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Influences of Stigma, Culture, and Gender on Nursing Management of Children with Asthma in Saudi Arabia

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Abstract: ***This study explored the influences of socio- cultural factor in paediatric asthma management in Saudi Arabia.This study employed a qualitative research, based on Burawoys extended case method, using a multi-method data collection approach consisting of observations, and semi-structured interviews with 9 doctors, 12 nurses and 11 parents of children with asthma to identify multiple perspectives. The findings of this study confirm that culture, gender and stigma are the factors that contribute most to influencing the nursing asthma management. Further these findings suggest that a supportive environment was most important to the nursing management in a chronic disease in order to actively engage with KSA society to meet patient's needs.Implications for future studies to evaluate the scope of these recommendations through a longitudinal study are very important to explore and develop the identity of nurses and their role within the healthcare environment.***

Keywords: culture; gender; stigma; nursing care;case study design

1. Introduction

Medical institutions in many countries are facing the challenges involved in growing cultural diversity among patients and issues that are arise during interpersonal interactions between healthcare providers and patients from a range of diverse backgrounds (Aliza- deh, 2013). Medical disputes, which may escalate into physical assaults on healthcare providers, can occur due to lack of cultural competence on the part of providers (Aoki, Uda, Ohta, Kiuchi, & Fukui, 2007; Kopelman, 2014; Wang, 201 Medical institutions in many countries are facing the challenges involved in growing cultural diversity among patients and issues that are arise during interpersonal interactions between healthcare providers and patients from a range of diverse backgrounds (Aliza- deh, 2013). Medical disputes, which may escalate into physical assaults on healthcare providers, can occur due to lack of cultural competence on the part of providers (Aoki, Uda, Ohta, Kiuchi, & Fukui, 2007; Kopelman, 2014; Wang, 201

Childhood asthma is one of the common chronic diseases, and has had a marked increase in prevalence over the past 25 years. Asthma epidemiology and it's severity exist are explained by some factors such as genetics, environmental, social, cultural, and economic factors. It has become a challenge for healthcare organisations. Asthma can be considered as a significant health problem, which often requires the use of emergency care, and hospital admission.

Health institutions in different countries are facing the challenges involved in growing cultural diversity among patients and issues that are arise during communication between healthcare providers and patients from a range of diverse backgrounds (Aliza-deh, 2013). Healthcare may escalate into physical assaults on health care providers, can occur due to lack of cultural competence on the part of providers (Aoki, Uda, Ohta, Kiuchi, &Fukui, 2007; Kopelman, 2014). Nurses' practice must incorporate and understand the influences of cultural needs and beliefs into their nursing practice to provide care that is individualized for the patients and appropriate to the patient's needs.

Saudi Arabian culture in fact represents a complex blend of historical and geographical influences, which also affect the perceptions of nursing care. While Islamic history has lauded the status of nurses as providers of first aid and care, particularly in battlefield nursing (Gazzaz, 2009), since the establishment of the MoH in 1958 KSA has relied on non-Saudi nurses to meet the country’s nursing demands (Long, 2005). More than 70% of the total nursing population in KSA today are expatriates with different background from Asia and Western communities (Almaliki et al., 2012) which results in numerous causes of patient dissatisfaction (e.g. cultural and linguistic differences).

One intractable local feature is gender separation, which is socio-religiously approved and officially implemented (Al-Khateeb, 1998; Tumulty, 2001). A study showed that the gendered roles, traditions and culture of Saudi society, as well as a lack of support and mentoring of student nurses were the main issues affecting the development of student nurses (Alyami & Watson, 2014). Cultural differences, including cultural orientation, play an important role in care delivery and outcomes (Tse, Palakiko&Taxiera, 2005). Currently there is no published information identifying the

socio-cultural factors influence the nursing asthma management in clinical settings in KSA, or examining how these factors affect the childhood asthma care and why. Therefore, the aim of this study is to explore theinfluencesof socio- cultural factor in pediatric asthma management.

2. Methodology

A qualitative research (Case study approach) was chosen for this study because it can provide deep insights and offer rich sources of information. The main research question «what are the socio-cultural factors influencing the pediatric nursing asthma management in Saudi Arabia?» led to think about the elements that construct and conceptualize the nursing role and what socio-cultural factors may influence them during the implementation of paediatric asthma management.

Purposive Sample

Selected hospitals

The study was carried out in one of the government hospital in Tabuk city, KSA. Participants were informed about the research questions, methodology and data collection methods and (most importantly) were selected due to their relevance to the study as they contributed to development of the research [7]. Hence, the selections of participants were based on the following criteria [8].

- Saudi, non-Saudi; female, male.
- Staff nurses/managers or doctors working in, interacting with the study site, and working with children with asthma.
- Willing to participate and having the ability to communicate in Arabic orEnglish.

Ethical approval

A Level 2 Ethics Form was submitted to the School of Health in Social Science, University of Edinburgh Ethics Committee, for approval. Since the field work and data collection phase of the study was to take place in Tabuk, the policy of the School of Health in Social Science (HSS) at the University of Edinburgh entailed obtaining ethical approval (wherever possible) local to where participants would be recruited, provided such a system was in place. This was done by obtaining ethical approval from the MoH (KSA), which was accepted by the other academic institutions and governmental hospitals.

