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EDITORIAL

"THIS IS 2019! BUT I STILL NEED TO WORK DOUBLE SHIFTS AND HAVE MULTIPLE JOBS TO KEEP ME ALIVE": A PHENOMENON AMONG NURSES IN INDONESIA

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Visiting hospitals in Indonesia is one of my hobbies to observe and explore situations related to hospital services and management, especially about nursing care quality, care delivery, personnel management, and leadership, which give me the insights about the current phenomena and the gaps that need to be filled up. In addition, I will never forget to ask every nurse about his/her progress and complaint. Surprisingly, salary is still becoming the biggest concern among nurses in 2019, like three nurses said, *"there is nothing change about our salary since 5 years ago, but we are demanded to work harder", "I am not happy with my salary because we paid higher to get diploma degree, but our pay may be the same with cleaning service pay", and "this is 2019! we will never be rich if we just become a nurse in our beloved country, I still need to have double shifts or multiple jobs to keep me alive. But our salary may be a bit higher than the other nurses in the other provinces. Do you think 30 USD per month is a good salary for nurses?"* (Arifin et al., 2019).

Actually, nurse salary in Indonesia can be discussed among government and non-government employees. For nurses who are government employees, their salaries are based on a regional minimum wage in Indonesia, which is enough for nurses to live their families. However, the main issue among them is about a functional position, which is grouped into low classification (I/a-d) to high classification (IV/a-d), which influences salary they get (The Audit Board of the Republic Indonesia, 2019). In other words, the higher classification, the higher salary will be. At this point, nurses who hold a Diploma and Bachelor degree are treated the same when they become a civil servant, which is similarly classified at III/a level. This makes those who hold a higher degree feel less appreciated because they spend more time and money than those with a Diploma level. In addition, those with a Bachelor degree is often called as a first-professional degree that should have higher salary than those with a Diploma degree that is called as a technical degree (President of Indonesia, 2014). Therefore, it is expected for the government to reconsider about this regulation.

For those who are not government employees, such as contract nurses, the main issue is about the low salary under a regional minimum wage in all public health sectors in all regions in Indonesia. In fact, the issue of having salary 5-30 USD per month also still remains, even some new nurses are working voluntarily (Arifin et al., 2019; Jibril, 2019). Thus, majority of contract nurses are struggling to be a civil servant, or prefer to work in private health sectors which usually provides better compensation than public health sectors. This phenomenon leads to the next questions: "*Will Indonesian nurses stay longer in their profession? What has the Government of Indonesia been doing to improve the welfare of the nurses?"*

Does salary really matter for nurses?

Discussing about salary or a fixed amount of money is very subjective among individuals. Some people may said that salary cannot buy happiness, or lifestyle matters more than salary, while some may argue that salary is so important, especially for nurses who do not have such a good lifestyle, which they need

to work in a shift taking care for 20-30 patients per day with changeable living and sleeping time. Thus, giving enough or more salary for them is one form of appreciations of their works, regardless of their status (government or non-government employees) in both public and private sectors. Salary is one of the basic needs, which is well written by the famous theorist, Abraham Maslow, said that it is hard for employees to survive or to be motivated if the lowest level needs are inadequate (Maslow & Lewis, 1987). Thus, the government should pay more attention about this issue, as nurses are the key front of health care system.

Overview of Indonesian Nurses

Indonesia consists of multiple background of nurses, such as Diploma III, Diploma IV, Bachelor degree, Master degree/specialist, and Doctoral degree. Diploma III refers to a three year nursing program at college/university level. Diploma IV is one-year diploma program (after Diploma III) that focuses on one of clinical areas of nursing. Bachelor/Ners degree refers to a five-year program that consists of 3.5 years of academic program, and 1.5 years of profession program. Master degree refers to a two-year nursing academic program, followed by one-year specialty program in nursing based on area of interest of each nurse. Doctoral degree refers to a three-year nursing program that is more likely to focus on research (President of Indonesia, 2014). However, there is another degree established currently, namely "SMK Kesehatan", a senior high school with specialty in nursing, which is lower than a Diploma level. In addition, the government also has the idea to establish a Diploma for caregiver, which has unclear philosophy underpinning. Caregivers are not nurses. In fact, caring is the basic core of being a nurse.

Indonesia has 733 nursing schools (Aipni-Ainec, 2018), and they produce more than 100,000 nurses per year, which needs bigger capacities to absorb all nurses in both public and private health sectors. In fact, until today, Indonesia is only able to absorb 6,000 – 10,000 nurses per year (Gunawan, 2016; Gunawan & Aungsuroch, 2015a). And the others do not get better placement, some nurses work in clinics, administrations, supermarkets, banks, salons, etc.

Concerns and questions

There are five points are raised for consideration that may solve the problem of nurses salary in Indonesia. First, it is suggested to the Indonesian National Nurses Association (PPNI) to keep negotiating with the government to increase the total absorptive capacity of nurses although previous efforts such as demonstration and strike work just resulted in promises only.

Second, it is suggested to the government to stop giving a license to businessmen to open nursing schools without considering the placement of their products. Failure at this point may result in the increase of jobless nurses in Indonesia.

Third, the government should completely stop establishing senior high school level for nursing specialty and diploma for caregivers. Indonesia has nurse surplus already, which can be placed in both urban and rural areas in Indonesia. Having more different levels of nurses, which are lower than a Diploma, will not cope the problem, but adds more numbers of jobless in Indonesia. This phenomenon, however, brings a speculation if the government prefers to pay caregivers or senior high school nurses than pay Diploma nurses to reduce the health spending of the country, rather than to improve the quality of care.

Fourth, Indonesian nurses are suggested to find an alternative way by highly considering about the concept of entrepreneurship. Nurses, according to nursing act, are able to establish Independent nursing practice to serve community by giving nursing care (President of Indonesia, 2014). This definitely fits with the today's era where there is a transition from hospital-based service to community/home-based service, with nurses frequently visiting patients in their homes and interacting with the community as a whole (Mclaughlin, 2017). The technology is more likely to influence nursing practice, which is simply by one click service. So, nurses have job opportunities in more places.

Fifth, working overseas is one of the options. The whole world today needs nurses, and the receiving countries can pay higher and give more incentives. Today, India and the Philippines are the sending countries of the nurses with a lot of job opportunities and higher wages (Gunawan & Aungsuroch, 2015a), and their governments encourage them to work abroad, even there is a magic word among millennial nursing students in the Philippines, such as *"You are not competent enough if you are not working abroad"*, which motivate them to go out of their country. But, the question is "*can Indonesian nurses do that?"* Although there are some records that some nurses go to Japan, Saudi Arabia, Kuwait, USA, Canada and other countries (Gunawan & Aungsuroch, 2015b), however, this does not reduce the number of jobless nurses in Indonesia. Many nurses are still not able to take this opportunity because of the language barrier and family matter.

Conclusion

To sum up, these five points are to increase the awareness of Indonesian nurses about the phenomena in Indonesia, which can be affecting a decision-making of their lives. In addition, these points are also the subjects for further discussion among nurses, health professionals, and policy makers. However, the author emphasizes that being a nurse is not necessarily about money, but caring is the core of this profession to help others with compassion, skill and dedication.

It is also noteworthy that a nurse is also a human being that is similar with everyone else that is motivated by their basic needs such as salary to motivate and improve their performance. It is expected that for the next years the salary issue will not be the top concern among Indonesian nurses as we are now living in the fourth industrial revolution that everyone thinks creatively how to provide high quality care in simple, faster, and better way, rather than thinking of how to get paid. There should be no longer phenomena related to the basic needs among nurses in Indonesia. Like Abraham Maslow said, what is necessary change a person is to change his awareness of himself, if you deliberately plan on being less than you are capable of being,

you will probably be unhappy for the rest of your life (Maslow & Lewis, 1987).

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This is the original work of the corresponding author.

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REVIEW ARTICLE

UNDERSTANDING CLASSIC, STRAUSSIAN, AND CONSTRUCTIVIST GROUNDED THEORY APPROACHES

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Abstract
Grounded theory has been utilized in nursing research in order to develop theory from data. Since there are three approaches in the grounded theory methodology that consist of Classic grounded theory, Straussian grounded theory, and Constructivist grounded theory, thus understanding about perspective of each approach is needed. Those approaches have different points of views regarding the philosophical position, role of literature review, and coding process in data analysis. This review provides an understanding about the grounded theory approaches for researchers particularly the novice researchers, and selects an appropriate approach in their study.

KEYWORDS
Classic grounded theory; Straussian grounded theory; Constructivist grounded theory; literature review

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INTRODUCTION

Grounded theory is one of research methodologies in qualitative research that is widely known in a variety of disciplines such as education, economic, politic, psychology, and also nursing (Glaser & Strauss, 1967). This methodology is used to explore, develop, and describe social processes using the perspectives of the people experiencing the social problem or the phenomena being studied (Birks & Mills, 2012).

Grounded theory has been utilized in nursing research since Glaser and Strauss developed the original grounded theory. It was first introduced around the 1960s in the School of Nursing, University of California by two sociologists, Barney G. Glaser and Anselm L. Strauss. They studied about dying in hospital and collaborated to publish 'The Discovery of Grounded Theory in 1967'. Glaser is a sociologist who graduated in the doctoral program at the University of Colombia, which is known to have a quantitative tradition. He was influenced by Paul Lazarsfeld and Robert K. Merton who are known as innovators of quantitative methods. In contrast, Strauss graduated from Chicago University and was influenced by famous sociologists such as George Herbert Mead and Herbert Blumer. Therefore, he had a strong tradition in qualitative methods and was influenced by the writings of pragmatists and symbolic interactionists (Birks & Mills, 2012; Corbin & Strauss, 2015; Glaser & Strauss, 1967).

After published their book, they decided to work independently due to their different perspectives in the application of methodology approaches. Glaser worked alone and developed grounded theory approach that is common called Classic grounded theory, while Strauss asked Juliet Corbin (a nurse researcher) to work together. In 1990, Strauss and Corbin

published "Basic of qualitative research: Grounded theory procedures and techniques". Strauss and Corbin have been known as the second-generation grounded theorists and developed Straussian grounded theory approach. Over the year, Kathy Charmaz, a student of Glaser and Strauss from the University of California, has her own perspectives. Charmaz has been known as the third-generation grounded theorist since she developed a new approach of grounded theory, which is called as Constructivist grounded theory (Birks & Mills, 2012; Charmaz, 2006; Corbin & Strauss, 2015; Glaser & Strauss, 1967).

