Thai Nurses' Cultural Competency in Caring for Clients Living in a Multicultural Setting

Praneed Songwathana, Siriphan Siriphan

Abstract : The three southernmost provinces of Thailand are recognized as areas with a variety of cultural contexts. It is therefore essential for nurses to have cultural competency to respond to different health care needs. The purpose of this descriptive research was to assess the level of Thai nurses' cultural competency in caring for clients living in a multicultural setting. A self-report questionnaire on cultural competency was administered to 126 registered nurses working around the southern Thai-Malaysian border region, who were recruited from provincial hospitals, community hospitals and local health centers. The questionnaire was composed of five dimensions: *cultural knowledge, cultural awareness, cultural skills, cultural encounters* and *cultural desire*. The cultural knowledge dimension was tested for internal consistency using Kruder-Richardson (KR-20), yielding a value of 0.72. The other 4 dimensions were tested using Cronbach's alpha coefficients, yielding a total value of 0.84. Descriptive statistics were used for data analysis.

The results revealed that the nurses' overall cultural competency was at a moderate level. Cultural awareness, cultural encounters and cultural desire were at a high level, but cultural knowledge and cultural skill were at a moderate level. No significant differences were found according to period of working, health-care setting or training experience about multicultural care, but differences were found across religion ($p<.05$). The findings highlight the importance of cultural competency development among Thai nurses aimed at reducing stress and conflicts, and promoting nurses' adaptation when working in the multicultural settings of the Thai-Malaysian border region.

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Introduction

An increasingly diverse population due to migration has become more evident in Asia particularly in the 21st century. This phenomenon will present a challenge for nursing care delivery. Thailand is one

Correspondence to: Praneed Songwathana, *Associate Professor, Faculty of Nursing, Prince of Songkha University, Hatyai district, Songkha province 91200* ***E-mail:*** *Praneed.s@psu.ac.th*
Siriphan Siriphan*, Assistant Professor, Faculty of Nursing, Princess of Naradhiwas University, Muang district, Naradhiwat province 96000*
E-mail: *noinara@hotmail.com*

country recognized as having diverse ethno-cultural groups. The considerable ethnic and religious diversity, include the Thai Buddhist, Malay Muslims, and Thai native of Chinese descent who have migrated from other regions of the country such as in Northeast Thailand, which has hill tribes and people from Myanmar.[1] In addition, Thailand has been a destination for refugees and migrant persons for more than three decades, particularly from Myanmar. About 4 million migrants live in Thailand and half of them are not registered.[2] This diversity means that people who have to live together require adaptation, especially the acceptance and assimilation of a variety of social and cultural contexts.[3] In addition, the people in diverse cultures mostly express their different life and wisdom when they come together, as well as health care needs in cultural differences.[4]

A better understanding of the caring needs of community people in three southernmost provinces and characteristics of nurses was provided in an earlier descriptive study.[5] Some specific behaviors of nurses were identified such as politeness, hospitality, and readiness to listen and provide assistance with warm welcome and greeting manners, deep understanding of patient and relatives' feeling and communication with an appropriate language. The ability to speak and communicate within the same language as patients such as Malay should improve trust in patient care. Nurses who are born in a region and have lived for long periods there are recommended to work with that area's diverse populations, since they would have gained insight into their area, culture, traditions, and beliefs better than those new to the region.[5] Our previous study's findings also suggest that nurses in the three southernmost provinces of Thailand, especially newly graduated nurses, required a better knowledge and ability to provide culturally appropriate health care to respond to the community demands. Furthermore, an attempt to improve cultural competency of new nurses working in the areas by giving a preparation course and training related to cultural care was performed in some hospitals but there was no evaluation of cultural competency.[5] As researchers we were interested to study the level of cultural competency in providing health care services to clients living in the three southernmost provinces. The information will be useful to develop a potential intervention to improve nursing capacity and care quality.