Data collection

Data collected by multiple data sources, including observations, and conducting semi-structured interviews. Semi-structured interviews were audio taped and each interview tapelasted between 45-60 minutes. The tapes were then transcribed and each tape listened to at least twice to familiarize with the participants whole story at the time of analysis. Total of 12 nurses (Table 1), 9physician and pharmacist (Table 2) and 11 parents of the patients (Table 3) were recruited as per screening criteria set earlier in thisstudy.

Table Error! No text of specified style in document.**.1:** Nurses' characteristics in CSB

Status	*Experience (yrs)*	*Age (yrs)*	*Education*
Non-Saudi female nursing director	20	52	BND**
Saudi female head nurse of ED	9	29	DND*
Saudi female in charge nurse	5	26	DND
Saudi female staff nurse	2	30	DND
Saudi female staff nurse	5	27	DND
Saudi female staff nurse	2	25	DND
Saudi male staff nurse	3	25	DND
Saudi male staff nurse	2	24	DND
Saudi male staff nurse	2	24	DND
Non-Saudi female staff nurse	1	28	DND
Non-Saudi female staff nurse	1	26	DND
Non-Saudi female staff nurse	1	29	DND

*Diploma Nursing Degree **Bachelor of Nursing Degree

Table 1: Demographics of nurses.*Diploma Nursing Degree **Bachelor of Nursing Degree

Table Error! No text of specified style in document.**.2:** Participants' characteristics, CSB

Status	*Experience (yrs)*	*Age (yrs)*	*Education*
Non-Saudi male paediatric consultant (Syrian)	6	38	M*
Non-Saudi male general paediatric specialist(Egyptian)	12	54	M
Non-Saudi male general paediatric specialist (Syrian)	15	45	M
Non-Saudi female general paediatric specialist (Pakistani)	8	39	M
Non-Saudi female general paediatric resident (Egyptian)	7	37	M
Non-Saudi male general paediatric resident (Pakistan)	8	35	M
Non-Saudi female general practitioner (Sudan)	4	34	B**
Non-Saudi male general practitioner (Sudan)	7	32	B
Non-Saudi female general practitioner (Sudan)	2	30	B

* Master's degree ** Bachelor's degree

Table 2: Demographics of physicians

* Master's degree **Sub-speciality ***Bachelor's degree ****Diploma degree.

Table 3: Demographics of parents of the patients

Characteristics	*CSB*
Gender	
Male	3
Female	8
Age	
18 to 39 years	10
40 to 55 years	1
≥ 56 years	0
Education category	
University	3
Secondary school	2
Elementary school	2
Primary school	2
No formal school	2
Place of living	
City	10
Village	1
Do you work?	
Yes	5
No	6
Total number	11

Data analysis

Data were transcribed verbatim and entered into QSRNVivo, a software programme suitable for facilitating the analysis of qualitative research [5-7]. Overall, 17 changes were recommended for those texts that were inappropriately translated from Arabic into English (semantic issues). Thus, changes were made to those sentences that did not reflect the exact meaning of the original Arabic sentences.

Reliability and validity of data

Credibility of data was achieved by utilizing the multiple-case study design and method triangulation, which made possible the exploration of different types of data within and across the cases. Moreover the dependability level was increased in this study by developing a guide for semi-structured interviews, which were conducted after carrying participant observation.

3. Result

The transcribed data were read and re-read, new ideas emerged, which led to the development of two substantive inductive codes:« asthma management», «gender» and «culture» (Table 4).

Table 4: Main themes and sub themes emerging from the data

Aim	Themes	Data Extract
Socio-Cultural Factors	Saudi societal views and culture	"I think nurses face some restricting forces in practising asthma management when the father comes; because of the traditions and culture here, he will not talk to the female nurse without his wife. " Saudi female staff nurse 3
	Gender issues	"I tried to explain about the asthma management... I cannot talk to the mothers. This is a red line here, because I am a male nurse. " Saudi male staff nurse 2
	Perceptions of asthma: stigma and beliefs	"As a result of asthma stigma by the parents, they do not come for follow-up. Non-compliance to medication even, even some like on this child, they agree for an inhaler, for prevention, but they are not using it at home. They bring the child back here, and when you ask them about this, 'No, we did not give... because he was ok.' So, non-compliance is the big issue. " Saudi female head nurse

The particular socio-cultural factors identified in this study include Saudi societal views and culture, gender issues, and perceptions of asthma such as stigma and beliefs. These factors are explored further below.

Saudi societal views and culture

The need to discover the socio-cultural effects that characterised the individual stories fairly was realised by repeatedly reading the transcribed texts and carefully listening to the ways in which participants articulated their responses. Most interviews with the participants showed that they viewed Saudi societal views and culture as one of thesocio-cultural factors affecting nursing experiences. Socially, nursing in Saudi Arabia has been perceived as an unacceptable occupational choice for Saudis.

There was a consensus among the nurse participants that nursing is a challenging occupational option that places them under a great deal of family and social pressure. As the female staff nurse participants' responses suggested, culture and traditions are restricting factors in educating the fathers who come with their asthmatic children.

> *The societal view and culture are affecting [this issue] clearly. For example, people think nursing is dirty work and nursing duties such as night shift work, long time working. Saudi female staff nurse 7*

> *Saudi culture is still affecting our practice... the Saudi culture is different from region to region, and here in Tabuk, it is based on the environment and the people, they are not educated enough. Saudi female head nurse*

The interviews suggested that these work-related issues are likely to impose social pressures on female nurses.In traditional urban society in KSA, women were not allowed to work outside their home boundaries. Hence, the emergence of nursing as an occupation for women has been perceived as a challenge to the society's social norms.