Given the multiple approaches of grounded theory among the experts, it potentially leads to confusion and debate in novice researchers to understand the theory. Therefore, this paper aimed to discuss the differences of three-grounded theory approaches by describing the philosophical position, role of researcher, place of literature review, research questions, and coding process.

Philosophical Position

Symbolic interactionism is a philosophical root of grounded theory (Aldiabat & Navenec, 2011). Symbolic interactionism is an empirical social science perspective that studies human group life and human conduct, and focuses on human behavior. This philosophy emphasizes on seeing the world by interpreting human interaction, which uses symbols to give meaning or value (Blumer, 1986). Therefore, in a grounded theory study that uses a philosophy of symbolic interactionism, the researcher needs to understand how the social interaction and the meaning that the participants give to their experiences shape their behaviors (Aldiabat & Navenec, 2011).

Blumer (1986) specified three basic premises to clarify the application of symbolic interaction. First, humans act toward things on the basis of the meaning that they hold and "things" can be defined as everything a person interacts with during her/his life. Second, the meaning of things is developed from social interaction with other people. The source of meaning for symbolic interaction is collective and not intrinsic to objects (Blumer, 1986). Mead (1962) as cited in Blumer (1986) stated that people do not only imagine their position in other people, but also in the objects and places that interact with them. Consequently, inanimate objects can influence human responses and interactions (Pascale, 2011). Third, the meanings are modified by an interpretive process. Everyone's reality differs and how they define specific meaning depends on the consensus among people and processes of interpretation. Also, perceptions of symbols can change and impact either negatively or positively on a person's reaction to health problems. Pascale (2011) stated that a sense of meaning involves an interpretive process during an individual's communication with him/herself. He/she may suspend, re-form or change meanings.

Over the year, grounded theorists show a variety of philosophical beliefs and differentiate their studies. Their differences of philosophical position were in the way to understand about reality (ontology) and how to get the knowledge (epistemology) (Singh & Estefan, 2018). Consequently, their philosophical viewpoints influence on their grounded theory perspective (Singh & Estefan, 2018).

Glaser (1978) considers going further with positivist philosophy in Classic grounded theory approach. He believes that a phenomenon of study should reflect a social process (Glaser, 1978). Positivists view the reality exists in the field, and also adopt an objectivist epistemology that emphasize independently of human interaction (Hall et al., 2013). This perspective leads Glaserians view that the reality is independent of researchers, and the researchers should do a passive approach. The researchers can understand the reality by remaining their objectivity and letting the data manifest itself. Glaser (1978) believes that the personal bias of researcher will contaminate the data.

Strauss' background led the philosophical position of Straussian grounded theory approach, which was influenced by interactionism and pragmatism. Pragmatists believe that the truth is temporary, conditional, and an evolutionary action. The truth lives, but it is not ready-made and is waiting to be discovered. Pragmatism emphasizes on practice as consequences to determine the meaning or truth (Corbin & Strauss, 2015; Pascale, 2011). Therefore, Strauss and Corbin viewed that the reality needs to be constructed, and it is asserted the possibility of multiple perspectives. However, to develop theory that describes knowledge, the researchers' ability is needed, which should use systematically approach in order to avoid subjectivity of researchers and maintain an objective view (Strauss & Corbin, 1998). The epistemological position encourages the researcher is not separated from the method, thus, the researchers actively involve and develop the theory together with the focus of the inquiry (Strauss & Corbin, 1998).

Constructivist grounded theory approach also has a distinct philosophical position from both of Glaser and Strauss's perspectives. Charmaz (2006) offered a Constructivist perspective that believed in the possibility of multiple perspectives of reality. Reality is change over time and as an outcome of researchers' interpretation (Charmaz, 2006). Constructivist grounded theory approach maintained much of Classic grounded theory approach (Hall et al., 2013). However, Charmaz (2006) has different views on how to get the knowledge of reality. She encourages the researchers to engage with the multiple views of phenomenon and make multiple interpretations. Therefore, this approach is based on previous experiences of researchers (Charmaz, 2006).

Since the three grounded theory approaches have derived from the root of grounded theory's philosophy, they have similarities of common origin of methodology, such as obtaining data from natural setting, applying theoretical sampling as an analytic tool, and doing data collection and analysis simultaneous (Singh & Estefan, 2018). However, each philosophical position also influences their opposing methodological approach, such as the role of the researchers, the place of the literature review, the research questions formulation, and the coding process, as discussed in the following sections.

Role of Researchers

The three grounded theory approaches have their own philosophical position, and those approaches will guide each grounded theorist in positioning the role of researchers to work with participants, approach to data and analysis, and formulate theory in order to gain knowledge about the reality (Birks & Mills, 2012). According to philosophical orientation of Glaserian grounded theory, Glaserian positioned the role of researcher as a distant observer and independent researcher. It reflects the view that the researcher and participants' relationship should be objective, and Glaser encouraged the researcher to find 'true meaning' (Glaser, 1978). This approach leads to a theory emerging directly from the data to avoid any bias or the researcher's interpretation (Hall et al., 2013; Lauridsen & Higginbottom, 2014).

Contrarily, Strauss and Corbin viewed the truth is a result of interpretation and construction by a researcher. Thus, the analysis of data requires the involvement and interpretation of the researcher, or the researcher is a part of the method (Hall et al., 2013; Strauss & Corbin, 1998). In other words, the Straussian approach encourages interactive relationship with participants and the intensive involvement of the researcher in the development of the theory. However, the researchers should maintain their objective view by keeping a distant from data and analysis through systematic approach (Strauss & Corbin, 1998).

For Constructivist grounded theory approach, Charmaz (2008) stated that the generated theory is co-constructed data collected by the researcher from the constructions of the participants from interaction. Researchers should take an active role by engaging passionately in the process of theory construction. Therefore, researchers cannot be separated from their research. The reality will be discovered by mutual relationship between the researchers and the participants (Charmaz, 2006).

Place of Literature Review

In terms of the place of the literature review, the Glaserian approach warns the researchers not to review literatures in the substantive and associated area before collecting data to avoid their ideas that influence the data. Additionally, reading the literature can restrict the freedom needed to discover a theory (Glaser, 1998; Walls et al., 2010). Glaser (1978) encouraged researchers to be open and trust in emergence of theory. However, Glaser (1998) recommended to review literatures in the substantive area and link it into the theory to a constant comparison when the last stage of grounded theory or in the stage of writing up the study.

Contrarily, the Straussian grounded theory approach suggests using the appropriate literatures before going into the field and every stage of the study. The researchers must be familiar with and have a clear understanding of the substantive knowledge (Strauss & Corbin, 1990). Therefore, this approach encourages the researchers to review the literatures and extant theories before collecting data as part of the preparation of the research, particularly for novice researchers (Hall et al., 2013; Lauridsen & Higginbottom, 2014). Early and on-going review of literatures is useful to enhance theoretical sensitivity, provide secondary sources of data, provide an inspiration to make some questions for interview, guide in determining of theoretical sampling, and facilitate a supplementary validation (Corbin & Strauss, 2015; Strauss & Corbin, 1990). However, Strauss and Corbin (1990) cautioned that "we do not want to be so steeped in the literature as to be constrained and even stifled in terms of creative efforts by our knowledge of it".

Similar with Straussian grounded theory, Charmaz (2006) also encouraged the researcher to do literature review. However, review should be done in a specific literature and compiled in a short section of paper. Furthermore, Charmaz (2006) recommended holding a comprehensive literature review after data analysis to facilitate the openness and creativity of researcher. The short section is needed to give the researchers a foundation to discuss with the area of study (Charmaz, 2006).

Research Question

In regards to the formulation of research question, Glaser (1978) stated that the research questions should comprise of the six-Cs, which are causes, contexts, contingencies, consequences, covariances, and conditions. In Classic grounded theory, the research questions should be based on general sociological perspective and general subject or problem area (Glaser & Strauss, 1967). In Straussian grounded theory approach, the research question should explain about the specific topic area (Corbin & Strauss, 2015). In addition, its form should identify the phenomenon and subject of the study (Strauss & Corbin, 1990). In Constructivist grounded theory, its research question is similar to Straussian that focuses on particular topic area. However, Strauss and Corbin (1990) mentioned that this specific issue can be generalized in broader context, while Charmaz (2006) mentioned that this local topic area is for local context only.

Coding Process

In the data analysis process, coding is the essential analytical process that is used to develop a theory. Actually, the three grounded theory approaches use the same terms in the coding processes. However, the performance of each process is conducted in different ways.

Originally, Glaser and Strauss (1967) described two levels of coding: substantive coding and theoretical coding. Glaser and Holton (2004) collaborated and presented the coding procedures of Classic grounded theory with increasing lucidity while maintaining the original coding procedure. They described that substantive coding is comprised of open and selective coding (Glaser & Holton, 2004). With this coding procedure the theory will be naturally emerged from the content of data. Therefore, the essential attitudes of the researchers during the coding procedure are being patience, trust that the theory will emerge, and careful and rigorous to employ the constant comparison technique, which make the data will be objective (Kenny & Fourie, 2015).

Strauss and Corbin (1990) proposed different level of coding procedures that consist of open coding, axial coding, and

selective coding. These procedures are more specifics that provide step-by-step fashion. In axial coding, researchers are required to generate categories and connections between them by using the paradigm model as guidance. The paradigm model consists of causal conditions as sets of events or situations that influence a phenomenon, action/interactional strategies as the tactics of a person to handle situations, problems, and issues; and consequences as the outcome of strategies (Corbin & Strauss, 2015; Kenny & Fourie, 2015; Strauss & Corbin, 1990). But, this complex structure is criticized by Glaser (1992) due to the researcher is forcing the data and lost its nature. Charmaz (2006) also criticized that Strauss and Corbin changed the coding guidelines from original flexible to immutable rules. However, Strauss and Corbin (1990) clarified that the application of coding procedure should be flexible. They also argued that this paradigm model would guide and facilitate an accurate and systematic data analysis to create the theory.

Moreover, Charmaz's Constructivist approach also resists Straussian grounded theory approach to the coding processes. Charmaz (2008) argued that Straussian's coding process stifles and suppresses the researcher's creativity. She emphasized that the principle of flexibility is that the researcher has to learn to tolerate ambiguity and become receptive to creating emergent categories and strategies. The coding procedure of this approach consists of initial coding and focused coding. It emphasizes on interpretative of researcher based on intensive interviews. These interviews are analyzed and presented in the form of telling as the conceptualization and conclusion of the research (Charmaz, 2006). Glaser (2002) criticized that the Constructivist approach more emphasizes on description of participant's experiences, and facilitate the researcher to recast the participant's experiences, which contradicts the true conceptual nature. However, Charmaz (2006) argued that we are part of the world we study and the data we collect, thus it is impossible to avoid the interaction of researchers on data.