Literature Review

The shift of demographics with expanding immigration, increasing globalization, and minority population growth has led to the nursing profession needing to effectively prepare to respond to diverse health care. In recent years, public awareness has raised the issues of health care needs in diverse population and highlight the expansion of the health care workforce and increase provider cultural competence.[6] This creates a major challenge for nurses both in education and practice.

The meta-analysis on cultural competence education interventions from 13 studies by Gallagher[7] demonstrated that individual educational interventions had a significant positive effect on improving nursing students and professional nurses' knowledge and skills in caring for patients in different cultural backgrounds. However, those studies were conducted in developed countries. A literature search performed on publications during 2010-2014 from CINAHL using keywords of 'cultural competence', 'nurse in Asia' and 'nursing,' revealed no studies specifically about how cultural competence is perceived and measured in Asian nurses except for Thai literature.[8] Due to an extensive number of patients are seen in Thai hospitals, there is a need for additional research to be done in Thai cultural settings.

The population in Thailand, as elsewhere, continues to rapidly growth in diversity, but nurses have remained a homogenous group being mostly Thai Buddhist. However, the three southernmost provinces constitute an area with a variety of cultural

contexts, and differ markedly from other areas. It was found that people with different cultures tended to have different patterns of health-care use. For example, the Thai Muslim religion uses the doctrines of God in everyday life including health-care practice.[9] However, the Buddhist way of Dhamma in Thailand is regarded as natural health care based on the doctrines of Buddhism. Both Thai Buddhists and Thai Muslims adhere to the doctrines of the religion by ignoring evil, doing the good and having a pure mind.

Therefore, the service provider must be aware of the cultural diversity in providing health services under the context of the cultural diversity among individuals, families and communities.[10] A literature review found that cultural competency is defined in the principle of holistic nursing care practices that will benefit both service providers (nurses) and service users (clients) to understand each other. Therefore, in accessing a variety of cultural consumers, nurses need to develop cultural competency.[11] The concept of cultural competency[10] has as its basis the development of five dimensions, namely cultural awareness, cultural knowledge, cultural skills, cultural encounter and cultural desire. These concepts emphasize the development of a system and process that is consistent and coherent on each side, self-development and learning, and understanding of the cultural service process in order to provide health-care service correctly. These concepts have been used to evaluate cultural competency of nurses, students enrolled in nursing curricula and nurse practitioners in the country.[11]

However, the perception of cultural competency depends on many factors, for example, religion. People tend to practice in the way that they believe.[12] According to the study by Dumkeang[13], it was found that Thai Muslim nurses paid more attention to spiritual nursing in elderly Muslims than Buddhists. Those who had more understanding in religious beliefs could apply it to spiritual nursing. However, most nurses had little knowledge of Islamic religious beliefs. A study of Bangroy[12] in a psychiatric hospital found that the nurses had a low score of knowledge about religious beliefs of Thai Muslim clients. Most nurses who had been working in the southern region were Buddhist. Although they may have worked in the area for a long time, they still lacked a deep understanding of Muslim clients. Furthermore, another study found that nurses who had training experience about cultural diversity care had a higher knowledge score of competency in caring for patients[8,11].

Nurses' working period and service setting may be related to cultural competency. Those who worked many years had more expertise or practical role than less experienced nurses.[14] Especially, registered nurses who worked >10 years or who worked in the primary health care settings have had an opportunity to listen and learn the way of life and culture of the community.[13] They gained better understanding about values, religion and culture in the three southernmost provinces.[15]

Changes in society, culture and environment affect the quality of health-care services and competency of nurses. The focus of current practice is that nurses must show knowledge, skills and characteristics of effective nursing practice related to desirable society and culture. A culturally competent model of health care developed by Campinha-Bacote[16] was used to guide the pattern of health-care services with an emphasis on cultural competency of providers. The process was composed of 5 interaction concepts as follows: cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire.