The nurse director pointed out that those married female nurses would eventually encounter family conflicts regarding work-related issues. These referred to the female nurses' need to obtain permission to work from their husbands, a permission that would most probably be conditional on the nurse working on a particular shift, unit, and area of work:

> *Of course, the culture has an effect on the practice. Female nurses experience a serious struggle when they get married; their husbands do not want them to*

work with male patients and do not accept the night duties. The change is forced on her. You can immediately tell she has a family conflict... she comes to us and says, 'I want to work in the clinic.' Husbands also come to us and speak on their wives' behalf; they even bring the necessary paper work. Non-Saudi female nurse director

A non-Saudi male doctor suggested that in Saudi culture, the parents' permission would be needed to allow a female nurse to continue her education overseas. In addition, female nurses would need also to get permission from their guardian (father, brother or husband) to complete their study overseas:

There are programmes in foreign countries, like the UK, America, Canada... and in Saudi culture; I do not think the parents will let their girls go there alone. Therefore, it is a cultural factor as well. Non-Saudi male paediatric specialist 2

Some parent participants suggested that their families and the tribe (Bedouins) at large used to perceive nursing as an occupation that brought shame and disgrace to the family. They explained that, for some tribal families, women (wives, daughters, sisters) are not allowed to interact with men who are not close family members.

The majority of parent participants made explicit reference to a widespread perception that society's culture has an obvious effect on nurses' practice, as men may perceive Saudi female nurses as socially unprotected and as more liable to commit a social offence. This perception was linked to work-related social concerns, such as long work hours, night shifts, and a mixed-gender work environment. One of the parent participants' responses revealed that their fear was that their daughters may not get married because of their work as nurses, and consequently, they were worried about their social status:

I feel fear that my daughter wants to become a nurse because her father will refuse that, and he is thinking that nursing is not good job for girls because this profession is working with long hours and night shifts. People perceived teaching as a good job for women. I think working in the environment like the bank or school would be acceptable for my daughter. Mother 4

However, three of the parent participants raised a different opinion of a socially acceptable nursing role:

The people have now changed because the culture has changed as well due to education. The people are accepting of Saudi nurses so the number of nurses has increased and they can become more than just teachers.Father 7

The view of the father quoted above was replicated by two other fathers who suggested that the culture has changed and nursing is now more socially acceptable because of the increase in education of the population. However, a lack of awareness of the nursing profession was often used by the parent participants to explain the development of an interest in nursing as a professional job. It also illustrates the associated social struggle and fears experienced by the participants. This struggle was understood as being specific to Saudi nurses working in a Saudi context, which was closely associated with wider gender issues.

Gender issues

Nurse participants' accounts illustrated a range of gender-related issues that influenced their nursing experiences. Issues faced by nurse participants are examined below in order to explain the gender-related struggle. Nevertheless, these male and female nurse participants were faced with varying degrees of social resistance associated with nursing in the clinical area. One of the male staff nurses stated:

Female nurses experienced similar difficulties with fathers:

We need more staff to educate the fathers who need to be educated about asthma and the effect of smoking cigarettes on their child's condition. For the fathers, we cannot do lectures. As you know, the people here are thinking very negatively about female nurses who come and want to educate them. Saudi female staff nurse 3

Researchers noted the following in the observation notes:

One mother came with her daughter (10 years old); the body of the girl appeared big for her age. The girl was wearing an abaya (loose gown) without covering her hair or face. The child was complaining of a recurrent cough, and they came by ambulance to the hospital. The male nurse asked the mother to help the child to lie on the bed and get her comfortable, but the mother looked shy and she was wearing a full abaya, from head to toe, with only her eyes uncovered; when the male nurse came she tried to cover her eyes, and she said:

I want a Saudi female nurse to come and touch my daughter. Sorry, but I feel more comfortable if you call a female nurse.' The male nurse was quiet, the male doctor was there, and the male nurse went to call the in-charge nurse to come and solve this issue. The in-charge nurse is a female Saudi nurse who came to do the male nurse's job so the patient and her mother were satisfied. Field note observation

The social and professional challenges experienced by male and female nurse participants varied considerably. Responses obtained from the female nurse participants suggested that female nurse participants had advantages over their male counterparts such as they worked in a predominantly female occupation. In contrast, the male nurse participants had minimal social constraints in relation to their choice of work settings, working hours and late or weekend duties. For example, for male nurses, unlike for their female counterparts, it is socially acceptable for them to be working at night.