CONCLUSION

This paper provides an overview of Classic, Straussian, and Constructivist grounded theory approaches. These three approaches have different perspectives regarding to the philosophical position. In consequence, each grounded theory has divergent methodological approach, such as the role of researchers, the place of the literature review, the formulation of research question, and the coding process of data analysis. According to this review, researchers can select the three approaches and methods of grounded theory underpinning their study.

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ORIGINAL RESEARCH

PERCEPTIONS AND ATTITUDE ON USING SOCIAL MEDIA RESPONSIBLY: TOWARD SOCIAL MEDIA LITERACY IN NURSING EDUCATION

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Abstract

Background: As future professionals, nursing students are expected to exhibit online professionalism and to be responsible users of social media. However, the rapid sharing of information on social media exposes nursing students to the risk and danger of spreading unprofessional behaviors like breaches of privacy and confidentiality.

Objective: This study looked into the nursing students' perceptions and attitude toward responsible use of social media.

Methods: A descriptive cross-sectional research design was utilized and participated by 298 nursing students in a College of Nursing in Iloilo City, Philippines. The Responsible Use of Social Media Attitude Scale (RUSMAS) created by the researchers was used to collect the data.

Results: Findings indicated that nursing students widely use social media and that nursing students had good perceptions and had positive attitude toward responsible use of social media. A significant difference was found in the attitude of nursing students when grouped according to year level.

Conclusion: Social media continue to gain interest among nursing students and using it responsibly must be continuously upheld. Academic nursing institutions should develop approaches promoting social media literacy in nursing education.

KEYWORDS
nursing students; nursing education; professionalism; social media; social media literacy

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INTRODUCTION

Social media which include a mixture of online tools and Web-based technologies via the internet like Facebook, Twitter, and Youtube have become a popular communication system of choice and popular activity among students (Nyangeni et al., 2015). Social media sites are generally used to communicate with others by sharing personal information, photos, videos, comments, etc., and therefore have user-generated or user-created contents (Berthon et al., 2015) that must be used responsibly. As consumers and creators of social media contents, it is common to assume that social media users are responsible for the contents posted or shared on these platforms.

Responsible use of social media is linked to terms like digital, online or e-professionalism (Cain et al., 2009; Duke et al., 2017; Jackson et al., 2018; Prescott et al., 2013), social media etiquette (Harrison et al., 2014) and cybercivility (De Gagne et al., 2016; Marnocha et al., 2017). Likewise, responsible use of social media relates to social media literacy or the competent handling of contents published on social media platforms (Beheshti-Kashi & Makki, 2015).

Social media offer many benefits since these platforms have no limitations in terms of time, place and distance (Nyangeni et al., 2015). As with any technology, there are also legal and ethical

issues associated with its use (Nyangeni et al., 2015; Ross & Myers, 2017) that can have potential implications on one's professional fitness to practice (Kenny & Johnson, 2016). It is within the legal and ethical responsibility of nurses to maintain the privacy and confidentiality of their patients (Nyangeni et al., 2015). The Code of Ethics for Nurses by the International Council of Nurses (2012) and the Philippine Board of Nursing (2004) strongly dictate that nurses should keep confidential information private. On the legal aspect, federal laws like the Health Insurance Portability and Accountability Act (HIPAA) of 1996 in the United States have a primary goal of protecting the confidentiality and security of healthcare information (U.S. Department of Health and Human Services, 2013). In the Philippines, Republic Act 10173 or Data Privacy Act mandates that the human right of privacy must be secured and protected (National Privacy Commission of Philippines, 2012). As the popularity of social media continue to grow, healthcare professionals need to be mindful of their professional interactions either face-to-face or in the online environment (Nason et al., 2018). There are international and local news reports as well as pieces of anecdotal evidence that nurses get terminated or even sued after posting offensive, sensitive or confidential information on social media. More importantly, the misuse of social media can potentially jeopardize the nurse-patient relationship (Smith & Knudson, 2016).

Usage of social media is not only limited among professional nurses but involves nursing students as well (Wahila et al., 2018). In nursing education, social media is beginning to be integrated into the undergraduate nursing program as an innovative teaching strategy (Ross & Myers, 2017). However, misuse and irresponsible use of social media may result to disciplinary actions and program dismissal (Westrick, 2016). Unfitting online activities possess a risk to the reputation of universities and teaching programs, hence students should be educated on the dangers of social media (Nason et al., 2018).

Issues of professionalism on social media are prevalent (Soares et al., 2017) causing emerging concerns in the medical and allied health professions education. Previous studies have documented that students engage in unprofessional behaviors on social media. One survey reported that of 293 schools of nursing, 77% encountered at least a single occurrence of students posting unprofessional content on social media (Marnocha et al., 2015). Misconduct and indiscriminate use of social media by nursing students have also been reported in South Africa (Nyangeni et al., 2015). A study in Canada revealed that all nursing students conveyed they had posted information on social media that they would not have any desire to be seen by a future employer or member of the academic staff (Duke et al., 2017). Another study disclosed that posting of unprofessional content was highly prevalent among medical students despite awareness of professionalism guidelines (Barlow et al., 2015). There was also a concerning level and exposure to unprofessional and inappropriate social media content among dental students (Kenny & Johnson, 2016; Nason et al., 2018).

Perceptions, beliefs, and feelings are affective and cognitive components of attitude (Pickens, 2005). Attitude is theorized to influence behavior. According to the Theory of Planned Behavior, attitude is a determinant of behavioral intention (Ajzen, 1991). That being said, the attitude of nursing students toward social media may influence their behavior. It has been documented that nursing students' unethical behavior is significantly related to their use of social media (Smith & Knudson, 2016). As nursing schools continue to produce future professional nurses, there is a need to explore nursing students' views regarding the responsible use of social media to prevent impending online misconduct and avoid legal and ethical issues that may arise regarding the use of social media.

While the use of social media among nurses and nursing students have been previously investigated, there is a dearth of study on social media use among nursing students in the Philippine setting. The aim of this study was to determine the perceptions and attitude toward responsible use of social media among nursing students and whether or not significant differences existed in their attitude when grouped according to sex, year level and hours spent daily on social media.

METHODS

Study Design

A descriptive, cross-sectional survey research design was utilized in this study.

Setting

This study was conducted in a College of Nursing located in Iloilo City, Philippines and self-reported data were collected between August to September of 2018 during the first semester of academic year 2018 to 2019.

Participants

A total of 298 nursing students (141 first-year and 157 fourth-year) participated in the survey. All nursing students who were willing to participate and who were available at the time of the conduct of the survey were included. This study involved only first and fourth-year nursing students since these were the only existing year levels in the College where the study was conducted. The University opted not to accept first-year college enrollees in 2016 and 2017 to prepare for the implementation of the new curriculum in its colleges. This was also a consequence of the transition of the country's educational system into the K to 12 program.

Instrument

The data were gathered using the Responsible Use of Social Media Attitude Scale (RUSMAS). The RUSMAS is a researcher-made, self-administered questionnaire developed to assess the perceptions of nursing students toward responsible use of social media. The development of items in the RUSMAS was based on relevant existing literature. Identification of unprofessional behaviors was based on the work of Barlow et al. (2015). The scale was subjected to face and content validation in a panel of four (4) jurors: faculty members in the

College of Nursing and College of Communication, a lecturer of the Bioethics course in Nursing, and a professor with a degree in Information Technology and Nursing. Jurors were asked to evaluate each item on the scale for relevance and clarity. Irrelevant items were removed and ambiguous items were revised for clarity. The comments and suggestions of the validators were incorporated in the final version of the scale. The participants were asked to indicate their responses to the items using a 5-point Likert scale format ranging from "1 = strongly disagree" to "5 = strongly agree". For the scoring of attitude, a "strongly agree" response was given a score of 5 for items 1 to 6 while scoring was reversed for items 7 to 14. It must be noted that the sequence of items on the actual questionnaire is not similar as it appears on this report. Moreover, the following interpretation of mean was used: 1.00-2.33 = negative attitude; 2.34-3.66 = ambivalent; and 3.67-5.00 = positive attitude. A pilot study was conducted among 33 nursing students in another College of Nursing in the City to ensure the clarity of items of the scale. The RUSMAS has a reliability of Cronbach's alpha values ranging .65 to .76 based on the pilot and actual survey data.

Data Analysis

All statistical computations were carried out using SPSS version 23. Mean, standard deviation, t-test and ANOVA were used to analyze the data. A p-value less than .05 was considered significant.

Ethical Consideration

Ethical conduct of research was followed in the entire duration of the study. Initially, written permissions to conduct the study were secured from appropriate academic heads of the College. Written informed consent was then obtained from the participants as a manifestation of their voluntary involvement in the research. Full disclosure of the study was given and the participants were assured of their confidentiality and anonymity. No formal ethics review committee scrutiny was undertaken for this study. Nevertheless, the technical and ethical soundness of the study was reviewed by the thesis panel of the College. The University has not fully instituted ethics review for all types of research. The National Ethical Guidelines for Health and Health-Related Research states that research not involving more than minimal risks or survey procedures may be considered by the Research Ethics Committee for exemption from review (Philippine Health Research Ethics Board, 2017).

RESULTS

Table 1 shows that on the average, nursing students strongly agreed that social media posts should be thoroughly thought out (M=4.58; SD=.82) and that clinical cases of patients should not be shared on social media (M=4.49; SD=1.01). Moreover, nursing students agreed that only genuine news should be posted (M=4.16; SD=1.11), everything should be direct and clear when commenting (M=4.04; SD=.91), it is not a good idea to post photos or videos taken in a clinical environment (M=3.78; SD=1.20) and it is bad to swear (M=3.61; SD=1.07) on social media. On the other hand, nursing students generally disagreed that fake name or pseudonym on social media profile is considered "cool" (M=2.07; SD=1.03). They also disagreed in statements stating that it is okay to accept a friend request from a complete stranger (M=1.93; SD=.95) and to post photos or videos while smoking (M=1.83; SD=1.04). Furthermore, nursing students strongly disagreed that confidential information of patients can be posted on social media (M=1.59; SD=1.17). They also strongly disagreed in statements that convey it is appropriate to support posts containing racism (M=1.55 SD=.99), it is fine to post photos or videos that contain people on illegal drugs (M=1.49; SD=.83), it is acceptable to bash to hate others (M=1.48; SD=.83) and it is alright to post sexually suggestive acts and contents (M=1.41; SD=.74) on social media. Overall, nursing students had positive attitude toward using social media responsibly (M=4.23; SD=.42).

