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Cultural Competency in Professional Nursing: Some Considerations for Thai Nurses

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Abstract

The growing research focusing on cultural competency in the nursing profession necessitates a contextual evaluation of the Thai nursing profession. This paper gives an overview of the definitions, related concepts, and existing measures of cultural competency for nurses. Data was retrieved from electronic databases such as CINAHL, Science Direct, and ThaiLis. The inclusion criteria were peer-reviewed and primary source articles regarding cultural competency of nurses within the past 15 years since it is a time-sensitive subject. The findings revealed the levels of nurses' awareness of the diverse ethnicity of the population and its impact on value conflict in health care. From the meta-analysis of the literature, it was found that cultural knowledge and strategies to gain cultural competency and to foster learning in the workplace remain minimally explored among Thai nurses. To conclude, this study proposes strategies in which cultural competence can be acquired and developed.

Keywords: *cultural competency, nursing education, psychometric assessment*

Introduction

Health care workers of the 21st century experience rapid changes in ethnically-diverse customer populations. In the nursing profession, whether the area of practice is education, clinical, or research, nurses encounter this dilemma as a result of globalization. According to the statistics of Foreign Business Certificate classified by the Business Sector and Foreign Laborers Registered as Workers in Thailand during July 1-30, 2009 (Nitisiri, 2009), migration has dramatically increased and included non-registered laborers and foreign residents.

In the health care area, the growing number of foreigners in Thailand may affect the way nurses deliver care and the quality of care patients receives. An example is health care access. Patients who are the majority are generally accustomed to feeling at ease in their environment. It is also common that the privilege of being in the majority brings a sense of belonging and control. Conversely, the minority may feel less willing and comfortable to seek contact or be among health care providers. Furthermore, for under-privileged foreigners, their socio-economic status and disparities in insurance coverage have an impact on their access to care; therefore, they use fewer health care resources. These inequities may be partly attributable to racial, cultural, and communication barriers between clients and health care providers (Tervalon & Murray-Garcia, 1998; Cooper-Patrick, Gallo, & Gonzales, 1999; Satcher, 1999).

In addition, the number of international students in Thailand has increased rapidly. Thailand may become the center for international study programs in the future as evidenced in the increasing number of foreign students from Japan, Korea, Hong Kong and other countries because of the standard of international study programs in Thailand (Kitthisathaporn, 2007). However, it is unclear how nurses perceive and adjust to the situation nowadays in order to gain competency in attitude, knowledge and skill for cultural care. Furthermore, questions are raised whether health care institutions provide culturally competent care to clients. These questions remain because of the following reasons.

First, almost all nurses in Thailand are Thais originating from the four regions of Thailand. There are no foreign nurses to serve foreign clients even though their numbers are growing rapidly. Clearly, there is a discrepancy between cultural backgrounds of health care providers and clients among this multiethnic group. Secondly, there is neither mandatory regulation to include cultural diversity content in nursing curricula nor

expectation of accreditation and approval boards for nursing program education in preparation for nursing students caring for this special group of clients. Inadequate knowledge regarding clients' health beliefs and life experiences, as well as unintentional and intentional racism, influences the care of clients negatively. Thirdly, faculties in nursing schools are also challenged to develop culturally appropriate skills among all students, both Thais representing their society and international students from various ethnic backgrounds, since they have a different worldview in definition of health and illness and how illness should be managed.

For more than a decade, Leininger (1995) has urged schools of nursing to examine structure, worldviews, and environment as influences on clients' health. Many studies were conducted in this area for a numbers of years in Western countries; however, minimal progress has been observed and little empirical evidences available to describe the knowledge, attitudes, or skills in caring for diverse cultural population of nurses in the Non-Western world.

This paper aims to review the meaning and concept of cultural competency (CC) among nurses and nurse educators. Furthermore, it aims to explore how CC is gained and perceived. Finally, this paper also aims to review existing tools to measure CC. The identification of literature related to CC was primarily done through electronic databases such as CINAHL, Science Direct, and ThaiLis. Inclusion criteria used were publication on CC of nurses between 1999-2009, peer-reviewed, primary source, and written in English or Thai. Since this study is a time-sensitive subject; therefore, studies published before 1999 would be used only if it contains important relevant information especially studies from Asian countries.

Definition of Cultural Competence

In general, competency is displayed as the ability to do something well or effectively (Cobuild, 2006). Many scholars have defined CC as a process, not an endpoint, in which the nurse continuously strives to achieve the ability to work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background (Campinha-Bacote, 1994), or a dynamic process of framing assumptions, knowledge, and meanings from a culture different than our own and a way of becoming self-aware and of understanding how meaning is assigned (Bartol & Richardson, 1998), or the ability to recognize an essential to value people differences and preferences, and the self-awareness to respect and try to understand patients from whom we differ (Flores, 2000).

Therefore, the definition of CC is a process of gaining ability in terms of attitude, knowledge, and skills to effectively interact with and care for people who differ in ideals, values, assumptions about life, language dialect and goal-directed activities which change from time to time and transfer from one group to the other continuously. The application of this capability is not limited to people from a different ethnicity only, but also includes people from different demographic backgrounds (the Other) such as age, gender, education, faith, sexual orientation, socio-economic status, political preference, ability, and geographic orientation.