Some of the female nurse participants agreed that working with male nurses is important. These female nurse participants said that male and female nurses were working as a team. Despite gender issues in nursing, they chose to work in nursing because they believed working alongside male nurses to be important since those male nurses would be able to deal with any fathers who come with their asthmatic children. Being part of nursing, some nurses may have started to realise the seriousness and impact of the mixed-gender field:

> *We are working with males, and every one respects their job. We are not sitting and chatting with each other. We respect each other. We work as a team. Male nurses have an important role here; they help us to deal with fathers, and we help the male nurses to deal with the mothers. We work cooperatively. Saudi head nurse*

Another statement below by a female nurse participant used the assertion that "mixing… is acceptable now." She explained that the situation for Saudi women has changed, and that women are becoming involved in different work disciplines:

> *Mixing with males, it is acceptable now because the women now have an important role in different disciplines. Nursing in Saudi Arabia could be developed and the education improved. Now, the number of nurses is increasing because it will be easy to get a job in future. Not like for teachers. Saudi female staff nurse 4*

However male participants had minimal institutional facilities such as a nursing room and felt there was no-one supporting their particular needs because of their gender:

> *As male nurses, we do not have a staff nurse room. The room here is for female nurses; we stay in the reception of the hospital. There is no one listening to our tale of woe; those who are in charge of us, as female nurses, never support us. Saudi male staff nurse 6*

Individual stories showed that, due to the effect of gender issues, some female nurse participants went through phases of rejection, anger, frustration, fear, worry, regret and disappointment. Some felt angry about working in a mixed-gender field, something they had never considered before. Some were worried and scared about the negative perceptions held by their immediate family and wider society. These overwhelming mixed feelings seem to have obstructed the participants' coping mechanisms and were always linked to the prevalent nursing images, the perceived low status of nurses, the expectations of a career in nursing, and the lack of support systems:

> *My husband does not want me to work in a hospital. He says, 'You mix with men,' and he wants me to work in a Primary Healthcare Centre. As you know, we live in a conservative society. I do not feel comfortable working with fathers who come with their sick children, but we have only a few male nurses around. Saudi female staff nurse 5*

> *Mixing with male doctors or nurses is affecting me. I saw how the Saudi nurses are avoiding the male nurses... Personally, I do the same... I avoid the male nurses as well. Because of the gender issues religion...It is better to separate the work of men and women. Non-Saudi female paediatrician 1*

Some nurse participants indicated that the community at large continued to perceive mixed-gender work settings as socially unacceptable. A female non-Saudi doctor also attributed her personal preferences to feeling uneasy when providing sensitive types of care to male patients.

I observed how a female nurse received an order from the doctor to apply a nebulizer to a 7-year-old child who was with his father:

> *One father came with his child, 7 years old, asking for a nebulizer. A female nurse got the paper for the nebulizer doses. The nurse asked the father to sit on the chair with the child so she could prepare the nebulizer and give it to him. The nurse handed the nebulizer to the father and asked him to put it on his child. I asked the nurse why she did not put it on herself, as it is part of her job. She replied: 'I feel shy to be near to the father because he is hugging his child. If his wife were with him, I would ask the mother to hold her child so I could put on the nebulizer.' Field note observation.*

Analysis of interviews with the Saudi female nurse participants suggested that they were experiencing the social effects associated with working in socially unacceptable mixed-gender settings. The female nurse participants indicated that the following areas have contributed to their individual struggle, such as "a female nurse cannot educate fathers with an asthmatic child," "Some people will misunderstand her." Thus, most of the females avoided educating the fathers. This is an issue for female doctors too. These perceptions were associated with expectations that Saudi men who choose nursing as a career might face resentment and ridicule from their families, relatives, and friends. Three of the male nurses talked about being referred to as workers doing women's jobs. A male nurse expressed his feelings in this way:

> *I feel that nursing is female profession. Some of my relatives asked me, 'Why are you working with women?' It is affecting my practice through avoiding communicating with mothers because of society culture. Saudi male staff nurse 9*

The participant in the extract below clearly said that he and his male nurse colleagues avoided communicating with female nurses because they felt shy talking to women, as this is unusual in Saudi society:

> *Sometimes I avoid communicating with female nurses. Some of my friends avoid communicating with female nurses. My male nurse colleagues are*

shy talking to the female nurses. I had a very bad experience in the beginning of working in the hospital. I tried to ask one female nurse about the place where the medications were. She was very rude and ignored me because she thought that I wanted to say something bad to her. Saudi male staff nurse 8

A non-Saudi doctor confirmed this:

It is obvious; I saw that the Saudi female nurses are avoiding talk to the fathers. The problem will be greater for male nurses because they will not be able to talk to the mothers or educate them... as you know, based on the culture. Sometimes, families with a female child more than 9 years old come to the treatment room where the doctor is working and ask to change the male nurses who are giving the injection. Non-Saudi male medical director

Male nurses were more vulnerable to harsh comments, which may adversely influence their interest and confidence. As the above responses obtained from male staff nurses suggested, they have experienced difficult times and hardship going through their nursing studies and early years of work. Male nurse participants were frustrated and disappointed particularly when the pressure came from close family members. Their interviews suggested that it was very difficult for them to come to terms with nursing and, at the same time, cope with the perceived images of nursing held by their families and relatives.

One mother expressed her opinion of gender mixing, because she had not experienced working in a mixed-gender field. This participant felt easy communicating only with females:

I prefer to avoid mixing. I feel comfort if they are all females and I can talk easily and communicate. Mother 5

Another parent participant avoided asking the doctor about her child's condition because she felt shy and was restricted by the environment:

Usually I do not ask the doctor every visit about my child's case... because I feel shy and hesitate to talk to the male doctor that I meet for the first time. I prefer to write everything on paper. It is better to write the medication in Arabic. Mother 8

Perception of asthma: stigma and belief

The perception of asthma as a stigma among the nurses, doctors and parents participants was one of my unexpected findings. According to Corrigan et al (2004) stigma, works at different levels, including individuals, families, and society. Health-related stigma exists across cultures (Deacon, 2006). In my study, stigma is considered as one of the major obstacles to good health and poses a great risk to asthma sufferers. The experience of being stigmatized can lead to a refusal to seek treatment, to medication noncompliance, and to social rejection.