Table 1 Perceptions and Attitude Toward Responsible Use of Social Media

Category	M	Description	SD
1. Social media posts should be thoroughly thought out.	4.58	Strongly Agree	.82
2. Clinical cases of patients should not be shared on social media.	4.49	Strongly Agree	1.01
3. Only genuine news should be posted on social media.	4.16	Agree	1.11
4. When commenting on social media, everything should be direct and clear.	4.04	Agree	.91
5. It is not a good idea to post on social media photos or videos taken in a clinical environment.	3.78	Agree	1.20
6. It is bad to swear on social media.	3.61	Agree	1.07
7. Fake name or pseudonym on social media profile is considered "cool".	2.07	Disagree	1.03
8. It is okay to accept a friend request from someone who is a complete stranger.	1.93	Disagree	.95
9. Posting photos or videos on social media while smoking is okay.	1.83	Disagree	1.04
10. Confidential information of patients can be posted on social media.	1.59	Strongly Disagree	1.17
11. Supporting social media post that contains racism is appropriate.	1.55	Strongly Disagree	.99
12. It is fine to post on social media photos or videos that contain people on illegal drugs.	1.49	Strongly Disagree	.83
13. Offending in the means of bashing or hating others on social media is acceptable.	1.48	Strongly Disagree	.83
14. It is all right to post sexually suggestive acts and contents on social media.	1.41	Strongly Disagree	.74
Overall	4.23	Positive Attitude	.42

Table 2 Differences in Attitude Toward Responsible Use of Social Media

Variable	N	M	SD	Interpretation	t/F	df	Sig.
Sex					-1.242	296	.215
Male	79	4.18	.45	Positive attitude			
Female	219	4.25	.41	Positive attitude			
Year Level					3.385	294	.001*
First Year	141	4.32	.41	Positive attitude			
Fourth Year	157	4.16	.42	Positive attitude			
Hours Spent Daily (M = 4.7)					1.411	294	.240
1-2 hours	46	4.15	.47	Positive attitude			
3-4 hours	108	4.28	.40	Positive attitude			
5-6 hours	96	4.25	.42	Positive attitude			
7 hour and above	48	4.18	.40	Positive attitude			

**significant if p < .05*

Table 2 shows that on average, nursing students use social media for about 5 hours (M=4.7). The t-test and ANOVA result revealed that there were no significant differences in nursing students' attitude toward responsible use of social media according to sex (t(296) = -1.242, p = .215) and hours spent daily on social media (F(294) = 1.411, p = .240). However, while both first and fourth-year nursing students posted positive attitude toward responsible use of social media, statistical analysis using t-test revealed a significant difference in the attitude of nursing students according to their year level (t(294) = 3.385, p = .001). First-year nursing students (M=4.32; SD=.41) had a better attitude than fourth-year nursing students (M=4.16; SD=.42).

DISCUSSION

This study assessed the perceptions and attitude of nursing students toward responsible use of social media. Understanding the demographics and perceptions of students are imperative in developing better student guidelines related to social media literacy. While it is considered essential to back the results of this present investigation with related studies regarding perceptions and attitude toward responsible use of social media, there is a paucity of published information regarding differences in attitude on the responsible use of social media among nurses and nursing student cohort. Nevertheless, prior studies available to the researcher to substantiate the findings of this study are discussed.

In this study, there is a high report of daily usage of social media among nursing students. This is consistent with earlier findings where both students and faculty widely use social media (Cain et al., 2009; Duke et al., 2017; Kitsis et al., 2016).

This study also found that nursing students had positive attitude and had good perceptions about using social media responsibly. Perhaps, this may be attributed to the fact that issues relating to privacy, confidentiality, and maintaining professionalism whether in person or online are being upheld in nursing school. This result is consistent with most of the studies pertaining to attitude toward social media concerning professionalism, privacy, and confidentiality. Jordanian student nurses held positive attitude toward professional and academic use of social media (Al-Shdayfat, 2018). It was also reported that dental students were aware of the relationship between social media use and professional practice and considered that it is unprofessional to post drunken photographs and interact with staff and patients online (Kenny & Johnson, 2016). At the same time, nearly all students, including nursing students in UK University were aware of the availability of Facebook's privacy settings and used them to limit public access to their profiles (Prescott et al., 2013). Likewise, it was also noted in previous studies that students were aware and concerned of breach of confidentiality when posting patient identifiers on social media platforms (Barnable et al., 2018; Marnocha et al., 2015). Student concerns about educational and professional affiliations on social media were also documented (Marnocha et al., 2015). On the contrary, among pharmacy students, many felt that they should not be held accountable to authority figures for information posted on social media (Cain et al., 2009).

It is significant to note that while nursing students in this study generally had favorable attitude toward using social media responsibly, looking closer at the numerical mean (5 as the highest), not all students in this study strongly agreed that clinical cases of patients should not be shared on social media. Likewise not all strongly disagreed that confidential information of patients can be posted on social media. It has been held that details of diagnosis, procedure, or emergency medical event in the clinical setting can lead to the inadvertent release of the patient's identity on social media among those familiar with the healthcare facility (Reiling, 2006). Therefore, it is important to consistently enhance social media literacy among nursing students to properly address professionalism concerns as reports of irresponsible and indiscriminate use of social media are prevalent in medical and nursing literature (Barlow et al., 2015; Duke et al., 2017; Kenny & Johnson, 2016; Nason et al., 2018; Nyangeni et al., 2015). Issues related to context, clarity, and confirmability in the use of social media

must be taken into consideration (Ryan, 2018). In this digital age, nursing students do not only require guidance in the areas of academic, social and career aspects (Oducado et al., 2017) but as well as in using social media responsibly.

This study also revealed that not all nursing students seem to strongly agree that it is not appropriate or acceptable to swear and to bash or hate others on social media. Students may view these types of posts as simply personal expressions. However, any perception of disrespect can be viewed negatively and can be disadvantageous to the professional reputation of a nursing student (Edge, 2017). Moreover, not all nursing students in this study seem to strongly agree on the idea that certain behaviors on social media such as using fake names, posting smoking, and sexually suggestive acts are inappropriate, unacceptable or unprofessional. This can be due to the idea that except for privacy and confidentiality related concerns, consensus on what constitutes unprofessional behaviors remain vague and unclear (Soares et al., 2017). This is supported in a study where nursing students' lack of awareness of a universally acceptable description of responsible use of social media resulted to varying perceptions on how to use it responsibly (Nyangeni et al., 2015). Likewise, it was earlier reported that students of healthcare courses had varying definitions of cyberincivility (De Gagne et al., 2016). On the other hand, while the use of fake names may not be considered by some to be an unacceptable behavior on social media, the proliferation of fake social media accounts is argued to likely perpetuate behaviors like cyberbullying (Barlett et al., 2018).

Moreover, no significant difference in the attitude of nursing students toward social media in terms of sex was disclosed in this study. In the same way, a prior study found no significant difference in the attitude toward privacy in social networking sites between male and female students (Kim & An, 2017). However, one study revealed significant differences in sex regarding accountability related questions on social media (Cain et al., 2009). For example, female students pointed out that individuals should be held accountable for unprofessional attitude on Facebook (Cain et al., 2009).

This study as well demonstrated that there is no significant difference in the attitude toward responsible use of social media according to hours spent on social media daily. Regardless of how many hours they use social media in a day, nursing students in this study had positive attitude on social media. On the contrary, it has been reported that nursing students' unethical behavior is significantly related to their social media usage (Smith & Knudson, 2016).

Surprisingly, this study indicated a significant difference in the attitude toward responsible use of social media between first-year and fourth-year nursing students in favor of the first-year students having better attitude. This is opposed to the popular belief that as students progress through the university and become familiar to the professional school climate, they become more aware of professionalism (Prescott et al., 2013). As neophytes in the nursing program, first-year nursing students in this study may feel more compelled to behave appropriately and follow the rules compared to the senior ones. Moreover, senior ones may have gained more confidence in dealing with professionalism issues or may have strengthened their positions to certain behaviors on social media that could be considered vague and elusive. Similarly, a previous study found that there were significantly more third year than first-year students who agreed that students in their profession should not register on Facebook (Prescott et al., 2013). Varying opinions based on educational status on whether Facebook profile information should be referenced for hiring decisions of employers was also noted in an earlier investigation (Barnable et al., 2018). Likewise, a study found that second-semester students had less unethical behavior than other students (Smith & Knudson, 2016). Another study even reported that younger nursing students had better skills in using social media applications (Tuominen et al., 2014). In contrast, it was previously revealed in a study that there was no association between year of medical school and posting of unprofessional content on social media (Kitsis et al., 2016).

Notwithstanding the interesting findings, this study has its limitations. This study is limited to a single college of nursing in two-year levels limiting the generalizability of the results. A larger sample size for future research that may involve different year levels may be considered. Also, this study used self-report data. While self-report is generally used to study attitude and perceptions, this is subject to self-report bias. Also, some listed unprofessional behaviors such use of fake names may be considered subjective as certain unprofessional online behaviors remain unclear. Moreover, the study may have benefited from an additional qualitative investigation to support the quantitative aspect of the study. Due to these limitations, the researchers recommend using caution in the analysis and interpretation of the findings of this present study. Nevertheless, this study contributed to the existing body of knowledge about responsible use of social media, online professionalism or social media literacy among nursing students. More importantly, the findings contributed to the limited literature about social media literacy and responsible use of social media of nursing students in the Philippine setting.

CONCLUSION

Extensive use of social media remains to be pervasive in nursing education and nursing students have good cognitive evaluations on the responsible use of social media. Nevertheless, students must be reminded always to consider the potential effects of their social media use. Continuous guidance and effort to raise social media literacy and prevent cyberincivility are imperative in the undergraduate nursing program. Nursing schools must provide clear expectations of acceptable student behaviors online such as specifying social media behaviors that could lead to disciplinary action. Moreover, specific and up-to-date policies must be in place within academic nursing institutions on what constitutes unprofessional, unethical, and unacceptable behaviors on social media. Without proper guidance and awareness of professional conduct on social media, a potential rise in the number of

unprofessional behaviors on social media can be anticipated that may steer ethical and legal consequences.

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Authors Contribution
All authors have contributed from conception to the finalization of this study. Most of the significant intellectual content of this publishable copy of the article was done by the corresponding author.

