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Application of Theoretical Concepts of Nursing Anthropology and Transcultural Nursing in Improving The Performance of Infection Prevention and Control Nurses (IPCN) in Hospitals

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ABSTRACT: Infection prevention and control (IPC) is a fundamental component in ensuring patient safety within hospital environments. The performance of Infection Prevention and Control Nurses (IPCN) significantly determines the success of IPC programs, yet it often faces complex challenges related to staff adherence, frequently rooted in internal organizational cultural aspects. This study aims to cognitively explore how theoretical concepts of nursing anthropology and transcultural nursing can be integrated to enhance IPCN performance, particularly in addressing cultural barriers affecting IPC practice compliance in healthcare facilities. The method used was a conceptual literature review enriched with cognitive exploration based on field studies based on reflection on the author's personal experience and observation in the hospital environment. Core concepts such as cultural competence, culturally congruent practice, and cultural context, along with transcultural nursing care models and the analogy of family theory serve as the primary analytical framework. The study's exploration reveals that a comprehensive understanding of healthcare staff's values, beliefs, and cultural practices is essential for designing effective and culturally sensitive interventions to improve IPCN performance. Further discussion describing the design of the application of theoretical concepts of nursing anthropology and transcultural nursing for IPCN performance improvement was explained through the adaptation of the Five-step problem solving process in Transcultural Interprofessional Practice Model (assessment, mutual goal setting, planning, implementation, evaluation) as a guide for IPCN. The conclusion recommends a transcultural approach as a transformative strategy for IPCN include the development of cultural competence, advocacy for supportive policies, and the necessity for further empirical research to test the effectiveness of this model.

KEYWORDS: Cultural Competence, IPCN, Infection Prevention, Performance, Transcultural Nursing.

INTRODUCTION

Healthcare-Associated Infections (HAIs) management has become one of the top priorities in quality assurance and patient safety across global healthcare facilities. HAIs not only increase patient morbidity and mortality rates, but also contribute to increased duration of hospitalization, antibiotic use, and significant financial burdens on patients and the health system (Haque et al., 2018). Therefore, an effective infection prevention and control (PPI) program is an essential pillar in an effort to maintain a safe hospital environment.

The role of Infection Prevention and Control Nurse (IPCN) in hospitals is very vital and central to the sustainability of the PPI program. IPCN is responsible for conducting infection surveillance, developing evidence-based policies and procedures, conducting ongoing education and training for staff, to monitoring compliance with PPI practices across service units. The success of the PPI program is directly correlated with the performance of the IPCN and their ability to influence the behavior of all health staff to comply with the established standards (Thakur, H., Rao, R., 2024).

However, in practice, IPCN are often faced with complex challenges in an effort to ensure staff compliance with PPI standards. These challenges do not solely stem from a lack of technical knowledge or skills of staff, but are often rooted in a deep cultural dimension within hospital organizations (Braithwaite et al., 2017). Organizational culture, which is formed from shared values, beliefs, assumptions, and norms internalized by all members of the organization, has a significant influence on the individual and collective behavior of staff (Runtu, T. M., Novieastari, E., & Handayani, H., 2019). For example, a thick hierarchical culture, less effective communication patterns, the existence of myths or false beliefs about the transmission of infections, and norms that unwritten ignore PPI practices for the sake of efficiency, can be substantial obstacles to IPCN efforts. This phenomenon shows a gap between knowledge and practice, where staff may know the correct procedures, but do not always apply them in their work

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routines (Yee et al., 2021).

Anthropology of nursing and transcultural nursing offers a unique and crucial perspective in analyzing and understanding the cultural factors behind these phenomena. Nursing anthropology specifically examines how culture shapes individual perceptions and responses to health and illness, including in the context of professional behavior in a clinical setting. Meanwhile, transcultural nursing emphasizes the importance of nurses understanding and appreciating cultural diversity to provide culturally congruent care (Andrews & Boyle, 2019). Although the context of transcultural nursing is often associated with nurse-patient interactions, the principles are particularly relevant and can be applied in the context of IPCN's relationship with multidisciplinary staff in hospitals, as the staff themselves are part of a wider cultural community that forms sub-cultures within the organisation.