In addition, a variety of cultural contexts in the three southernmost provinces and different patterns in health care needs have been observed. This may affect the perception of cultural competency which may vary depending on personal factors such as religion, period of working and services, and training experience about multicultural care. When working under the concept of cultural competence, each individual must assess and understand his or her own cultural competence before understanding another

culture. It is therefore essential to assess the level of cultural competency among nurses in the areas.

Aims of Study

To assess the level of Thai nurses' cultural competency in caring for clients living in a multicultural setting in the three southernmost provinces.

To compare nurses' cultural competency classified by religion, period of working, service setting, and training experience about cultural diversity.

Methods

Study design: This study was a descriptive survey using a self-report questionnaire.

Participants and setting: The participants were newly registered nurses (RNs) who worked in a public hospital, district hospital or primary health care center in the three southernmost provinces of Thailand working in the health service of less than 5 years. A sample of 150 participants was needed, calculated on the basis of 5% of the population of 3,000[17], and 20% was added for allow for attrition. Finally, 180 participants were enrolled using 2:2:1 stratified random sampling from the public hospital, district hospital and primary health-care centers, respectively. The number of returned questionnaires was 126, accounting for a 70% return rate.

Ethical consideration: Research approval for the study was given by the Ethics Committee of the Faculty of Nursing, Prince of Songkla University (MOE0521.1.05/1802). The purpose of the study and study procedures were explained to all participants in a cover letter attached with a consent form and questionnaire. Confidentiality and anonymity of the participants was assured by using code numbers used instead of real names. The participants were guaranteed confidentiality and their right to withdraw from the study without any negative consequences. Moreover, they were asked to give permission for publication of the findings of the study in a consent form.

Instruments

A demographic data questionnaire was administered covering age, sex, religion, place of living, working experience and health care service, training about multicultural care, colleagues with a different culture, language in daily communication, experience in caring for multicultural patients and facing conflicts when providing care for multicultural patients.

The Self-report Questionnaire on Cultural Competency (SRCC) was developed based on the cultural competency model of health care by Campinha-Bacote.[16] The questionnaire of cultural competence[18] comprised 5 dimensions and was organized into two parts. Part 1 was multiple choice on cultural knowledge (20 items), and Part 2 contained 16 items using a 5-rating Likert scale and covered 4 dimensions. The score of Part 1 was modified by dividing it into 4 groups depending on the correct item score as follows: 1-5 points (item score) was equal to 1, 6-10 points was equal to 2, 10-15 points was equal to 3, and 16-20 points was equal to 4. Examples of items related to cultural knowledge are: "Which one is correct about the Muslim cultural belief?" or "What are the most important barriers in communicating with clients from ethno-cultural backgrounds?". The second part was a self-report about cultural competence in 4 dimensions: cultural awareness (4 items), cultural skill (6 items), cultural encounter (3 items), and cultural desire (3 items). Examples of items related to cultural awareness are: "I realize that the development of cultural competence must be done continuously", or cultural skill: "I assess ideas, beliefs, and things of value to others, especially for whom I perform service". The interpretation of average total mean score in Parts 1 and 2 was divided into 4 groups as the following: 0-1 points meant low, 1.1-2.0 points meant fair, 2.1-3.0 meant moderate and 3.1-4.0 meant high. The overall interpretation score of SRCC questionnaire in 5 dimensions was divided into 4 groups as the following: 1-5.09 points meant lower level, 5.10-10.09 points meant fair level, 10.10-15.09 points meant moderate level and 15.10-20.0 points meant high level. Prior to use in

the study, the SRCC was pilot-tested on 30 nurses who had similar characteristics to the subjects in the study. Reliability of Part 1 was assessed by the Kuder-Richardson-20 statistic and that of Part 2 was determined by Cronbach's alpha coefficient, yielding values of .72 and .84 respectively.

Data collection: The researcher obtained permission to conduct the study from each district hospital and primary health care center in the three southernmost provinces Thailand. New nurses from the selected hospitals were recruited using a random sampling technique according to the number of nurses in each hospital.