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ORIGINAL RESEARCH

MASCULINITY, ILL HEALTH, HEALTH HELP-SEEKING BEHAVIOR AND HEALTH MAINTENANCE OF DIABETIC MALE PATIENTS: PRELIMINARY FINDINGS FROM BRUNEI DARUSSALAM

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Abstract

Background: Literature revealed that men tends to use healthcare services much lesser and visit much later, resulting in poor health outcomes. This is often regarded as a way of exhibiting masculinity. In Brunei, there is an increasing number of mortality resulting from the complication of diabetes mellitus, a non-communicable disease, which arguably can be prevented.

Objectives: To explore their health-help seeking behavior and health maintenance pattern of male diabetic patients in Brunei.

Methods: Qualitative research guided by phenomenology research design. COREQ Checklist was used to prepare the report of this study. Individual semi-structured interview on eleven men were conducted from February to November 2018. Interviews were audio-recorded, transcribed and analyzed thematically.

Results: Three themes were developed: "*Maintaining health to enable the performance of masculine roles", "Men delay seeking healthcare services", and "Maintaining control and self reliance in looking after own sick body".*

Conclusion: Health is perceived as important - it enables men to perform their 'masculine responsibilities'. When men are in ill-health and realized how this could jeopardize their masculine roles, they would actively involve in taking care of their own body. This suggested how masculinity is in fact context –dependent. Level of knowledge and experiences with healthcare services and treatments also influenced men decision in health-help. Despite evidence that suggests how men often decline involvement with health promoting activities and delay seeking health from healthcare professionals, it was found that being able to continue supporting their family act as a legitimate reason for them to access healthcare services.

KEYWORDS: men; health maintenance; diabetic

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INTRODUCTION

Diabetes mellitus (DM) is a non-communicable disease affecting significant global health. Epidemiological evidence suggests that without effective prevention and control programs, the prevalence will continue to increase globally (International Diabetes Federation, 2006). In Brunei, diabetes is the third leading cause of death from 2012 to 2017. Diabetes and diabetes-related complications could lead to blindness, renal failure, myocardial infarction, stroke and lower limbs amputations resulting in premature adult mortality, as almost half of all diabetes-related deaths occur before the age of 70 (World Health Organization, 2016).

This study focuses on men due to the compelling epidemiological data, which showed that men have a lower life expectancy and poorer health outcomes in comparison to women (Richardson, 2004). Prior studies suggests that men have different ways of maintaining their health, such that men often decline to take part in any health promoting activities (Courtenay, 2000). Moreover, men are often reluctant to visit their GP and even if they do visit, it is often too late to prevent or treat. Literature revealed that men tends to use healthcare services much lesser and visit much later, resulting in poor health outcomes. This is often regarded as a way of exhibiting masculinity (Courtenay, 2000).

In 2014, the percentages of people with diabetes in Brunei were 8.9% in male and 9.2% in female. The Ministry of Health revealed an increased in male mortality rate of 11.1% in 2015, and a slight increase of 9.3% for female. The increased mortality rate in male resulting from complication of DM reflected the lifestyle, health awareness and health maintenance. Although there are limited studies on health maintenance for diabetic men, few studies highlight the importance of health maintenance in men, and their risk taking behaviors were found but none were looking specifically from the lens of men and masculinities.

BACKGROUND

Bateman (1990) found that adolescent diabetic men struggle to achieve "normal" development, as a consequence of the daily insulin injections and strict glucose monitoring. It could be argued that adolescents are rebellious, and rejection of and poor adherence to treatment are common (Lewin et al., 2005).

King et al. (2017) argues that the management of DM faces challenges to attain an optimal health care. Diabetes management relies on the patient's responsibility, which may be difficult with the addition of other physiological and sociological stresses in their lives. Therefore, it is important to look into their attitudes and perceptions on the long-term effects of DM, and explore their knowledge on health management to prevent complications.

Moreover, it could be considered that gender is a risk factor for many diseases. In regards to male, this is due to the social construction of masculinity and how it affects health-seeking behavior. According to Galdas et al. (2005), men experiencing illness often delay in seeking help, because men are expected to be strong and independent. Additionally, Del Mar García-Calvente et al. (2012) posits men as 'reluctant users' of health care services. Unless there is strong legitimate reason, men would avoid or delay in seeking help from health care professionals. Consequently, this affects their overall health.

Healthcare system in Brunei

There are four major government hospitals in Brunei, with one in each district. Medical services are free and easily accessible for its citizens. Therefore, getting treatments or visiting a doctor is not a problem. However, despite this, there is a high incidence of DM and its related complications in the country. Recently in Brunei, there is no evidence to support what diabetic Bruneian men do to maintain their health or whether they seek professional help. This study aimed to explore the health maintenance pattern and the health help-seeking behavior of male diabetic patients in Brunei Darussalam.

METHODS

Design

Qualitative study guided by phenomenological research design.

Participants

The study was conducted from February to November 2018, at one the main hospital in Brunei. Eleven participants (N=11) were interviewed individually (Table 1). The gatekeeper helped to disseminate posters containing information about the study. Information about the study that was provided on the posters includes, brief background of the study, aims and significance of the study, data collection method, issues of confidentiality and contact detail of the researcher.

Interested participant contacted the researcher via phone and appointment was made for the interview. These participants were recruited purposively. The inclusion criteria for this study includes Bruneian male diabetic patient of aged 18 years and above, and able to write and speak both English and Malay languages.

All interviews were carried out by two research members. NSH (a female, undergraduate student nurse) conducted six face-to-face interviews, while DRI (a male nurse with PhD who has high interest in mens' health seeking behavior) conducted the remaining five. Venue for the interview was at one of the room at the hospital. During the session, only researcher and participant were present at the allocated venue. With the consent from participants, all interviews were audio recorded and transcribed.

Table 1 Socio-Demographic Detail of Participants

Pseudonym	Age	Marital Status	No. of children	Academic qualification	Occupation
Ali	54	Married	2	Diploma	Private company
Jamal	48	Married	3	Secondary	Self-employed
Kamil	41	Single	0	Undergraduate	Nursing Officer
Bakar	67	Married	7	Certificate	Retired
Shahrin	60	Married	5	Undergraduate	Officer
Indra	52	Single	0	Secondary	Private company
Zul	45	Married	3	Diploma	Officer
Rahman	55	Married	3	Secondary	Self-employed
Imran	47	Married	2	Diploma	Officer
Khai	43	Single	0	Secondary	Officer
Saiful	42	Married	3	Secondary	Unemployed

Relationship with participants

No face-to-face contact was made between the researchers and the potential participants. Recruitment was done by the gatekeeper. Upon agreement to participate, the researcher will meet for the interview session and introduce herself (NSH) and himself (DRI). Both researchers introduced themselves as researcher from Universiti Brunei Darussalam. Written consents were then sought from the participants prior to the interview.

Data collection

COREQ tool (See Supplementary File 1) is used in guiding the reporting of this study finding. This qualitative study was guided by phenomenology approach. The open-ended nature of the question used in the semi-structured interview not only defines the topic under investigation, but also provides opportunities for both interviewer and interviewee to discuss some topics in more detail.

Prior to the interview, all participants were asked to fill in a socio-demographic sheet containing relevant information such as age, occupation, marital status, religion, number of dependent and existence of co-morbidities. The interviews were conducted in language preferred by the participant. Each participant was only interviewed once. An interview guide containing questions and prompts to be used during the interview was provided to the researcher. This is to ensure uniformity in terms of the questions asked. All sessions were audio recorded as agreed by participants. No field notes were taken during the session. On average the interview takes approximately 35 to 45 minutes. Questions asked were surrounding their experiences with maintaining their health while managing their everyday life and also controlling their sugar level. The following (Table 2) are the interview guide used during the session.

Table 2 Interview Guide

TOPIC GUIDE
Please can you share your experiences of managing your diabetes
Prompts: a. When were you diagnosed? b. Did you notice any signs and symptoms that indicate that you may have diabetes? c. What brought you to the hospital that time to check for your sugar level? Or blood test? d. How are you managing your diabetes now? What treatments are you currently on? e. Do you think it is important to take control and maintain your health? Why? Please explain. Could also explore complications of Diabetes if not managed. f. What did you do to maintain your health?
How does diabetes affect your life as a man?
Prompts: a. Explore family background and relevant socio demographic i.e. no of children? Occupation? Family/ support system? b. Could you share, if there is any changes or modifications that has to be made to your everyday life as a result of Diabetes? c. How does having diabetes made you feel?

Data analysis

Upon achievement of saturation point, interview was then ceased (N=11). The researchers agreed that having additional interviews (12th interview) would not give any more new data. This was followed by analysis.

Thematic analysis was performed manually on the verbatim transcripts by all the researchers independently, and then themes and subthemes were compared and discussed in a face-to-face meeting with all the researchers to achieve an agreement on final themes. This process enhances the credibility of this study (Birt et al., 2016). Except NSH who was a nursing student, DRI and NS are both nursing lecturers with PhD and MSc, respectively and have experiences with qualitative research. Coding system using table and '*Coding tree'* comprises of themes and categories were made during the discussion to visualize the findings and facilitate the discussion.

The verbatim transcripts were produced in its source language i.e. Malay or English or both; in this case, mostly were mixture of both. Analysis was done based on these transcripts. The research team did not attempt to translate the transcript at this stage as to avoid mistranslation. Relevant excerpts were translated into English for writing up.

Validity and rigor

The individual analysis of the transcripts followed by meetings between all the researchers to compare and discuss the themes is argued to enhance the credibility of this study. This study also analyzed the data in its original language used during the interview. This helped to reduced the issue of mistranslation.

RESULTS

The following are themes derived from our data.

Maintaining Health to Enable the Performance of Masculine Roles

Majority of the participants agreed that maintaining health is important. Although the participants came from different socio-demographic backgrounds, most agreed that as a man they carry big responsibilities in their life. This includes being a father, breadwinner and leader of the family. This was seen as a strong reason for them to stay healthy. This is reflected in the excerpt below.

"…I have a family member to look after, I am the leader of the family so it is important, If I don't take care of my health my family will suffer..." (Ali, 54-years-old, married)

In the above excerpt, Ali talks about how he needs to earn money to support his family, as it is his responsibility as a man, and being a leader of his family.