By applying concepts from these two disciplines, IPCN has the potential to develop a much more culturally sensitive approach in an effort to improve staff compliance and optimize the performance of PPI programs holistically. This involves a shift from a normative or instructive approach to a more collaborative and adaptive approach to the values and habits that apply within the hospital. The urgency of this writing lies in the need to address the cultural barriers that are often an "invisible barrier" to the success of PPI programs, which will ultimately have a direct impact on improving patient safety and health service efficiency. This study explores cognitively how these theoretical concepts can be implemented to empower the IPCN in its crucial role. In addition, this study also considers the results of preliminary studies that have been conducted by other researchers that show a correlation between organizational culture and PPI compliance levels (Runtu, T. M., Novieastari, E., & Handayani, H., 2019).

RESEARCH METHODS

Research Design

The method used in this study is qualitative with a descriptive design, which is a qualitative approach that aims to describe, analyze, and understand the cultural aspects and practices of infection prevention and control (PPI) in hospitals with reflective analysis based on experience and field observation (reflection-on-practice). The researchers did not go directly into the field to collect primary data, but used literature and reflections based on the author's experience in the hospital. This is useful for providing a practical and in-depth perspective on theoretical discussions. The researcher uses a descriptive qualitative approach because the problem being studied is not looking for relationships or influences, but rather to understand in depth the meaning, process, and context of PPI implementation that occurs in the field.

Data Collection

Data collection in this study uses 2 (two) approaches: (1) Literature study, namely searching, selecting, and analyzing journal articles. The literature search strategy involves the use of Scopus academic journal databases, pubMed, and Google Scholar. The researcher then screened articles based on inclusion criteria (scientific journal articles, full-text available) and exclusion (irrelevant, duplicate, non-scientific journal articles). The search results are then read, analyzed, and synthesized according to the problem and research objectives. (2) Reflection and observation, which is based on the author's experience and direct observation in the field (hospital) related to infection prevention and control.

Data Analysis

The data analysis techniques used in this study are: (1) Data reduction, namely filtering and selecting important information according to the problem and purpose; (2) Data presentation, which is to present in detail and structured aspects that occur in the field and are available in the library; (3) Verification and drawing of conclusions, namely analyzing and concluding based on theoretical, reflective, and observational aspects.

Trustworthiness

To maintain the validity of the data, the researcher used: (1) Triangulation of sources, which is connecting and comparing data from the literature, reflections, and observations; (2) Member checking, which is discussing and reflecting on findings with practitioners (nurses, IPCN) and experts (lecturers) in order to get feedback and confirmation on data interpretation.

Research Ethics

This research does not involve humans directly, so ethical approval is not needed. The researcher maintains academic integrity, namely mentioning and providing complete citations to the sources used, in order to maintain the honesty and originality of the writing.

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RESULTS AND DISCUSSION

This section presents the results of the conceptual exploration of the phenomenon and its discussion by applying the theoretical concepts of anthropology of nursing and transcultural nursing. Because this manuscript is not the result of empirical research, this section does not contain data on the characteristics of the subject/object/sample/respondent of the study, the results of descriptive statistical data analysis, instrument testing, or hypothesis testing. Instead, this section focuses on the identification, analysis, and interpretation of conceptual findings that emerge from cognitive exploration and literature review.

Identification of Cultural Phenomena in PPI Performance in Hospitals

Based on the author's cognitive exploration and past experience in the hospital setting, several significant cultural phenomena have been identified that directly affect the adherence to Infection Prevention and Control (PPI) practices and the performance of Infection Prevention and Control Nurses (IPCN). This phenomenon represents cultural aspects that are often a challenge for IPCN in carrying out its role.

The first phenomenon is the knowing-doing gap. This refers to a condition where hospital staff have adequate knowledge of PPI standards and procedures, but do not always apply them in daily practice. For example, almost all nursing and medical staff in hospitals have received training on the importance of five-moment hand washing. They understand the theory behind the transmission of microorganisms and the role of handwashing in preventing them. However, field observations often show low levels of handwashing compliance, especially during high workloads or in poorly supervised areas (Yee et al., 2021). This phenomenon is often caused by the perception of time efficiency, where staff feel washing their hands thoroughly will hinder a quick workflow, or the assumption that the risk of infection in certain patients is lower.