A letter of permission was attached to the questionnaires including an informed consent form. The researcher explained the objectives, benefits, confidentiality, and method to collect data by cover letter to all participants. A set of questionnaires was left for two weeks for them to complete and return by post. However, there were some questionnaires returned with help from the head nurse later than two weeks owing to the delayed responses. Questionnaires were checked for completeness before analysis.

Data analysis: Data were analyzed using frequency distribution, percentage, mean and standard deviation of each cultural competency dimension and overall score. Independent t-test and F-test were used to compare cultural competency score according to religion, period of working, service unit, and training about multicultural diversity.

Results

Characteristics of participants

The participants were 126 newly registered nurses; the majority were female (84.9%) between the ages of 20 and 30 (92.1%) with the mean age of 25.97 years. Most were of the Muslim religion (90.5%), living in the three southernmost provinces (97.6 %) and having the period of working >1 year (93.7%) with the mean of 1.17 years. Nearly all participants used Thai as a common language and used Yawee or Malay to communicate with others from the same region (91.3%), as shown in Table 1.

Table1 Demographic characteristic of participants (N =126)

Demographic characteristic	N	%
Sex		
Female	107	84.9
Male	19	15.1
Age (Min = 23, Max = 41, $\overline{X}$= 25.97, SD = 3.142)		
20-30	116	92.1
31-40	9	7.1
41-50	1	0.8
Religion		
Buddhism	12	9.5
Muslim	114	90.5
Hometown		
Three southernmost provinces	123	97.6
Other province	3	2.4
Period of working (Min = 1 , Max = 5, $\overline{X}$= 1.17, SD = .678)		
1 year	118	93.7
2 years	1	0.8

Table1 Demographic characteristic of participants (N =126) (Continued)

Demographic characteristic	N	%
3 years	2	1.6
4 years	4	3.2
5 years	1	0.8
Workplace		
District Hospital	48	38.1
General Hospital	58	46.0
Regional Hospital	20	15.9
Training experience in multicultural care		
No	82	65.1
Yes	44	34.9
*Language use in daily life communication**		
Thai Dialect		
Central	121	96.0
South	34	27.0
Northeast	10	7.9
North	13	10.3
Other local language		
Yawee/Malay	115	91.3
English	24	19.0

* More than one answer

Cultural competency level

The overall perception of cultural competency level was at a moderate level ($\overline{X}$= 14.47, SD = 1.940). Considering each dimension, it was found that cultural desire, cultural awareness and cultural encounter were at a high level ($\overline{X}$=3.23, SD = .671, $\overline{X}$=3.11, SD = .509, $\overline{X}$=3.08, SD = .519 respectively), whereas cultural skill and cultural knowledge were at a moderate level as shown in Table 2 and 3 ($\overline{X}$=2. 84, SD = .405, $\overline{X}$=2.21, SD =.531 respectively).

Table 2 Descriptive statistics of five cultural competency dimensions (N =126)

Cultural competency	Possible and Actual Ranges	Score				Level
		Min	Max	$\overline{X}$	SD	
Cultural knowledge	1-4	1	3	2.21	.531	Moderate
Cultural awareness	1-4	1.75	4.00	3.11	.509	High
Cultural skill	1-4	2.00	4.00	2.84	.405	Moderate
Cultural encounter	1-4	1.67	4.00	3.08	.519	High
Cultural desire	1-4	1.67	4.00	3.23	.671	High
Overall	5-20	8.92	18.25	14.47	1.940	Moderate

Table 3 Number of participants classified by level of cultural competency (N =126)

Overall cultural competency	N	%
High Level (score 15.10– 20)	52	41.3
Moderate level (score 10.10 – 15.09)	72	57.1
Fair level (score 5.10 – 10.09)	2	1.6
Low level (score 1 – 5.09)	-	-