"...It is important to maintain health so that I will be able to provide more (do/contribute) *to my job..." (Kamil, 41-years-old, single)*

Bakar, a 67-years-old man, also shared the similar sentiments whereby he shared that:

*"...Health is important; we cannot be ignorant especially for a pensioner like me because I small children to take care of (*financially*)..."*

Here we can see how men talk about being able to financially support their family and see it as their responsibility. It is noted that men in this study regularly referred to themselves as a leader. Being a leader in this case refers not only to someone who has responsibility to provide for the family, but a status acquired as a man and a husband through performance of their provider-role in the family. In this study, these men equated being a husband and being a leader for the family. For them, as a husband they need to provide, protect, guide and lead their wife and children. Again, these are described as cultural practices and beliefs passed from one generation to another.

Men Delay Seeking Healthcare Services

It was found that delay in seeking healthcare amongst the participants is rather common. Most of the participants reported that after experiencing the sign and symptoms of diabetes, it took them a few weeks or months before going to the hospital. There are several reasons for the delay. This includes lack of knowledge about the sign and symptoms of diabetes, and unpleasant past experience with health care services.

Needing strong valid reason to access healthcare services

Feeling uncomfortable and experiencing symptoms that are unbearable was seen as a factor that convinced them to seek health help. This was shared by Jamal and Andra when they reflected back on what made them see a doctor.

"…(Usually I just ignored) *…but I went to see my doctor when I started to feel very uncomfortable and it really bothers me…" (Jamal, 48-years-old, married)*

"...At first I put it at the back of my mind because I thought it was a minor headaches or maybe I was just tired, but after sometime it became unbearable, I get tired easily while at work then I decided to go for a checkup..." (Indra, 52-years-old, single)

"...It all started with the sign and symptoms such as waking up at nights, I felt very thirsty, frequent urinating so as it gets uncomfortable, and I went to see my doctor…" (Zul, 45-years-old, married)

Lack of knowledge about diabetes and its sign and symptoms
It was found that neither qualification nor occupation influence one's health help-seeking. This is echoed in an interview with a nursing officer, Kamil, 41 years old. He shared that:

*"…I actually didn't know that I have diabetes, it took me one and a half year to know, I started to have the sign and symptoms of diabetes but at that time I was just putting it at the back of my mind and ignored it (*thinking it was nothing serious*)…"*

Furthermore, Kamil mentioned they busy nature of his work and this makes him tired. He never thought of having any medical problems. Hence, he ignored it.

Few participants admitted that diabetes never came across their mind. Bakar and Shahrin found only when they went for their medical checkup at their local health center. They added that the medical checkup was required for work and part of a procedure for performing Hajj in Mekah, respectively.

Bakar did not notice any signs or symptoms, and he generally felt well, except some episodes of tiredness, but believed that it is due to his age. He added that he only knew when he went for his medical check up. He said that:

"…I am not aware because I have not done any medical checkup, during that time, I had to go because it is required by the company prior to offering me the job. It never crossed my mind that I was going to have diabetes…"(Bakar, 67-years-old, married)

"…I am not aware until I went for medical checkup for Hajj (pilgrimage)…" (Shahrin, 60-years-old, married)

Previous experiences with healthcare services and treatments
Bad experiences with health care services in the past were seen as a factor that deters and delays men from making immediate visit to healthcare centers.

"…I was admitted in the ward for three weeks but there are no improvements until my condition gets worse and I am not happy with the doctor …" (Bakar, 67-years-old, married)

Long queues, prescribed medications and advices that are perceived as ineffective were also shared as deterrent factors. Shahrin stated that:

" …You have to queue too long and the medications given were very not effective (did not cure me)…" (Shahrin, 60-years-old, married)

"…When I see a dietician for a consultation, the food that they suggest is not relevant with our culture..." (Khai, 43-years-old, single).

*"…From what I see, the drugs that are given by the hospital…we cannot depend on it 100%, there are some drugs that causes the illness itself (*side effects and adverse effects*), therefore it is better for us to go for the natural way which is to watch we're eating and doing exercise…" (Rahman, 55-years-old, married)*

When prompted further, Rahman revealed that he uses alternative treatments to control his blood sugar:

*"…I also use like those Jamu (*traditional medicine mostly made of herbs*) you can buy them from the local shop and sometimes I also boiled some herbs myself and drink the water (*believe that it will controls his blood sugar level*)…"*

Maintaining Control and Self-Reliance in Looking After Own Sick Body
It was noted that after they were diagnosed with DM, they realized how it could impact on their daily life and activities, as they would want to be actively in-charge of their situation and not want to rely on others. They recognized the importance of maintaining health as much as they could, so that they can continue with their life and performing their daily roles.
Ali shared this sentiment:

"…I get advice primarily from the health professionals, the doctors, the nurses and I take my medications as prescribed but that was during the initial stage but after a while I kind of know what I need to do and I start to monitor my own blood then I check it from time to time…cannot relying on others too much…" (Ali, 54-years-old, married)

A 41-years-old bachelor, Kamil, shared how he usually refers to Internet and books for additional information particularly on how to maintain his health despite his uncontrolled blood sugar level.

"…Apart from the medication from hospitals and what the doctor told me well I normally Google for medication and supplements, what I think is right and good then I will take otherwise I won't, I also read on testimonials as well..."

He also added that:
"…I need to be well despite my diabetes, so I can continue working and earning money to support myself and my parents…my parents live with me and they are both pensioners and in their 80's now…" (Kamil, 41-years-old, single)

These men expressed that modifying lifestyle such as diet and exercise is necessary.

"…Before this, I used to eat whatever I want, I love foods but now everything has to be controlled…my body not as well as before anymore.. I still can enjoy my food but I just need to adjust and change few things..It's still OK.. as long I control my food.. it's me who needs to control it…" (Jamal, 48-years-old, married)

What is interesting in the above excerpt is how Jamal maintains his positive attitude and places the responsibility of controlling the situation, in this case, by accepting that he is diabetic and his life must change secondary to the diagnosis. He is actively in-control of his situation and acknowledges that it is important to be in charge of his own well-being.

Indra a 52 years old bachelor also shared the importance of having positive attitude, i.e. be able to accept the diagnosis. He emphasized how psychological acceptance is crucial in order to maintain his health.

"…When you overthink of the illness, it will affect our health and life, but if you think positive, everything will be alright, just accept it.. it's still like usual.. only with few adjustments but still OK as long you can control yourself.. your medicines and what you can eat and not eat…" (Indra, 52-years-old, single)

DISCUSSION

The overarching issue here is men's idea and portrayal of masculinities for the delay in seeking health help, as evident from prior studies. Moreover, men are regarded as reluctant health service users (Galdas et al., 2005; O'brien et al., 2005). It is argued that, men portrayed dominant masculine behaviors that reflect the socially constructed masculine attributes, such as being independent, self-reliant, robust and tough male (Courtenay, 2000). In the Western countries, the socio-cultural norms surrounding ideal masculinity include the idea that men should be healthy, strong and self-sufficient (Robertson, 2006), demonstrate independence, competitiveness, emotional stoicism and self control (Ogrodniczuk & Oliffe, 2011). These characteristics are reflected as "hegemonic masculinity".

Connell and Messerschmidt (2005) defines hegemonic masculinity as the current configuration of practice that legitimizes men's dominant position in society and justifies the

subordination of women, and other marginalized ways of being a man. Hegemonic masculinity explains how and why men maintain dominant social roles over women, and other gender identities, which are perceived as "feminine" in a given society. This is regarded as the dominant form of masculinity and because of its dominance all men are required to position themselves in relation to it. In Western society, this dominant form of masculinity includes certain characteristics such as strength, courage, toughness, risk taking, competitiveness, aggression and stoicism (Donaldson, 1993).

Emslie et al. (2006) concluded that men tend to rely on themselves and not others. Acknowledging this is no surprise why men tend to delay their visit to the doctor. Robertson (2006) suggested that most men worried that by getting help they are seen as weak and effeminate. However, this is not always the case. Various factors influence men's health help-seeking behavior and their healthcare services utilization.

Lack of knowledge about sign and symptoms of DM, unpleasant experiences with healthcare services, and believing that treatments are unnecessary were highlighted as the few factors that delay men from visiting their doctor, not merely due to adherence to masculine ideology. While wanting to be in control and self-reliance and able to continue performing their role as a man for their family are considered as important masculine attributes, men in our study also revealed that in the episodes of ill health they would go to seek for health help and will take active control of their treatment. This was to ensure they would be able to continue performing their masculine role to their family. This shows how complex men health seeking behaviors and health maintenance are.

Our study is in agreement with previous studies, which suggest men often delay accessing healthcare services (Galdas et al., 2005), and they are legitimate users of healthcare services, i.e. men need strong reasons to go to see the healthcare professionals (Noone & Stephens, 2008). In our case, because of unbearable and bothersome signs and symptoms, these men agreed that health is important. Moreover, these men regarded the ability to perform their role and responsibility as a man of the family just as important.

Participants acknowledged that unless they are well, they would not be able to perform this role. This roles and responsibilities are culturally shaped and learnt from home (Seidler, 2006). This finding echoes previous study conducted by Idris et al. (2019) that looked at health help-seeking behavior of men in Brunei. Men in his study revealed that family and the importance of their ability to perform their masculine role is an important factor for them to adopt a much positive health seeking behavior and maintaining a good health. In Brunei, men are expected to be leader of the family and to earn for the family. Boys grow up seeing their father performing this role and are culturally expected to continue this tradition and role, and it is what they regarded as an important attribute to their masculinity. The presence of ill health therefore may jeopardize their ability to fulfill these roles (Idris, 2018).

Similar findings were found in a big scale questionnaire survey involving 5134 men from five Asian countries including China, Japan, Korea, Malaysia and Taiwan whereby, the participants considered the ability of men to work and earn money for the family is one of a quality of being masculine, thus maintaining their health is important to them (Ng et al., 2008). Similarly, a British study by Galdas et al. (2005) found that in comparison to men from the West, South Asian men regarded the role of being male holds the responsibility as a breadwinner to the family, therefore health help-seeking is one way to prevent from any ill health that can cause them to be discharged from the responsibility.

Notably, familial responsibilities and work are important in hegemonic masculinities in the global north and south, and Asia, as evident in the literature. However, it is unique that the existence of cultural-political context and the drive to enforce and maintain a particular set of gender role relationships and form of family life are seen in Brunei.

Thus, when health and well-being is threatened by illness such as DM, men have to find ways of giving meaning to their experiences and managing the impact in the context of being a man. The concept of care of the self is a means of understanding and managing ill health in socially acceptable ways (Foucault, 1978). Thus, people are expected to take care of themselves and lead a healthy way of life (Armstrong, 1995). This concept proposes that medicine, science and technology should not be regarded as holding the sole responsibility to cure people, but in order to be a good citizen, the individual is required to follow, for example, the recommendations and guidelines that are proposed to them by the healthcare team (Pylypa, 1998).