The second phenomenon is the culture of hierarchy and authority in PPI compliance. Strong hierarchical structures in hospital organizations can influence the dynamics of PPI compliance (Runtu, T. M., Novieastari, E., & Handayani, H., 2019). Staff tend to be more obedient to instructions coming from direct supervisors or senior doctors, but may be less responsive to recommendations or reprimands from the IPCN who are sometimes considered to have a "non-clinical" or "inspectorate" position. In addition, the existence of a culture of "shyness" or "unpleasantness" among fellow staff can prevent them from reminding or reprimanding each other regarding inappropriate PPI practices (Kim & Lee, 2021). This also applies to IPCN, which faces challenges in providing feedback to senior staff or other professions without generating resistance.

The third phenomenon is the "shortcut culture" and operational pragmatism. In an effort to achieve work efficiency or cope with high workloads, staff often take "shortcuts" that override the correct PPI procedures (Malik, J. A., Musharraf, S., Safdar, R., & Iqbal, M., 2022). For example, reusing personal protective equipment (PPE) that should be disposable, cleaning equipment in a hurry without following complete decontamination protocols, or ignoring patient isolation procedures. This phenomenon is rooted in pragmatism, in which staff prioritize task completion and reduction of obstacles, despite the risk to patient safety. Past experience shows that time pressures and lack of resources can trigger this behavior.

The fourth phenomenon is myths and false beliefs about infections. Despite continuing education, there are still myths or misconceptions among staff regarding the transmission of infections or the effectiveness of certain PPI measures. For example, the belief that "a person with a strong immune system will not contract the infection", or that "infection only occurs in severely ill patients" (Malik, J. A., Musharraf, S., Safdar, R., & Iqbal, M., 2022). This kind of trust can reduce staff motivation to comply with PPI protocols because they feel they are not at risk. This myth can be passed down informally through conversations between colleagues and become part of the "oral" culture in the unit.

The fifth phenomenon is the lack of ownership and collective responsibility of PPIs. Often, PPI responsibilities are considered the exclusive domain of the IPCN or PPI team, rather than the collective responsibility of the entire hospital staff (Thakur, H., Rao, R., 2024). This can lead to a passive attitude or lack of initiative from staff in practicing PPI independently, without direct supervision from IPCN. This phenomenon reflects an organizational culture that has not fully internalized patient safety culture as a core value shared by all professionals (Liu, Y., Wang, Y., & Zhang, Y., 2020).

Analysis and Synthesis of Theoretical Concept Applications

This discussion analyzes the above cultural phenomena through the lens of theoretical concepts of nursing anthropology and transcultural nursing, and synthesizes how these concepts can be applied to improve IPCN performance.

Each of the cultural phenomena identified above does not stand alone, but rather is firmly embedded in the hospital's Cultural Context (Andrews & Boyle, 2019). Environmental factors, such as infrastructure limitations (e.g., inadequate number of sinks or

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the location of hand sanitizers far from the patient's point of care), directly contribute to knowledge-practice gaps and "shortcut cultures" (Yee et al., 2021). The physical conditions of the work environment shape how PPI practices can or cannot be realistically performed. Strong social and hierarchical dynamics create power distance that affects IPCN communication (Kim & Lee, 2021). Social norms "reluctantly" hinder peer-to-peer accountability. Stressful social environments and high workloads fuel pragmatism, where staff prioritize speed over compliance. Hospital budget constraints can affect the availability of quality personal protective equipment (PPE) or innovative PPI training, which in turn can contribute to suboptimal practices. If the hospital's management philosophy emphasizes the financial aspect more than patient safety, then the patient safety culture may not be well internalized, contributing to a lack of PPI ownership among staff (Liu, Y., Wang, Y., & Zhang, Y., 2020). Staff's varying levels of education and understanding influence their response to PPI education and facilitate the spread of false myths (Malik, J. A., Musharraf, S., Safdar, R., & Iqbal, M., 2022). IPCN must understand how staff learn and process information. Inconsistent hospital policies or weak enforcement of rules by management can create "loopholes" in the system, allowing "culture of shortcuts" and a lack of ownership to flourish.