Health professionals highlighted the importance of overcoming the perceptions about inhaler addictions and of the need for asthma education for all families and their children. Their views considered parent reactions during asthma management in the hospital. The nurse and doctor participants reported that children might be affected by their parents' stigmatization of asthma and the need for long-term management and compliance:

Many families in Tabuk have bronchial asthma; they feel stigmatized because they are not coming to the hospital. You find many aggravating factors at home, as if we tell them, 'Don't use perfume...' They use it. You also find babies with bronchial asthma; we tell them, 'Protect him from people with viruses and infections so he won't develop an infection.' The issue is complicated because the people self-deny the disease and might not be educated. Non-Saudi male paediatrician 2

As stated above, health professionals believed that people self-deny asthma due to lack of education. An indicator of stigma is attached to asthma, as is revealed by the euphemistic terms parents use to avoid acknowledging that their children has asthma, such as "chest allergy" (*hasasiyia*) rather than "asthma" (*rabou*):

Yes. In all Arabic countries, if the baby wheezes they call it 'rabou,' they hate this word. Therefore, if there is a wheeze, we call it 'hasasiya,' which is less distressing. This is a point of deny among society. Because some say, they do not want inhalers; because they fear, the child will become addicted. Saudi female staff nurse 3

Most parents do not want the asthma medication such as inhalers. That is why they do not want to come for a follow-up; they do not want this inhaler - they just need a nebuliser. You see even if sometimes like this, we ask them to take this inhaler at home, they say, 'No, you just prescribe for us the medications; we will buy the machine, the nebuliser, not the inhaler. Saudi male paediatric specialist 5

Interviews with parents showed that they are reluctant to disclose their child's asthma status to schools or relatives; many children do not take inhalers at home or at school, and their parents do not have easy access to information about the disease or how medications work. The stigmatization of asthma has different harmful impacts on self-management of the disease. For example, parent participants expressed their scary feelings about using the inhalers and other asthma medications, and the issues they thought the child might encounter related to school, physical activity, future employment and relationships. In some instances, parent participants mentioned that the parents of healthy children do not let their children play with asthmatic ones. Some parent participants indicated an association between fears of using asthma medications for their children and child symptomatology:

I do not give my daughter inhalers sometimes because I get afraid of those medications, and she

could be addicted to them. I feel scared that is why I do not let me daughter to use it in front of her friend in the school. mother 8

I feel scared about my child's condition. I feel like he has become addicted to the inhalers. I do not like to give my child inhalers all the time. His brothers had severe asthma attacks and now they are fine. mother 7

The mother expressed above their concerns that a child who had been given a diagnosis of asthma would be socially isolated from their peers with consequential impacts on the child's emotional and psychological well-being.Asthma was perceived as a transient symptom, not as a long-term treatment. Some parents insisted on regarding asthma as a chest allergy that periodically came and went; this conceptualization caused them to abandon adherence to medication regimens as soon as the symptoms of the asthma attack abated:

I cannot say my child has asthma... it is an allergy.... However, lung allergies come and go based on the circumstances or triggers. I think asthma is difficult. I have four children with this respiratory disease. mother 15.

During the winter, twice a month... we come to ER. Sometimes, when I see my child has an attack, I give him bronchodilator syrup at home. I do not have inhalers for my child because the doctor does not prescribe them, I think because all the children of this age have chest allergies. It is not asthma. Father 16

Parent participants exhibited and reported numerous attitudes and beliefs in relation to health and illness that, while generally harmless in themselves, could be considered negative if they inhibit interaction with conventional healthcare resources, including using traditional folk medicine, such as honey and herbal treatments and reading from the internet:

I think the challenges of asthma are society…. people feel scared of asthma and asthma medications, of becoming addicted. The people do not understand what asthma is and its symptoms. For example, the teachers in school have no idea about this disease; my child suffers from his asthma in school more than at home. If the people found the service and the attention to asthma education, they would comply with the management. Mother 5

Beliefs lead to the use of traditional remedies rather than asthma medications. Parental influences, attitudes, knowledge, and beliefs about asthma perceptions and misunderstandings can affect children's engagement with prevention and optimal asthma management:

I do not depend on what the doctor says; I read on the internet, search, and see what things harm my daughter, but I trust doctors, and what they say. Father 1

When I see my child cannot breathe, and is coughing, and her face is pale and tired... If the weather is not cold, I tell her to open the window and drink water or honey. My grandmother told me that honey is good for an allergy in the chest, and some herbal drinking is useful... of course, take her medications. Mother 2

As these parent participants illustrate, societal beliefs contributed to inadequate asthma management.

There are some herbs, like honey, I like to give it to my child... it does not harm him... I think the home is the second most important aspect for my child's care... if we get the correct information and understand how to give medication. Mother 5
The doctor gives us information about the disease. However, I do plan for my child. I told the mother, 'If you see your child has a runny nose and starts to have an asthma attack... just give a cold bath and apply a moisturizer and give the inhalers.' I tried that with my child, and it is working, and he became normal. Father 2

While these factors are largely independent of each other, there is some degree of overlap and interaction, particularly socio-cultural factors that are 'universal' and underpinning the nursing role such as Saudi cultural views, gender, stigma and beliefs.