Here, it was noted that despite delaying seeking for health help, these diabetic men wanted to get better so that they can perform daily tasks. They considered this as valid reason for the action (Noone & Stephens, 2008). Men in this study shared how they took extra measures by doing their research and reading on the Internet, and few taking alternative treatment such as using traditional medicines. Tendency to engage in such activities point towards men's risk taking behavior and poor health outcomes. Our finding is in line with earlier study by Pagán and Tanguma (2007) whereby they found that diabetic men do care about health. In fact they put extra effort to find other alternatives such as complementary and alternative medicines (CAM) to maintain their health and to prevent further complications of DM. They found that 89% of the participants believed these methods are important in maintaining their health.

This altogether reflect men active involvement and their ways of taking control of their own life, rather than leaving it to the health professionals. This relates to the ideology of men wanting to be seen as self-sufficient and independent (Connell, 2005). This is in line with finding from Robertson (2006), in which he illustrated using the concept of '*Don't care/Should care dichotomy*'. He posited that there is a general agreement in the research literature that men are reluctant users of health services, but he argued with good and strong reasons, a man would move towards the 'should care' offside of this dichotomy.

Limitation of the study

This study did not conduct any pilot prior to the actual phase of the data collection. Hence, the questions were not tested prior to interview. Member checking was also not done. The transcripts could have been given back to the participant to ensure it is correct. Similarly, this applies to the findings of the study. By doing this, it would have further enhanced the credibility of the study.

CONCLUSION

Three themes were discussed including *the importance of being healthy as to adhere to roles and responsibility*, *men delaying assessing healthcare services*, and *taking control of own sick body*. Therefore, it can be concluded that men's perception on the importance of performing the culturally shaped gender roles and responsibilities as the main reason for them to stay as healthy as possible despite their DM. It is also found that factors such as level of knowledge and experiences with healthcare

services and its treatments influence their decision to seek professional healthcare. Through findings of this study, it could provide new information, develop appropriate changes or guide the policy maker into making the healthcare service more attractive and therefore consequently, develop a positive health seeking behavior amongst the diabetic Bruneian men.

Despite evidence that suggests how men are usually taking risks and often decline involvement with health promoting activities and delay seeking health from healthcare professionals, it was found that with the right motivation and reason to seek health help and stay healthy i.e. in this case being able to continue supporting their family act as a good valid reason for them to access healthcare services. Healthcare professionals could consider this in constructing their health advices and teaching. Healthcare professional should also explore the use of CAM amongst their patients. It is important to ensure that these treatments are safe to be taken and do not interact with the current prescribed treatment.

It is recommended for future research to look at Diabetes men who suffered from diabetes-related complications and how it affects their views on masculinity and overall health and wellbeing need to be explored. The use of CAM and how this may interact with the treatment warrants further exploration.

Declaration of Conflicting Interest
None declared.

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ORIGINAL RESEARCH:
RESEARCH METHODOLOGY PAPER

VALIDATION OF NURSING OUTCOMES' INDICATORS OF NURSING OUTCOMES CLASSIFICATION OF SELF-CARE FOR PATIENTS WITH STROKE

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Abstract

Background: Evaluation of nursing outcome based Nursing Outcome Classification (NOC) is very important. However, there is dearth of information regarding its validation in Indonesian language.

Objective: To validate four nursing outcomes' indicators of the Nursing Outcome Classification (NOC) for stroke patients with self-care deficit problems.

Methods: This was a descriptive quantitative study with cross sectional design. Outcomes indicators of self-care: bathing, dressing, eating, and toileting were developed for measuring its relevance, clarity, simplicity and ambiguity. Content validity index was used for analysis, which involved three nursing experts.

Results: Out of the 59 outcome indicators, 49 (83.05%) were considered as passing indicators and 10 (16.95%) were eliminated.

Conclusion: The passing indicators can be applied in caring for stroke patients. The NOC indicators can be implemented in clinical setting, particularly for stroke patient with self -are deficit problems.

KEYWORDS
content validity; nursing outcome classification; self-care; stroke

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INTRODUCTION

Measuring patients' outcome is a very important step after conducting some interventions, and Nursing Outcomes Classification (NOC) has been widely used to measure the outcome (Head et al., 2004). Most of patients with stroke are experiencing self-care deficits. Thus, NOC can be used to measure patient's ability in doing self-care. NOC is a measurement of a patient's status before and after nursing interventions. Standard criteria in NOC are developed to measure the outcomes of nursing actions used in all areas of nursing, individual, family, caregiver, and community (Moorhead et al., 2013). NOC has been used extensively throughout the world. However, its use in every country requires certain adjustments, especially in terms of language. Thus, NOC should be translated into the target language in the particular country. The translation results require further tests to ascertain if they differ or not from the original concepts. One method to measure whether the translated NOC is reliable for use is to test its validity. This study examined the content validity of the NOC of self-care deficits, which have been translated into Indonesian language (or called *bahasa Indonesia*), and its indicators have been operationalized according to stroke patients and hospital settings.

As an instrument, the NOC checklist should be valid and reliable. Validity and reliability are indicated by the high accuracy and precision of the measurement results (Scholtes et al., 2011). Content validity reflects every item of instrument, and describes domain concept that will be measured (Noor,

2013). Content validity can be measured through rational analysis by competent panel or expert judgment toward advisability or content relevance of an instrument (Scholtes et al., 2011). This study aimed to measure the content validity of NOC of self-care: bathing, dressing, eating, and toileting in *bahasa Indonesia* among stroke patients in a hospital setting in Yogyakarta, Indonesia.

METHODS

Study Design

This was a descriptive quantitative research with cross sectional design. It was conducted in one hospital in Yogyakarta on November 2017.

Validation of Instrument by Expert Panels

There were three experts in nursing for instrument validation. Two experts were academics and one expert was a clinician. Expert were chosen based on their experience in caring stroke patients and their education background in basic nursing (Polit et al., 2012). The educational background of the experts were two masters and one doctor in nursing science with 3.5- 27 years of experience in their fields. Researchers listed the name of lecturers from School of Nursing, Faculty of Medicine, Universitas Gadjah Mada. There were five lecturers who are experts in basic nursing. From those five, two experts were willing to participate in this study. One was a clinician chosen due to the highest degree and longest experience in the field, and the other was a nurse at the biggest public hospital in Yogyakarta.

NOC has been previously translated in *Bahasa Indonesia* by Nurjannah and Tumanggor (2013). Back translation has been performed to gain semantic equivalent of the instrument (Polit et al., 2012) by language translator agent in August 2017. The English translator was Indonesian and has been qualified and sworn as a translator. Back translation was then reviewed by three people who were fluent in English in 14-26 September 2017. The results of back translation indicated that the instrument of NOC of self-care: bathing, dressing, eating, and toileting in *Bahasa Indonesia* has the similar substance with the English version.

The total of indicators being assessed was 59 (NOC *self-care: bathing* has 14 indicators, *self-care: dressing* has 14 indicators, *self-care: eating* has 16 indicators, and *self-care: toileting* has 15 indicators). The underlying setting of the instrument in this research was the stroke patients in hospital settings in Yogyakarta, Indonesia.

In this study, Five-Likert scale ranged from one to five (1 = Severely compromised, 2= Substantially compromised, 3= Moderately compromised, 4= Mildly compromised, and 5= Not compromised) was used to give score for its indicator. Each indicator score was operationalized in order to be relevant with the object. In addition, the experts evaluated the relevance, clarity, simplicity, and ambiguity of the indicators using Likert Scale one to four (scale 1 for not relevant to scale 4 for highly relevant). Four point scale was preferable to avoid having a neutral and ambivalent midpoint (Lynn, 1986). They were also asked to give their comments and advices regarding the indicators. If agreement were achieved among experts, the next step is making decision toward the items whether it will be retained, revised, or eliminated (Polit et al., 2012).

Data Analysis

I-CVI and S-CVI were used for data analysis. Data were analyzed using Microsoft Excel. I-CVI score more than 0.78 was considered having a good content validity (Lynn, 1986; Polit et al., 2007). S-CVI (Scale-Content Validity Index) of ≥0.80 is an acceptable agreement (Bellido-Vallejo & Pancorbo-Hidalgo, 2017; Lynn, 1986; Polit et al., 2007). The content validity is excellence if I-CVI is >0.78 and S-CVI is ≥0.90 (Polit et al., 2012).

Ethical Consideration

Ethical approval was obtained from the Ethics Committee of the Faculty of Medicine, Universitas Gadjah Mada. The number of ethical approval was Ref: KE / FK / 1121 / EC / 2017.

RESULTS

The results showed that self-care indicators mostly have a good score in I-CVI and S-CVI. However, some indicators were dropped due to low score in relevance, clarity, simplicity and ambiguity for *self-care: dressing, bathing and eating*, but not for *self-care: toileting*. Therefore, *self-care: bathing* has 5 eliminated indicators, *self-care: dressing* has 3 eliminated indicators, *self-care: eating* has 2 eliminated indicators, and *self-care: toileting* has no eliminated indicators (see **Table 1**). The results of the I-CVI and S-CVI assessment of each indicator can be seen in **Table 2**.