The phenomenon that arises in PPI compliance is a manifestation of health-related values, attitudes, beliefs, and practices embraced by hospital staff. If staff collectively value "efficiency" or "team solidarity" more than "procedural compliance," then non-compliance behavior will become the norm. The IPCN needs to explore these dominant values. Indifference, defensiveness, or skepticism towards PPI inhibits the acceptance of innovation or feedback from IPCN. This attitude often stems from negative experiences or a lack of understanding of the real consequences of infection. Myths and false beliefs about infection are a big obstacle. For example, the belief that "I won't get sick" or "it's just the common cold" underestimates the risk of transmission (Malik, J. A., Musharraf, S., Safdar, R., & Iqbal, M., 2022). The IPCN must be able to identify and correct these beliefs in a non-confrontational manner. Entrenched work habits, even if they are not up to standard, are often difficult to change. This practice becomes part of the professional identity and change requires significant effort (Park & Choi, 2025).

To overcome the above phenomenon, IPCN must have and apply cultural competence. The IPCN must be able to conduct a self-assessment to recognize personal biases (e.g., frustration with non-compliant staff, the assumption that they don't care). This awareness is the first step to developing a more objective and empathetic approach (Campinha-Bacote, 2002). IPCN needs to develop an in-depth knowledge of the sub-cultures in each unit, the reasons behind certain practices (e.g., high work pressure that leads to shortcuts), unwritten norms, and informal reward/punishment systems among staff. This includes understanding effective communication styles in each unit. IPCN should be skilled in the assessment of organizational culture by using ethnonursing research methods (McFarland & Wehbe-Alamah, 2020) to identify relevant cultural values, norms, and barriers. IPCN must also have culturally sensitive communication skills to provide constructive feedback and education on PPI, use language that is easily acceptable, and avoid judgmental or degrading language. Negotiation and mediation skills are necessary to find a win-win PPI solution that can be implemented in a work culture. The design of adaptive interventions, such as the development of PPI training programs or campaigns tailored to staff learning styles and organizational cultural norms, is also essential. Without the intrinsic motivation to understand and cooperate with staff, IPCN efforts will feel compelling, so cultural desire is very important (Campinha-Bacote, 2002). IPCN need to be aware that they do not have all the answers and that staff have important insights into the challenges of practice on the frontline, so that cultural humility allows IPCN to be a facilitator of change, not just an infection police (Agga et al., 2022).

Cultural phenomena in hospitals can be analyzed by analogizing the Hohashi family model into organizational structures. IPCN should focus on the unique dynamics and culture in each unit (e.g., ICU vs. Inpatient) as an analogy of the Internal Unit System or the Family Internal Environment System. Knowledge-practice gaps and "shortcut cultures" are often most visible at the unit level. Interactions between units (e.g., how the emergency room hands patients over to the inpatient ward) can affect the practice of PPI, this is analogous to the Inter-Unit System or Microsystem. The hospital's general policies, overall patient safety culture, and top management support form the PPI environment as an analogy of the Hospital as a Large System or Macrosystem. The lack of ownership of PPIs often reflects the culture of this macroecosystem. Government regulations, national/international accreditation standards, and pressure from external institutions affect how hospitals as a whole view and implement PPI, this is analogous to External or Suprasystem. IPCN needs to analyze PPI barriers from this multilevel perspective (Hohashi, 2019). Each staff individual has personal beliefs about PPI. This interaction of trust forms a collective belief system in the unit. For example, if some staff believe "full PPE is troublesome and unnecessary", this belief can spread and become the informal norm. The IPCN must identify

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and understand these belief systems in order to design interventions that can change or manage false beliefs, rather than just providing factual information. This involves strategic communication to influence the collective narrative (Hohashi, 2019).