Considering cultural knowledge competency, the items which were answered correctly by >70% of participants were the causes of ethnic differences (79.4%) and problems in communicating with different cultural groups (75.4%). The items with the highest score of cultural awareness were the continuous self-development of cultural competency ($\overline{X}$= 3.13, SD=.674), followed by an awareness of both words and actions used in providing services for clients ($\overline{X}$= 3.02, SD=.820). Regarding cultural skills, the highest-scoring items were listening to others and assessing ideas, beliefs and values of clients ($\overline{X}$ = 3.28, SD = .776, $\overline{X}$ = 3.01, SD = .701 respectively). For cultural encounter, the items with the highest scores were the ability to adapt to others who came from a different culture, and voluntarily providing care for those with different feelings and beliefs ($\overline{X}$ = 3.12, SD=.688 and $\overline{X}$ = 3.10, SD=.720 respectively). The items with highest scores in the culture desire dimension were the commitment of self in providing care to clients with diverse cultural backgrounds, and a willingness to care for clients from various cultures ($\overline{X}$= 3.24, SD=.731 and $\overline{X}$= 3.23, SD=.695) as shown in Tables 4 and 5.

Table 4 The 5 highest percentage of correctly answered item in cultural knowledge (N = 126).

Cultural knowledge dimension	N (%)
1. Causes of ethnic differences	100 (79.4)
2. The problem in communicating with different cultural groups	95 (75.4)
3. Muslim belief and culture	84 (66.7)
4. Features of nursing which is consistent with the culture	83 (65.9)
5. Nursing care in Muslim culture	82 (65.1)

Table 5 The two highest score item (>3) on cultural awareness, cultural skills, cultural encounter and cultural desire

Cultural competence	$\overline{X}$	SD
Cultural awareness dimension		
1. I realize that the development of cultural competence must be done continuously.	3.13	.674
2. I am aware of both words and actions used to provide services for clients.	3.02	.820
Cultural skills dimension		
3. I listen to other people, friends and colleagues. In particular, the clients who come to use the service no matter who they are.	3.28	.776
4. I assess ideas, beliefs, and things of value to others, especially those of the people I serve.	3.01	.710

Table 5 (Continued)

Cultural competence	$\overline{X}$	SD
Cultural encounter dimension		
5. I can adapt to the culture similar to me as well as those who came from a different culture to me.	3.12	.688
6. I volunteer to provide care for people/clients who have feelings and beliefs different to me without being disgusted.	3.10	.720
Cultural desire dimension		
7. I promise myself to provide care to clients with diverse cultural backgrounds and those different from me.	3.24	.731
8. I have a willingness to care for clients from various cultures.	3.23	.695

There were no statistically significant differences (P> .05) in cultural competency according to period of working, health-care setting or training experience in multicultural care, but cultural competency differed according to religion (Table 6).

Table 6 Comparing nurses' cultural competency classified by religion, period of working, health care settings, and training experience (N = 126).

Variable	N	$\overline{X}$	SD	t/F	p-value
Religion				t =6.108	.015
Buddhism	12	13.22	2.584		
Muslim	114	14.54	1.790		
Period of working				t =.339	.562
1 year	118	14.43	1.931		
2-5 years	8	14.24	1.612		
Health care settings				F=1.718	.184
District Hospital	48	14.77	1.610		
General Hospital	58	14.30	2.164		
Regional Hospital	20	13.89	1.676		
Training experience about multicultural care					
No	82	14.34	2.033	t =2.404	.124
Yes	44	14.56	1.660		

Discussion

Findings revealed that the majority of participants were Muslims aged between 20 and 30 years. According to the participants' home town, they all resided in the three southernmost provinces and thus would have an understanding of the local people and be familiar with the environment of a multicultural setting. In accordance with Saisamut,[19] living in their home town affectsaffects nurses' intention to stay and continue to work at hospitals in three southernmost provinces. By understanding the nature and cultural heritage of the area, including understanding the religion, would make nurses in this study easily adapt in the

southernmost provinces.