Table 1 Distribution of NOC Indicators for Stroke Patients with Self-Care Deficit Problem in *Bahasa Indonesia*

NOC Outcome	NOC Indicators (n=59)	Passing Indicators	Eliminated Indicators
Self-Care: Bathing	14	9 (64.29%)	5 (35.71%)
Self-Care: Dressing	14	11 (78.57%)	3 (21.43%)
Self-Care: Eating	16	14 (87.50%)	2 (12.50%)
Self-Care: Toileting	15	15 (100%)	0

Table 2 The Results of Content Validity of NOC of Self-Care: Bathing, Dressing, Eating and Toileting in *Bahasa Indonesia* on Stroke Patients with Self-Care Deficit Problems

No.	Indicators	I-CVI Score			
		Relevance	Clarity	Simplicity	Ambiguity
NOC Self-Care: Bathing					
1.	Gets in and out of bathroom	1	1	1	1
2.	Gets bath supplies	1	1	1	1
3.	Obtains bath water*	0.67	1	0.93	0.67
4.	Turns on water	1	1	0.87	0.87
5.	Regulates water temperature*	0.33	0.67	0.87	1
6.	Regulates water flow*	0.67	0.80	1	0.93
7.	Bathes at sink*	0.33	1	1	1
8.	Bathes in tub*	0.33	1	1	1
9.	Bathes in shower	1	1	1	0.73
10.	Washes face	0.73	0.93	1	1
11.	Washes upper body	1	1	1	0.73
12.	Washes lower body	1	1	0.80	1
13.	Cleans perineal area	1	0.93	1	1
14.	Dries body	1	1	1	1
	S-CVI	0.79	0.95	0.96	0.92
	S-CVI after indicators eliminated	0.97	0.98	0.96	0.93
NOC Self-Care: Dressing					
1.	Selects clothing	1	1	1	1
2.	Gets clothing from drawer	1	0.93	1	1
3.	Gets clothing from closet*	0.27	0.80	0.93	0.67
4.	Picks up clothing	0.80	1	1	0.80
5.	Puts clothing on upper body	1	1	1	1
6.	Puts clothing on lower body	1	1	1	1
7.	Buttons clothing	1	1	1	1
8.	Uses fasteners	1	1	1	1
9.	Uses zippers	1	1	1	1
10.	Puts on socks	1	1	1	1
11.	Puts on shoes*	0.47	0.80	0.80	0.87
12.	Ties shoes*	0.33	0.67	0.67	0.67
13.	Removes clothes from upper body	1	1	0.87	1
14.	Removes clothes from lower body	1	1	1	1
	S-CVI	0.85	0.94	0.95	0.93
	S-CVI after indicators eliminated	0.98	0.98	0.99	0.98
NOC Self-Care: Eating					
1.	Prepares food for ingestion	1	0.93	1	0.87
2.	Opens containers	1	0.93	1	0.87
3.	Cuts up food	1	0.93	1	0.93
4.	Uses utensils	1	0.93	1	0.93
5.	Gets food onto the utensil	1	0.93	1	0.93
6.	Picks up cup or glass	1	0.93	1	0.93
7.	Brings food to mouth with fingers	0.67	0.60	0.67	0.60
8.	Brings food to mouth with container	1	0.93	1	0.93
9.	Brings food to mouth with utensil*	0.67	0.60	0.67	0.60
10.	Drinks from a cup or glass	1	0.93	1	0.93
11.	Places food in mouth	0.80	0.67	0.67	0.67
12.	Manipulates food in mouth*	0.60	0.60	0.67	0.67
13.	Chews food	1	1	1	1
14.	Swallows food	1	1	1	1
15.	Swallows fluid	1	1	1	1
16.	Completes a meal	1	0.87	1	0.93
	S-CVI	0.92	0.85	0.90	0.86
	S-CVI after indicators eliminated	0.96	0.90	0.95	0.89

Table 2 *Continued*

NOC Self-Care: Toileting					

1.	Responds to full bladder in timely manner	1	1	1	1
2.	Responds to urge to have a bowel movement in timely manner	1	1	1	1
3.	Gets in and out of bathroom	1	1	1	1
4.	Removes clothing	1	1	1	1
5.	Positions self on toilet or commode	1	1	1	1
6.	Gets to toilet between urge and passage of urine	1	1	1	0.80
7.	Gets to toilet between urge and evacuation of stool	1	1	1	1
8.	Empties bladder	1	1	1	1
9.	Empties bowel	0.67	0.67	0.67	0.67
10a.	Wipes self after urinating	1	1	1	1
10b.	Clean self after urinating with water	1	1	1	1
11a.	Wipes self after bowel movement	1	1	1	1
11b.	Clean self after bowel movement with water	1	0.93	1	1
12.	Gets up from toilet or commode	1	1	1	1
13.	Adjusts clothing after toileting	1	1	1	1
	S-CVI	0.98	0.97	0.98	0.96
	S-CVI after indicators eliminated	0.98	0.97	0.98	0.96

Note: *= eliminated indicator

The outcomes *Self-care: Bathing* is defined as personal actions to perform the most basic physical tasks and personal care activities independently with or without assistive device, contains 14 indicators (Moorhead et al., 2013). Among those, the experts considered that *gets in and out of bathroom* (I-CVI score for relevance= 1), *gets bath supplies* (1), *turns on water* (1), *bathes in shower* (1), *washes face* (0.73), *washes upper body* (1), *washes lower body* (1), *cleans perineal area* (1), and *dries body* (1) as passing indicators. The indicators of *obtains bath water* (0.67), *regulates water temperature* (0.33), *regulates water flow* (0.67), *bathes at sink* (0.33), and *bathes in tub* (0.33) were eliminated. The S-CVI score of relevance, clarity, simplicity and ambiguity in the NOC *self-care: bathing* instrument after eliminated indicators respectively were 0.97, 0.98, 0.96 and 0.93.

Self-care: Dressing is defined as personal actions to dress self independently with or without assistive device, contains 14 indicators (Moorhead et al., 2013). The experts considered *selects clothing* (I-CVI score for relevance= 1), *gets clothing from drawer* (1), *picks up clothing* (0.80), *puts clothing on upper body* (1), *puts clothing on lower body* (1), *buttons clothing* (1), *uses fasteners* (1), *uses zippers* (1), *puts on socks* (1), *removes clothes from upper body* (1), and *removes clothes from lower body* (1) as passing indicators. The indicators that eliminated were *gets clothing from closet* (0.33), *puts on shoes* (0.47), and *ties shoes* (0.33). The S-CVI score of relevance, clarity, simplicity and ambiguity in the NOC *self-care: dressing* instrument after eliminated indicators respectively were 0.98, 0.98, 0.99 and 0.98.

The outcomes of *self-care: eating* is defined as personal actions to prepare and ingest food and fluid independently with or without assistive device, contains 16 indicators (Moorhead et al., 2013). Among these, the experts considered *prepares food for ingestion* (I-CVI score for relevance= 1), *opens containers* (1), *cuts up food* (1), *uses utensils* (1), *gets food onto the utensil* (1), *picks up cup or glass* (1), *brings food to mouth with fingers* (0.67), *brings food to mouth with container* (1), *drinks from a cup or glass* (1), *places food in mouth* (0.80), *chews food* (1), *swallows food* (1), *swallows fluid* (1), and *completes a meal* (1) as passing indicators. The indicators of *manipulates food in mouth* (0.60) and *brings food to mouth with utensil* (0.67) were eliminated. The S-CVI score of relevance, clarity, simplicity and ambiguity in the NOC *self-care: eating* instrument after eliminated indicators respectively were 0.96, 0.90, 0.95 and 0.89.

Self-care: toileting is defined as personal actions to toilet self independently with or without assistive device, contains 13 indicators (Moorhead et al., 2013). There were 13 indicators and 2 additional indicators in this NOC *self-care: toileting*, which were on indicators 10b and 11b. The addition of 2 indicators was carried out based on considerations related to the prevailing culture in Indonesia. In Indonesia, using water is used for cleaning after urinating and defecating instead of using tissue or cloth. There was no indicator eliminated in this outcome. Passing indicators were *responds to full bladder in timely manner* (I-CVI score for relevance= 1), *responds to urge to have a bowel movement in timely manner* (1), *gets in and out of bathroom* (1), *removes clothing* (1), *positions self on toilet or commode* (1), *gets to toilet between urge and passage of urine* (1), *gets to toilet between urge and evacuation of stool* (1), *empties bladder* (1), *empties bowel* (0.67), *wipes self after urinating* (1), *clean self after urinating with water* (1), *wipes self after bowel movement* (1), *clean self after bowel movement with water* (1), *gets up from toilet or commode* (1), and *adjusts clothing after toileting* (1). The S-CVI score of relevance, clarity, simplicity and ambiguity in the NOC of *self-care: toileting* instrument after eliminated indicators respectively were 0.98, 0.97, 0.98 and 0.96.

DISCUSSION

The reason why some indicators in *self-care: bathing* were decided to be eliminated was that *obtains bath water, regulates water temperature, regulates water flow, bathes at sink*, and *bathes in tub* could not be observed at clinical condition in Stroke Unit and Anggrek 2 Ward of RSUP Dr. Sardjito hospital. For hospital conditions in Indonesia, especially in Dr. Sardjito hospital Yogyakarta, did not have a bathtub and patients were not used to bathing in the sink. Most of the patients at Stroke Unit and Anggrek 2 Ward were advised to bed rest and the activity was only limited to the bed. A shower was provided by nurses in both patients' bed or bathroom.

In the *self-care: dressing,* the indicator of *gets clothing from closet*, based on expert considerations, was that the operational definition and explanation of each indicator were similar to the indicator of *gets clothing from drawer,* and there was no wall cabinet in the hospital. The indicators of *puts on shoes* and *ties shoes* were excluded because stroke patients in hospitals rarely used shoes based on community culture. And the indicator of *picks up clothing* was not eliminated because the operational definition and explanation of each indicator only needs to be corrected so that the differences in each indicator were clear.

In *self-care: eating*, the validity test results showed that there were 4 indicators with low score of I-CVI 0.67 (<0.78), namely the indicator 7, indicator 9, indicator 11 and indicator 12. The indicators were corrected for the indicator 7 from *brings food to mouth with fingers* to *brings food to mouth with fingers (hand)*; the indicator 11 *places food in mouth* was corrected by clarifying the operational definition of items that were quantitative followed by qualitative information such as <75% (most), 25-75% (some) and> 25% (little). The eliminated indicator was the indicator 9 *brings food to mouth with utensil* because it has the same operational definition with the indicator 8 *brings food to mouth with container*, thus it was combined. And the indicator 12 *manipulates food in mouth* was decided to be eliminated because the score of I-CVI was <0.78 and the explanation of the indicator assessment made by the researcher was still considered difficult if observed to the patients.

In *self-care: toileting*, the indicators were decided to be revised, rather than to be eliminated. Items revised include changing the word *unable to carry out 1 of 4 indicators* on the operational definition indicators number 3, 4, 10a, 10b, 11a, 11b to be *unable to carry out all indicators*.

Given the specific reasons to eliminate and revise the indicators in each outcome, the instrument was then valid for use, with S-CVI (Scale-Content Validity Index) score was ≥0.80 that is acceptable (Bellido-Vallejo & Pancorbo-Hidalgo, 2017; Polit et al., 2012)

CONCLUSION

The four nursing outcomes' indicators of the Nursing Outcome Classification (NOC) demonstrate a valid results. Therefore, the indicators can be used for caring stroke patients who has self-care deficit problems (bathing, dressing, eating, and toileting). It is recommended to do further research for reliability test for this Nursing Outcome Classification.

Declaration of Conflicting Interest
None.

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Authors Contributions
SM and IN prepared for research proposal and process in data collection and ethical permission, contributed in creating the article and revising the content and discussion section, and provided final approval on the publication manuscript.

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