4. Discussion

Factors discussed in this study include Saudi societal views and culture, gender issues as well as stigma and beliefs. The findings of this study show that cultural aspects may affect perceptions of nursing care, access to health care services, and understanding of the disease and its treatment.

Saudi societal views and culture

In terms of access to healthcare facilities, cultural aspects comprise economic structure, and the quality of healthcare services provided within the cultural setting. KSA is influenced by Islamic cultural values, and this affects most aspects of Saudi society, including education, health, and lifestyle (Gashash, 2016). In my study, nurse participants made explicit references to how their male relatives do not approve of the nursing duties, night shifts, and weekend duties expected of nurses, making it less desirable as an occupation.

Nursing duties and situations in the hospital remain an issue of debate in Saudi society. Because Saudi Arabian people perceive nursing as having a low social status, individuals who choose nursing as an occupation struggle and face ignorance from relatives, friends, and society. Thus, culture may have an impact on the users of services and on healthcare providers. Additionally, the media have a significant part in creating this negative vision on the part of the public's perception of the nursing profession, as old television programmes and old movies depicted female nurses as unintelligent and flirtatious with male doctors (Mebrouk, 2008).

Nurse participants themselves were keenly aware of the impact of traditional beliefs, and although they themselves naturally did not share such sentiments they certainly suffered from the pervasive disapprobation which such beliefs entail in Saudi society, which they even encountered while executing their duties (i.e. from service users and other health professionals, as described previously). Cultural attributes must be worked with up to a point in nursing strategy, and they are a core part of culturally sensitive nursing care for patients, but the impact of culture on nursing recruitment and retention in KSA is inherently negative. Culture is a complex issue that has the potential to have a significant impact on healthcare providers and their service. Several studies have deliberated the images of nurses and the nursing profession in KSA (Lovering, 2008; Almutairi& McCarthy, 2012).

The literature review has stated that some factors such as culture, family, and religion influence powerfully the educational and professional choices of new generation of Saudis (MillerRosser, Chapman & Francis, 2006). As in the findings discussed in Chapters 6 and 7, the lack of perceptions of nursing that have been recognised in the literature, may be associated with the pictures of nursing as a job labelled for women, to the social class of women taking up nursing, and to the more basic level of education traditionally required for the profession. They may also be linked to historical explanations that nursing appears to provide assistance to medicine (Darbyshire, 2000; El-Sanabary, 2003) and is not an autonomous profession in its own right. It is also argued that even though nurses comprise the majority of healthcare professionals worldwide, they are largely imperceptible (Sullivan, 2004).

Regardless of Saudi societal views, culture, and lack of support, more than half of the nurse participants expressed their feeling of living in a society where the public undermine nursing and look down on nurses due to cultural issues. A Saudi nurse participant in my study who shared her experience with Saudi female parents who shared their views, said that the nursing profession is not suitable for Saudi women because of the mixed-gender setting in the hospitals and that they saw the job as suitable only for foreign nurses. She added also that Saudi society sees the nursing profession as immoral and disreputable. According to Arab Islamic society, to be compatible with Islamic and Saudi culture, Saudi females should work only with females. There are only a limited number of jobs that fit with these boundaries, such as in textiles and teaching in girls' schools (Miller-Rosser et al., 2006). Similarly, before Florence Nightingale brought respectability to the nursing profession, nursing in the UK in the early mid-19th century was not an activity that was supposed to claim any skill or training, nor did it command respect; people used to think that nursing involved the cleaning and feeding of another person, tasks that were regarded as domestic chores (Thomas, 2016).

In the Saudi context, in the early 1960s nursing was perceived as a field of study for women. At that time, there was strong public opposition and aggressive rejection by the conservative segments of the Saudi people about any formal public education for women (El-Sanabary, 2003). The reason behind that is that education implies the women leaving the home for part of the day for education or work, and such practices seemed by most Saudis to be against the common traditions and Islamic rules (ElSanabary, 2003). Education by making women more knowledgeable also encourages them to challenge the authority of men. By tradition, Saudi women were usually predicted to stay and provide care for the family in the home.

Some nurse participants indicated the negative image of nurses in Saudi society, where the nursing job is perceived as a menial and low-paid job compared to medicine. Therefore, although the nursing profession is perceived as a women's profession, its generally low socio-economic associations and cultural attributions discussed in the previous chapters mean that the desperately needed influx of native, Saudi female nurses that is required has not materialised, and the shortage of nurses will remain a major issue, which has been proven to result in inadequate healthcare delivery (McLaughlin, Muldoon & Moutray, 2010).

Gender issues

This study discusses how gender-related perceptions of nursing and of nursing specialists' professionalism still prevail in Saudi Arabia. The findings indicate that the negative image of mixed gender issues related to the nursing profession is still clear in KSA. Male nurse participants in perceived nursing as a profession for females and a majority thought that this had had an influence on people having mixed feelings about nursing as a profession. In addition, these findings are supported by a comment by one of the male nurses participating in this study, who chose nursing but who also faced criticism from friends; he commented that nursing is a female profession. Hence, there are several nursing myths, including about the profession and the people that work as a nurse. One of the most public misconceptions is that nursing is a female job.

Indeed, at the start of the 21st century, nursing was considered to be a female dominated occupation throughout the world (Evans, 2004), frequently related to gender-specific stereotypes (Kelly et al., 2013). Women dominate the nursing profession, and there are still relatively few men in nursing. Nursing in KSA, as in many Arab and Western countries, started as an occupation for females and remains an occupation where there are more females than males (Gazzaz, 2009).