Previous studies have reported that language is one of the main barriers among health care providers in caring for clients from diverse groups.[20] However, most participants living were able to use Yawee/Malay language (91.3%) and Southern Thai dialect (27.0%). This helped them communicate with people in the same language group. It was also suggested that although most participants (93.7%) had been working for at least 1 year, their background and previously living in three southernmost provinces would help them harmoniously adapt to the lifestyle and culture of the local Muslims.[21]

Tables 2 and 3 show that the level of overall cultural competency of the participants was at a moderate level ($\overline{X}$= 14.47 SD = 1.940) and accounted for 57.3%. Considering the items with the highest score of each dimension, the self-development and a desire to serve the people in different cultures in the three southern border provinces without pre-judgment or disgust were reported. In addition, an awareness of their own words and actions and a desire to provide care for clients with diverse cultural backgrounds was high. Hence, the overall skills and knowledge dimensions of cultural competency in the study was at a moderate level.

One of the competencies of professional nursing is a focus on the profession's awareness and understanding of the culture to provide maximum efficiency and benefit of nursing to respond to the demands of care from various clients. Although the duration of working was not long (a mean duration of 1.17 years), they were mostly domiciled in the three southern border provinces with a sense of commitment and familiarity with the location as their own community. In addition, Thai society recognizes that nurses should have compassion, patience, kindness and a desire to help others.[5] These characteristics would help nurses in the three southernmost provinces adapt to the lifestyle and learn the culture of the local service.

Cultural knowledge was shown to be at a moderate level ($\overline{X}$=2. 21, SD=. 531). When classified by each item, it was found that knowledge about health and health-related culture such as cultural traditions, beliefs and values in their own culture was correct. The highest correct answer was on the causes of ethnic differences (79.4%), and the problem in communicating with culturally different clients (75.4%). This may be due to most subjects being Muslim and domiciled for a long time and using Yawee/Malay language (91.3%), which was the same language used most commonly in the three southernmost provinces. However, the questions related to the Burmese migrant groups were the least answered (12.7%). This may be due to more than half the participants not having been trained in cultural diversity (65.1%). Therefore, the cultural competency regarding cultural knowledge was at a moderate level. On the other hand, knowledge is a key factor in giving nurses a better understanding of the culture and clients' situation, which leads to the further development of cultural competencies of nurses.

The study found that overall cultural skills were at a moderate level ($\overline{X}$=2.84, SD=.405). The two highest-scoring items in cultural skills were the intention of listening to others and the assessing ideas, beliefs and values of clients (Table 5). This is similar to the previous studies about head nurses' cultural competency in three community hospitals in the southern provinces[20] and among nursing students providing care in southern Thailand[5]. It was found that talking or having contact with people who have different ideas, beliefs, religion and way of life, promoted the ability to recognize and respond correctly according to cultural background. However, cultural competency skills were not as high as expected because those skills are required more experience, and the majority of the nurses had only one year's experience.

Cultural awareness showed a high level ($\overline{X}$= 3.11, SD=.509), with the highest scores in the items of continuous self-development of cultural competency and awareness of both words and actions used in providing services for clients. This is similar to a previous

study[22] where nurses were aware of not having prejudice or believing in stereotypes in providing services to people who are different from their own ethnic or cultural backgrounds. Therefore, high cultural competency awareness was reported in this study.