The synthesis of the above analysis shows that improving IPCN's performance in infection control is not just a matter of procedural enforcement, but rather a complex challenge of cultural change. IPCN must act as a transculturally competent agent of cultural change. This means that IPCN needs to understand cultural roots by being able to identify how cultural context and health-related values, attitudes, beliefs, and practices of staff affect PPI compliance, using the lens of nursing anthropology. IPCN must also be able to build core competencies by mastering cultural competence (awareness, knowledge, skill, desire, humility) to interact effectively and empathize with all staff. Analyzing systemically using the analogy of the Hohashi family model to analyze PPI barriers from a multilevel perspective, from the smallest unit to the entire organization is also critical. Finally, IPCN must design culturally congruent interventions by developing PPI strategies that align with the organization's culture, not just imposing standards. This means adapting education, communication, and feedback methods to be more receptive and internalized by staff. Thus, IPCN can shift from an "infection police" role to a "facilitator of cultural change," which will organically improve PPI compliance and ultimately contribute to a safer hospital environment (Agga et al., 2022).

Concept Application Design in IPCN Performance Improvement

The design of the application of the theoretical concepts of nursing anthropology and transcultural nursing for IPCN performance improvement can be explained through the adaptation of the Five-step problem solving process in Transcultural Interprofessional Practice Model (Andrews & Boyle, 2019). This model provides a systematic framework for IPCN to implement a culturally sensitive approach.

The first step is Assessment (PPI Cultural Assessment). This is a crucial phase where IPCN actively uses cultural competence skills to understand PPI culture in hospitals. IPCN begins with self-reflection on personal biases and prejudices against staff who may not be compliant with PPI (Cultural Self-Assessment) protocols (Campinha-Bacote, 2002). The IPCN needs to understand its own position and communication style that may affect interactions with staff. Then, IPCN conducts a comprehensive cultural assessment of staff and units in hospitals (Client Cultural Assessment) (Andrews & Boyle, 2019). This is not an individual assessment, but rather an assessment of the collective "PPI culture". Through experiential and observation-based field studies inspired by ethnonursing research (McFarland & Wehbe-Alamah, 2020), IPCN identified the Health-related values, attitudes, beliefs, and practices of PPI-related staff, including their beliefs, attitudes, values, and practices. This assessment requires cultural skills to ask respectful questions and active listening to understand the staff's perspective. IPCN analyzes the Cultural Context that influences PPI practices, such as environmental, social, economic, and organizational factors. The use of the analogy of Concentric Sphere Family Environment Theory (Hohashi, 2019) helped IPCN analyze how cultures at different levels (units, departments, hospitals as a whole) affect PPI performance. In addition, the analogous analysis of the Family Belief System Model (Hohashi, 2019) allows IPCN to understand how individual staff beliefs interact and form the unit's collective belief system, which is important for designing interventions that target the root of the problem.

The second step is Mutual Goal Setting. After the review, the IPCN does not set goals unilaterally, but rather collaborates with all stakeholders (unit heads, charge nurses, staff representatives, management) to set realistic, measurable, and culturally congruent PPI goals (Andrews & Boyle, 2019). Open discussions are facilitated to allow staff to voice their ideas and concerns. Negotiations and compromises are conducted to reach an agreement that integrates the PPI requirements with the unit's work culture, ensuring the goals set are acceptable to staff and are not considered an unrealistic additional burden.

The third step is Planning (Culturally Sensitive Intervention Planning). Based on a common goal, IPCN plans a culturally congruent PPI intervention, taking into account the results of the cultural assessment. Adaptive education is designed to fit the learning style of staff, using non-judgmental and solution-based language (Gaikwad et al., 2018; Dewi, 2018). The development of PPI "champions" in each unit was identified to act as role models and motivators. If the bottlenecks are systemic, IPCN plans to advocate to management for infrastructure improvements or workflow adjustments. A constructive feedback system that does not embarrass staff is planned (e.g., private feedback or peer coaching). In addition, an award system for compliant staff or units with good PPI performance, which is in line with the cultural values of the organization, can also be planned.