However, the number of Saudi male nurses has dramatically increased; at about 32%, the proportion of the nursing workforce is actually far higher than elsewhere in the world (Aldossary, While &Barriball, 2016). For instance, males comprise only 11% and 9% of the workforce of registered nurses in the UK and the USA, respectively, and the number of men entering the nursing profession has hardly grown in recent years (Clover, 2010).

As shown in my findings, it seems that nursing practice is gender-segregated and is affected by culture and social traditions and views of gender relations. Hence, in mixed situations, such as health institutes and hospitals, factors regarding cultural values and gender issues can affect nurses' sense of job satisfaction, especially in a country like

KSA, where there is a strong religious influence in culture (Lovering, 2008). A study by Al-Khashan et al. (2012) showed that some of the Saudi female nurses were leaving their jobs because they have to work with male patients. It also highlighted the demand for Saudi men to enter the nursing profession to overcome gender issues in hospitals (Al-Khashan et al., 2012). Therefore, a mixed pool of nursing staff could meet the needs of different people.

In the early 1950s when the Ministry of Health (MoH) was established, in the absence of Saudi nurses there was a necessity to contract non-Saudi nurses, the majority of whom were women (Mahran& Al Nagshabandi, 2012). It would seem that even with the strictly practical gender isolation, the Saudi government and public managed to find reasons for female nurses (Saudi and non-Saudi) to provide nursing care to male patients. These non-Saudi nurses were women working in mixed-gender backgrounds, covering rotating shifts, and providing all levels of service to male and female patients. They were not wearing the official dress code for Saudi women and were dealing with men who were not their immediate relatives.

My findings reveal that despite deeply ingrained negative attitudes toward nursing, the profession is beginning to be perceived more positively, partly because the rising cost of living in KSA has compelled many women to become part of the labour force due to economic constraints. Nowadays Saudi women find that nursing is a relatively easy profession to enter in terms of academic sponsorship, recruitment, and job security, with a good salary. Nonetheless, there is strong agreement on the need for gender balance in the health care context in KSA, particularly in nursing, and it is vital that more men that are Saudi are also recruited into the profession in order to meet the need of the Saudi population culturally and religiously (Alboliteeh, 2015). Despite the fact that there is a social agreement that women may work, little agreement exists about the situations and type of work in which women can participate (Tumulty, 2001).

Gender studies have shown many issues about how cultures make a gender hierarchy that causes a disparity division of power and prestige between men and women (Risman, 2004; Ward, 2016). A sociologist reflects that male power socially generates a social construction that leads to female subordination (Connell, 1987). He argued that this gender hierarchy is produced through labour and power conceptions (Connell, 1987). In Saudi society, men dominate over women. In the Saudi context, the social structure, views and activities act as agents of conquest for men. Therefore, the man automatically has the woman under his influence in home and in labour.

Perceptions of asthma: stigma and beliefs

The findings in this study show that parents of children with asthma perceive asthma in varying degrees. The participants' beliefs on asthma are indicators of stigma; stigmatization reflects the condition of individuals excluded from achieving full social recognition due to their 'spoiled' identity (Goffman, 1963). Stigma attached to asthma is a major challenge, as it can delay seeking treatment, and the diagnosis of the disease is associated with beliefs leading to non-adherence to long-term paediatric asthma management. People with such 'spoiled identities' may be stared at in public, questioned about their impairment and made conscious that their body does not fit normative principles (Goffman, 1963, Wilkinson and Carter, 2016). For example, the findings in my study make clear that fear is both an antecedent and an outcome of the asthma stigmatization process; discrimination, rejection, and ostracism are actions that result from stigmatization.

In addition, unfavourable and negative reactions persist towards socially stigmatized persons. Some parents said they were restricting their children's lives such as not taking them to weddings or not letting them exercise outside of the home. This opens up the debate to explain how factors such as social, economic and political power produce stigma within a social environment. Link and Phelan (2001) incorporated into their model of stigma an aspect of organisational discrimination, or the institutionalised problems forced on stigmatized people. A qualitative study by Lakhanpaul et al. (2017) identified parents' perceptions of barriers to asthma management in children from south Asian and white British families. There are individual, family, community and healthcare system barriers that restrict the effective asthma management. A risk of asthma is stigma, produced and constructed by the culture and dynamic social world (Das and Addlakha 2001; Goffman 1963).

The international reports on the stigma of asthma and frequent reporting from the literature have highlighted its worldwide prevalence. In Lebanon and other Middle East countries, to avoid the social stigma of asthma, the terms "chest allergy" or "recurrent dyspnoea" are preferred to mask the chronic nature and functional impairment of the illness (Zaraket, 2011). The use of such terminology, however, also masks that asthma is a condition from which children can die if it is not adequately managed.According to the Global Asthma Report (2014), breathlessness is one of the asthma symptoms that affects patients emotionally and psychologically. For example, feelings of low self-confidence and esteem, isolation, guilt and shame are the results of stigma (Positive Malaysian Treatment Access & Advocacy Group, 2012). In addition, asthma patients frequently struggle with the negative effects of stigma in terms of non-compliance (Jessop, 2003).