The overall cultural desire competency was at the highest level ($\overline{X}$=3. 23, SD=. 671). The particular desire was the development process of cultural competency, awareness, knowledge, skills and the desire to voluntarily serve clients of different cultures. This is consistent with the principles of the Thailand Nursing Council which consider professional nurse competency in terms of expressing sincerity in relationships, words and actions.[23] This is also congruent with the previous study that the nursing profession should meet the needs of community and some specific behaviors of nurses are required such as politeness, hospitality, readiness to listen and to provide assistance with warm welcome and greeting manners, and readiness to take care of clients of various cultures. The study is also similar to the survey of the head nurses' cultural competency working in the three border provinces that the cultural desire was at a high level[21] as was that of nursing instructors working in the southern Thai University.[23]

There were no statistically significant differences as shown in Table 6 when comparing the mean scores of cultural competency classified by period of working or training experience about multicultural care, but differences were found with religion. In general anyone can develop their own culture, and competency can be improved continuously and does not depend on the duration of working and effective training experience. Partly nurses have developed their own professional competency throughout the curriculum and multicultural care has been integrated into the teaching process. Some institutions have a clearly defined vision to develop their students' cultural sensitivity, understanding and ability to provide health-care services in a multicultural setting. According to the professional nursing role and policies of developing countries, nurses should be prepared for entry into ASEAN.[24] In addition, everyone has experience in both direct and indirect exposure to caring for patients of different cultures. Those who are domiciled in the three southern provinces will have to learn the way of life with a variety of cultures in a harmonious part of daily life. Similar to Vasalaemae[15] who found that a support of head nurses and senior nurses who were working in the three southernmost provinces during the unrest situation can adapt to events or issues that they were faced with over a long period of working.

Although 65.1% had never attended multicultural-care training, everyone had experience in both direct and indirect patient care. As a result, no differences were found. According to a study of cultural competency of nurses who had, or had not, undergone cultural training, the performance did not differ.[22] In addition, workplace service did not affect competency perception. Working in general hospitals, district hospitals and primary health care centers with all the diversity in the unrest, allowing nurses to learn the needs of the individualized clients and to be able to perform as planned.

Although Muslims had a significantly higher cultural competency score than Buddhists, this should not be seen as a real difference as the majority of patients are Muslim, and this may affect the comparative analysis. It was found that nurses can recognize the distinction between religious beliefs. They had the ability to work with colleagues of different religions without problems. In fact, all religion teaches to be good people. Religion then does not affect the cultural competency of nurses in providing health-care services in areas of cultural diversity in the three southern border provinces.[19, 22]

Limitation

The limitation in this study is that the participants were from the three southernmost provinces of Thailand with distinctive multicultural context. Thus the study population does not entirely reflect the nurses' cultural competency in Thailand.

Conclusions and Implication for Nursing Practice

This study found that the competency of cultural knowledge and skills among new nurses working in three southern border provinces were at a moderate level and more than half of the nurses had never received training on multicultural care. Therefore, the development of specific knowledge about different cultural care is important for new nurses who work in all types of hospitals in the area in order to modify the process of providing services to meet the cultural needs and issues of equality. In addition, it is necessary for teaching in the nursing curriculum to provide nursing student with adequate preparation for life and cultural skills to be ready for working in diverse cultures, to gain sensitivity to multicultural differences and to integrate their knowledge into practice.

We suggest a qualitative study be undertaken to explore the cultural content and the process of becoming a competent nurse who can provide care of a specific group reflecting direct experience. This will assist the development of nursing care within various cultures and strategies to help people to learn more on the issue of cultural conflict and how to minimize conflicts in each cultural group who live in the three southern border provinces.

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สมรรถนะวัฒนธรรมของพยาบาลไทยในการดูแลผู้รับบริการที่อาศัยในพื้นที่ที่มีความหลากหลายทางวัฒนธรรม