The fourth step is Implementation (Implementation of Culturally Sensitive Strategy). IPCN implements the plan with an attitude of cultural humility and cultural skill. IPCN is actively engaged in the field, observing, and interacting with staff (Agga et al., 2022). It builds trust and allows for ongoing cultural encounters. Flexibility and adaptation to the plan are also necessary in the event of

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an unexpected response or new obstacles arise. Ongoing communication with staff, listening to their input, and providing the necessary support are integral to this phase. Additionally, it is worth considering the impact of stress on IPCN and staff, as stress can negatively impact performance (Choi & Kim, 2020) and job satisfaction (Choi & Kim, 2015). Anthropological approaches assist management in designing more effective interventions to safeguard employee well-being (Green et al., 2023; -, & Das, 2024), fostering a supportive organizational culture (Green et al., 2023; Choi & Kim, 2015).

The fifth step is Evaluation (Evaluation of the Performance of IPCN and the PPI Program). The evaluation was conducted not only from a biomedical perspective (e.g., decreased HAIs rates, increased handwashing compliance rates), but also from a staff culture perspective (Andrews & Boyle, 2019). Broad evaluation criteria, such as whether the PPI program is perceived as Safe?, Acceptable?, Culturally congruent?, Culturally competent?, Affordable?, Accessible?, Quality?, Evidence-based?, Best practices?, need to be considered. Staff perception surveys or interviews can be used to gauge staff's perceptions of the safety and acceptance of the PPI program, as well as the level of IPCN cultural competence. If a goal is not achieved or a new problem arises, the IPCN returns to the assessment step to identify why the strategy is not working (for example, there are cultural barriers that are missed or not addressed) and modify the plan. This dynamic cycle ensures continuous improvement in the performance of IPCN and PPI programs. Managerial support in the form of policies, facilities, as well as adequate training and evaluation is also very important (Omisakin, 2018).

CONCLUSION

The performance of Infection Prevention and Control Nurses (IPCN) in ensuring compliance with Infection Prevention and Control (PPI) practices in hospitals is greatly influenced by the complex organizational cultural dynamics. Barriers such as the gap between knowledge and practice, rigid hierarchical cultures, pragmatic habits that ignore procedures, and the existence of myths and erroneous beliefs indicate the need for an approach that goes beyond just medical intervention. In this context, the use of anthropological theories of nursing and transcultural nursing is an important foundation for IPCN to understand the values, attitudes, beliefs, and health practices embraced by staff. Mastery of cultural competencies, including awareness, knowledge, skills, desire, and humility, is a fundamental element for effective IPCN. A systematic approach through cross-cultural problem-solving processes also allows IPCN to design interventions that are aligned with local cultures and evaluate the results thoroughly. Thus, IPCN not only plays the role of a compliance supervisor, but also as an agent of cultural change that is able to encourage continuous improvement in PPI implementation and patient safety.

SUGGESTIONS

Based on the results of the synthesis of the concept of transcultural nursing in an effort to improve the performance of IPCN, several strategic suggestions can be addressed to various parties. In nursing practice, IPCN needs to actively strengthen cultural competencies through continuing education and specialized training that includes cross-cultural communication, negotiation skills, and adaptive leadership, in order to be able to face non-technical challenges in a multicultural context. A comprehensive cultural assessment also needs to be an integral part of evaluating compliance with PPI standards, emphasizing the importance of understanding organizational culture, not just individual behavior. IPCN should take on the role of a collaborative facilitator, not just a supervisor, in order to build trust and increase acceptance of change. On the managerial side, hospitals need to develop policies that are responsive to cultural dynamics, including the provision of training, resource support, and the creation of a work environment that supports open communication and a collective culture of patient safety. In the field of education, the nursing curriculum needs to reinforce material on anthropology and transcultural nursing, as well as provide contextual learning experiences that are relevant to a multicultural clinical environment. Meanwhile, for the development of knowledge, further research is needed, both exploratory and interventional, to explore the influence of cultural factors on PPI compliance and test the effectiveness of transcultural-based IPCN performance improvement strategies, including the development of relevant measurement tools for the context.

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