The findings of my study are already known to apply in the Western world, particularly the fear of addiction to steroids (Jessop, 2003; Ghosh, 2014), but my findings offer new insights in showing that these attitudes and beliefs also exist in a Middle Eastern Muslim country. My findings also reveal that parents were avoiding using asthma medications such as corticosteroid inhalers and were reading from the internet about their children's condition, often using folk remedies and herbal medication to avoid using medical methods of asthma control at home. From the perspectives of patients and health care providers, the asthma diagnosis is always critical for proper asthma management. Similarly, a study in Lebanon conducted with the parents of children with asthma found a considerable misperception about the use of asthma medication, such as inhalers and the safety of inhaled corticosteroids. There was a recommendation to improve asthma control in children by providing adequate

asthma education to parents (Zaraket et al., 2011). As suggested by Osaretin, Uchechukwu&Osawaru (2013), effective asthma management and education in medical practice are always helpful in order to avoid prescribing unnecessary asthma medications and to reduce unjustified social stigma.

These worries are similar to many of the issues raised by the parents of children with asthma in Western countries, such as concerns about being addicted to oral steroids, fears that their children are perceived as being different from children without asthma, and the perception that asthma is an episodic condition which should be treated as symptoms arise rather than as a long-term condition which needs constant preventive medicine (Ring et al., 2011). Furthermore, the Asian Asthma Patient Coalition (2007) reported on the stigmatisation and reluctance of asthma patients to admit that they had asthma. This Coalition (from Australia, Bangladesh, Hong Kong, Malaysia, Korea, Singapore, Sri Lanka, Taiwan, Thailand and Vietnam) included asthma patients, staff nurses, other social and healthcare workers, and caregivers.

In the same way, Grover et al. (2013) found that half of the parents included in their study stated that they chose to hide their children's asthma diagnosis from relatives, friends, and schoolteachers due to stigma. According to Ungar et al. (2008), both children and their parents often deny the diagnosis of asthma, so there is an essential requirement to overcome stigma in these families so that children can reach their potential.

For example, Gupta et al. (2011) saw that the majority of asthma patients avoided using asthma medication such as an inhaler in a public area and preferred to use small-sized bronchodilators and single doses. In addition, the patients felt that inhalers are to be used only for the most serious symptoms, and that they are indicative of a major, debilitating illness (Gupta, 2011). A recent study by Abu-Shaheen, Nofal and Heena (2016) reported that about 60% of the participants were concerned about side effects from inhaled corticosteroids, 53.5% believed that asthma is just a hereditary disease and 32% of participants were concerned about the advance of dependence on asthma medicines. Parents of children with asthma were confused regarding asthma disease and showed ineffective practices in its management (Abu-Shaheen, Nofal&Heena, 2016).

In the context of Saudi society, a study that identified that parents had misunderstandings regarding asthma and showed ineffective practices in its management was conducted in schools located in Riyadh (Abu-Shaheen, Nofal&Heena, 2016). The study emphasised that parental education is the key to improve asthma care and compliance with treatment (Abu-Shaheen, Nofal&Heena, 2016). Cole, Seale and Griffiths (2013) stated that high levels of stigma are mainly linked to under-treatment and/or under-diagnosis in asthma, lack of educational programmes, and poor asthma information amongst health care professionals, compounded by affordability and access to health care locations. There are clearly low levels of knowledge among people about asthma which lead to a greater degree of stigma. Consequently, the prevalence and outcomes of stigma were variable depending on the level of knowledge and other educational factors among South Asian and other ethnic groups (Smeeton, 2007); it can be surmised that these same dimensions affect asthma care and stigmatization within Saudi Arabia among urban dwellers and rural Bedouins.

The few studies that have been conducted have found stigma to be associated with poor asthma control. For example, in a European study (Newman, 2004) it was found that 22.5% of members (230 of 1,022) shared their feelings of stigma about taking asthma medication in public, perhaps showing that little has changed about this aspect of asthma-related stigma. Charu (2013) created a program called *Sehatma and Saansen* ('Healthy Breathing'), which she piloted in a trial in New Delhi with 40 children and their parents recruited from a hospital outpatient clinic. The findings of the study revealed that stigma is one of the considerable issues arising in India and still attached to asthma. Parents are unwilling to reveal their child's asthma status to schools or relatives; many children do not use inhalers in school, and their parents do not have easy access to information about the disease or about how to use the medications (Charu, 2013). Generally, in this study found that stigma and shame were attached to being an asthma patient, especially with regard to the parents of children. This is perhaps also symptomatic of the stigma around asthma in that particular region of KSA. Parents felt embarrassed when their children were not able to participate with others (e.g. in sports), but instead were left behind, as stated by mothers of children with asthma.

5. Conclusion

This study highlighted the influences of many issues in the nursing clinical areas such as gender roles, Saudi societal views and culture, perceptions of asthma and associated stigma and beliefs. The findings suggests that one of the underlying issues is the prior orientation of society towards the nursing profession which shaped expectations, compounded by gender restrictions on the role of women and strict adherence to socio-cultural norms. The strong study design and methods elicited real-time data, and it potentially adds a holistic in-depth understanding of the nursing role in asthma care through in-depth accounts of stakeholders' perceptions of the factors that influence those nurses in the implementation of paediatric asthma management. Implications for future studies based on the above suggest that it would be important to evaluate the scope of these recommendations through a longitudinal study to explore and develop the identity of nurses and their role within the healthcare environment. In addition, such a study would provide invaluable evidence that could expand the understanding of the body of knowledge on issues related to the nursing management during asthma care.

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