Competency-Based Check-offs. In the event of unsatisfactory performance on any required competency due to educational issues, NE&R and the Clinical Instructors will provide direction and assistance. Should the unsatisfactory performance be due to non-compliance issues or lack of opportunity, the Head Nurse and Clinical Nurse Coordinator will provide direction and assistance. In either case, the responsible person in collaboration with the orientee will develop an action plan to facilitate the necessary opportunity to meet all requirements. The orientee will then be responsible for following through with the action plan.
- 3.5 **Head Nurse/Preceptor** will meet **individually** with the new employee on a scheduled weekly basis. The unit Clinical Instructors shall be included as needed.

The purpose of the meeting will be to:

- 3.5.1 Review progress during the orientation period.
- 3.5.2 Identify strengths and weaknesses of the orientee, including:
 - communication abilities with patients, families & staff.
 - problem solving/critical thinking skills.

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- adherence to policies.

3.5.3 Discuss any problems and/or concerns which may have occurred during the orientation period.

3.5.4 Assist the orientee in developing realistic goals and objectives for professional growth.

3.6 **Documentation** Successful completion of the unit orientation program will be documented by the Head Nurse. The completed Competency Summary Form and documented completion of required examinations by NE&R will be maintained by the Head Nurse in the employee's file.

4. Orientation of Head Nurse/Education Coordinator/Clinical Nurse Coordinator/Clinical Instructor/Assistant Chief

A designated preceptor will be responsible for ensuring that each new orientee is provided with a competency-based hospital orientation for 4 weeks, depending on the requirements of the unit and the needs of the individual employee.

4.1 **Program Director/Head of Service/Assistant Chief** for the area will be responsible for assigning a preceptor for each new orientee.

4.2 Roles and Responsibilities of Preceptor

- 4.2.1 Meet and greet orientee during the first 8 days of GNO. If orientee is an internal promotion meet prior to first day of orientation.
- 4.2.2 Develop the 4 week orientation schedule for the orientee.
- 4.2.3 Meet with the orientee weekly to discuss the progress of the orientation and for on going constructive evaluation.
- 4.2.4 Contribute anecdotal notes to the Program Director/Head of Service as necessary

4.3 Roles and Responsibilities of the Head Nurse Orientee:

- 4.3.1 Identify learning needs and collaboratively adjust the orientation plan to meet those needs.
- 4.3.2 Meet with preceptor weekly to discuss the progress of the orientation.

4.4 Resources

The appropriate Orientation Resource Manual to be utilized during orientation, will be given to the orientee. Upon completion of the orientation process, the resource manual is to be returned, by the preceptor to the immediate supervisor.

RESPONSIBILITY

The responsibility of implementing and ensuring compliance with this Policy and Procedure lies with Nursing Affairs. Responsibility for updating and archiving this policy rests with Nursing Affairs

SIGNATORY APPROVALS

Initiating Department:

Name: Heather Byrne

Signature: *(signature on file)*

Title: Head of Service

Department: Nursing Education & Research

**KING FAISAL SPECIALIST HOSPITAL
AND RESEARCH CENTRE**

INTERNAL POLICIES AND/OR PROCEDURE (IPP)

TITLE/DESCRIPTION: Paid Education Time			INDEX NUMBER: MCO-NA-NAA-01-012
EFFECTIVE DATE: 09 Rajab 1425 25 August 2004	REPLACES NUMBER: 29 Shawwal 1424 23 December 2003	APPLIES TO: Nursing Affairs	APPROVED BY: <i>Signature on file</i> Chief of Nursing Affairs

PURPOSE: This policy outlines education that will be undertaken in paid time within KFSH & RC and KFNCCC for Nursing Affairs employees.

DEFINITIONS:

Paid education time: Paid or on-duty time granted to Nursing Affairs staff to complete required and mandatory education activities.

Required education activities: Education which is deemed necessary by Nursing Affairs for nursing staff in various areas of the hospital. It is outlined in Attachment A.

Mandatory education: Education which is considered compulsory according to accrediting bodies or government authorities and which KFSH&RC have acknowledged as mandatory.

Challenge activity: An activity undertaken by a staff member to provide evidence of proficiency.

No: Not required by nurses in specified area.

All: Required by ALL nurses in specified area.

Yes: Not required for all nurses, but may be required by some as approved by the Head Nurse and Program Director.

REFERENCES:

JCIA SQE Standard 6.3, 2nd Edition (*The organization provides facilities and time for staff education and training*)

Management of Human Resources in Hospitals: Examples of Compliance, 1997, by the Joint Commission on Accreditation of Healthcare Organizations.