ประณีต ส่งวัฒนา ศิริพันธุ์ ศิริพันธุ์

บทคัดย่อ: พื้นที่สามจังหวัดชายแดนภาคใต้เป็นพื้นที่ที่มีบริบทเฉพาะของความหลากหลายทางวัฒนธรรม จำเป็นอย่างยิ่งที่พยาบาลจะต้องมีสมรรถนะทางวัฒนธรรมเพื่อตอบสนองความต้องการการดูแลสุขภาพที่แตกต่างกัน วิจัยนี้มีวัตถุประสงค์ เพื่อศึกษาระดับสมรรถนะทางวัฒนธรรมของพยาบาลไทยในการให้บริการสุขภาพในพื้นที่ที่มีความหลากหลายทางวัฒนธรรมสามจังหวัดชายแดนใต้ วิธีการวิจัย กลุ่มตัวอย่าง 126 คนเป็นพยาบาลวิชาชีพที่จบใหม่และปฏิบัติงานในโรงพยาบาลทั่วไป โรงพยาบาลชุมชน และสถานีอนามัยในเครือข่ายโรงพยาบาล สามจังหวัดชายแดนใต้ของประเทศไทย ประเมินตนเองเกี่ยวกับสมรรถนะด้านวัฒนธรรมทางการพยาบาล ทั้ง 5 ด้าน คือ ด้านการตระหนักรู้เกี่ยวกับวัฒนธรรม ด้านความรู้เกี่ยวกับวัฒนธรรม ด้านทักษะเกี่ยวกับวัฒนธรรม ด้านการมีปฏิสัมพันธ์กับผู้ใช้บริการต่างวัฒนธรรม และ ด้านความปรารถนาที่จะมีสมรรถนะทางวัฒนธรรม ด้านความรู้ผ่านการตรวจสอบความเที่ยงของแบบประเมินด้านความรู้ด้วยค่าคูเดอร์ ริชาร์ดสัน (KR-20)ได้เท่ากับ 0.72 ส่วนค่าความเที่ยงของเครื่องมือ4 ด้านที่เหลือ ทดสอบโดยค่าสัมประสิทธิ์ครอนบาค อัลฟาได้เท่ากับ 0.84 วิเคราะห์ข้อมูลโดยใช้สถิติเชิงบรรยาย

ผลการวิจัยพบว่า สมรรถนะด้านวัฒนธรรมโดยรวมของกลุ่มตัวอย่างอยู่ในระดับปานกลาง เมื่อพิจารณารายด้านพบว่า ด้านการตระหนักรู้ ด้านการมีปฏิสัมพันธ์กับผู้ใช้บริการต่างวัฒนธรรม และด้านความปรารถนาที่จะมีสมรรถนะทางวัฒนธรรมและด้านการมีปฏิสัมพันธ์กับผู้ใช้บริการต่างวัฒนธรรมอยู่ในระดับสูง ส่วนด้านความรู้และด้านทักษะทางวัฒนธรรมอยู่ในระดับปานกลาง ผลการวิเคราะห์เปรียบเทียบความแตกต่างของสมรรถนะทางวัฒนธรรมพบว่า ไม่มีความแตกต่างกันอย่างมีนัยสำคัญทางสถิติ เมื่อจำแนกตามระยะเวลาการทำงาน สถานบริการสุขภาพ และประสบการณ์การอบรม ยกเว้น ศาสนา การวิจัยนี้ พบว่า การพัฒนาสมรรถนะทางวัฒนธรรมมีความสำคัญยิ่งสำหรับวิชาชีพพยาบาล ช่วยลดภาวะเครียด และความรู้สึกขัดแย้ง และช่วยให้พยาบาลสามารถปรับตัวในการทำงานท่ามกลางความหลากหลายทางวัฒนธรรมได้

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คำสำคัญ: สมรรถนะทางวัฒนธรรม ความรู้และทักษะ ความหลากหลายทางวัฒนธรรม การพยาบาล ประเทศไทย

*ติดต่อที่: **ประณีต ส่งวัฒนา**, รองศาสตราจารย์, คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ อำเภอหาดใหญ่ จังหวัดสงขลา 91200*
***E-mail:** Praneed.s@psu.ac.th*
***ศิริพันธุ์ ศิริพันธุ์,** ผู้ช่วยศาสตราจารย์, คณะพยาบาลศาสตร์ มหาวิทยาลัยนราธิวาสราชนครินทร์ อำเภอเมือง จังหวัดนราธิวาส 96000*
***E-mail:** noinara@hotmail.com*