COMMENTS:

1. Nursing Affairs will annually review and approve a list of required education activities (called Attachment A).
2. Nursing Affairs employees will be granted education time either by release of duty or by payment for using 'own' time to complete required education activities.
3. Head Nurse or designee will ensure that a system is in place in each unit to support staff completion of required and mandatory education activities.
4. Based on a nurse's previous education and/or professional experience, she/he may be requested to take a 'challenge activity', in lieu of a "required education" activity. The challenge activity may be the competency assessment related to the education activity subject. If they meet the pass requirements of the challenge, the need for attending the 'required' education may be negated.
5. Notwithstanding the above 'challenge' clause, employees will complete all mandatory education as deemed necessary by Nursing Affairs and KFSH&RC.
6. Additional education may be requested for individual employees and be approved as 'required education' by the Assistant Chief/ Program Director/ Head of Service and the Chief of Nursing.
7. Basic Life Support (BLS) and Emergency Care Competency (ECC) are interchangeable unless otherwise specified.
8. All clinical instructors will be required to become BLS instructors. Advanced instructor requirements will be undertaken upon request of the relevant Program Director and Head of Service, Nursing Education and Research.

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Attachment A

Table 1: Required Education for Nursing Staff (SNI, Clinical Instructors, Education Coordinators)

Education	Med/Surg Oncology	Critical Care	Maternal Child	Peri Operative	Ambulatory Care	CCC	Cardiac Center
Basic Life Support (BLS) (every 2 years)	All	All	All	All	All	All	All
Advanced Cardiac Life Support (ACLS) (16 hours every 2 years)	No	DEM, MSICU's	No	RR	No	No	All except OR IV
Neonatal Resuscitation Program (NRP) (8 hours every 2 years)	No	NICU, DEM (females only)	L&D	No	No	No	No
Pediatric Advanced Life Support (PALS) (16 hours every 2 years)	No	PICU, DEM	No	RR	No	PICU and designated Nurses	CSICU, CVT, CVSDU
Adult Physical Assessment (8 hours)	All	MSICU's, DEM	A-1, D-1, L&D	DSU, SMU, RR2, IVF	All except Paediatric Clinic	No	All
Pediatric Physical Assessment (8 hours)	All	PICU, DEM	All except D-1	DSU, DMU, RR2	All	All	All
Chemotherapy workshop (2 days)	IV team A3, F3, E3, E1, F2-1, F2-2, F1	MSICU's, PICU	B1, B3-2, D1, A1	DMU	Oncology Clinic	All	No
Procedural Sedation (1 hour)	All	DEM	All	DSU, DMU, IVF	Endoscopy, Medical Clinic, Oncology& ENT	All	A4, CCU, CVT, CHU
Adult 12 lead ECG Interpretation (8 hours)	No	No	No	IVF	No	No	A4, CCU, CHU

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Education	Med/Surg Oncology	Critical Care	Maternal Child	Peri Operative	Ambulatory Care	CCC	Cardiac Center
Patient Controlled Analgesia Workshop (2 hours)	All	MSICU's PICU	All	RR	No	All	CVT
Epidural Workshop & inservice (2 hours)	All	MSICU'S	A-2, L&D, A-1, D-1	RR	No	No	CVT
Intra Aortic Balloon Pump (IABP) (8 hours)	No	No	No	No	No	No	CCU, CSICU
Veni puncture/ Intravenous (IV) certification (4 hours)	All	All	All	RR, DSU, DMU, IVF	Endoscopy, Oncology, HHC, Medical Clinic, ENT	All	All except OR IV
Continuous Renal Replacement Therapy (CRRT) (8 hours)	No	PICU, MSICU's	No	No	Hemodialysis SNI	No	CSICU, CCU
Cardiac Surgery Review (6 hours)	No	PICU	No	No	No	No	CSICU, CVT, CVSDU
Peritoneal Dialysis (4 hours)	B3-1	PICU	No	No	PD Clinic	No	CSICU, CCU, CVT, CVSDU
AV Fistula Cannulation	A-3 / B3-1	No	No	No	Hemodialysis	No	No
Pacemaker Workshop (4 hours)	No	PICU	No	No	No	No	CCU, CSICU, CVT, CVSDU
Preceptor Course (8 hours)	Yes	Yes	Yes	DSU, IVF, DMU, OR2, RR2	Yes	Yes	Yes
Student preceptor Workshop (4 hours)	Yes	Yes	Yes	IVF, OR2, DMU	Yes	No	Yes
Skills Marathon	As needed	No	As needed	As needed	As needed	As needed	No

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Education	Med/Surg Oncology	Critical Care	Maternal Child	Peri Operative	Ambulatory Care	CCC	Cardiac Center
Basic Dysrhythmia Interpretation Course(BDIC)	No	All	L&D	RRII	No	PICU & designated nurses	All
Charge Nurse Course (8 hrs)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

RESPONSIBILITY

The responsibility for implementing and ensuring compliance with this Policy and Procedure lies with Nursing Affairs. Responsibility for updating and archiving this policy rests with Nursing Affairs.

SIGNATORY APPROVALS

Initiating Department:

Name: Heather Byrne

Signature: _____ - *signature on file* -

Title: Head of Service

Department: Nursing Education