Concept of Cultural Competence

The concept of CC still remains vague due to its complexity and early stage of exploration in humanity. Its influences on human behavior exclude any definitive formulations of concept and generalized cultural care interventions. The knowledge, theory and research guiding the processes of culturally competent care are yet to be fully developed (Bartol & Richardson, 1998; Lester, 1998; Meleis, 1996; Smith, 1998) even though the issue has been studied in Western countries for decades. This study, the concept of CC is composed of: (1) the process of acquiring CC, (2) factors contributing to CC, (3) barriers, and (4) outcomes.

The processes of acquiring CC

Since the definition of cultural competency is a process of gaining ability in cultural attitude, cultural knowledge, and cultural skill to efficiently interact and care for people who are different in cultural backgrounds, the concept of CC involves the process of developing attitude, knowledge, and skill in CC.

Cultural attitude

Cultural attitude is the primary stage of acquiring cultural competence. It is the way nurses think and feel about culture and people from different cultures, especially when an attitude shows the way nurses behave. Nurses have to be aware of and sensitive to the issue of cultural attitude. According to Campinha-Bacote,

cultural awareness requires a person to be sensitive to values, beliefs, practices and life ways of the client's culture (1999).

Sensitivity and tolerance to surroundings are vital. Therefore, it is important for nurses to observe and realize that they interact with clients who have different cultural backgrounds. Nurses should be able to perceive the differences through their senses such as hearing, seeing, smelling, and feeling. Then, the received information is processed. Since the way people think and behave is based on their own worldview and background, the attitude of people toward the same and different culture varies. Hence, this process should involve assessment of personal biases toward other cultures and analysis of one's own values, beliefs, and practice in order to be aware of one's own cultural attitude (Sargent, Sedlak, & Martsolf, 2005). The self awareness of one's own attitude is very essential. This is reflected by a study in southern Thailand which found that the more you experience another culture and learn, the greater you realize what you do not know about people from other cultures (Songwathana, Hiruanchunha, Sangchan, Petpichetchian, & Kampalikit, 2008). Moreover, people who have positive cultural attitudes are more accepting of people from different cultures and more willing to learn about other cultures than those who have negative cultural attitudes (Sargent, et al., 2005).

Cultural knowledge

Cultural knowledge assists people to be more understanding about cultural differences. It supplies information that assists people with negative cultural attitudes to adjust easier and could also change one's attitude in a negative direction.

The elements of knowledge are varied. A good example is from the Ethnic Student Training Group Program that was conducted by Parker, Bingham, and Fukuyama in 1985 to emphasize the development of cultural knowledge. The content included value changes, acculturation, generational differences, parental pressures, and religious issue (Parker, Bingham, & Fukuyama, 1985). Furthermore, cultural knowledge includes particular biological variations, beliefs about illness causality, culture-bond illnesses, and forms of interaction among ethnic groups which are beneficial to the nursing profession (Campinha-Bacote, 1999). Nevertheless, it is obligatory that nurses also acquire the knowledge of transcultural nursing in many aspects such as communication, space, social organization, time, environmental control, biological variations, and health practice. The knowledge can be utilized when nurses encounter various types of client. A study in Thailand showed that the cultural care management of persons with DM in the community based on knowledge rooted in socio-cultural aspects and biomedical knowledge was well applied (Nakagasien, Nuntaboot, & Sangchart, 2008). Therefore, the more cultural knowledge people have, the stronger the foundation of cultural skill they will gain because cultural knowledge together with cultural attitude are essential for incorporating cultural nursing care for clients.

Cultural skill

Cultural skill involves a complex development in gaining cultural competency among these three sub-concepts. Many people can have both good cultural attitude and knowledge; however, they may still not be proficient in cultural skill. Sometimes, practitioners may not know how to use such knowledge, or they may not think or choose to use it in practice for a number of reasons (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Nurses who are culturally skilled are the ones who carry on activities with people not only from different ethnic cultures but also those of a different age, gender, education, faith, sexual orientation, socio-economic status, ability, and geographic orientation. The skill requires special cultural knowledge and training. Therefore, when nurses start an interaction with clients from different cultural backgrounds, it is necessary to use the cultural attitude and knowledge to assess their cultural needs. This step is also suitable because cultural skill is about learning how to determine a client's values, beliefs, and practices by conducting a cultural assessment (Campinha-Bacote, 1999). Following this, the planning and implementation can be undertaken to provide appropriate service and meet the client's cultural need. However, it is predictable that the more nurses expose themselves to this group of client, the more they will become competent because they accumulate skills, abilities, and experience that is necessary to perform CC care well.

Even though these three components are the process of becoming culturally competent, there are contributing factors and barriers that influence the level of competency of an individual.

Facilitating factors contributing to CC

Exposure to people from various cultural backgrounds

A study about CC in the nursing and health education revealed that nursing faculties who were more exposed to immigrant populations scored higher in CC tests than those who had less exposure (Kardong-Edgren, 2004). This is supported by another study saying that the comfort in caring for clients from diverse cultures was increased through repeated exposure to persons from other cultures (Kardong-Edgren, et al., 2005). Furthermore, some measures and studies imply that CC is achieved when practitioners have acquired sufficient awareness and knowledge of the other, often through repeated exposure and contact with the other (Bond, Kardong-Edgren, & Jones, 2001; Kumas-Tan, et al., 2007). Not surprisingly, cultural immersion and working with people from other cultures are the most effective strategies for gaining comfort with diverse cultures (Kardong-Edgren, 2004).

Correct attitude

A previous study showed that nurses who had low ego-defensiveness and open-mindedness had a more positive attitude toward Hispanic clients who are a minority in the USA (Bond, et al., 2001). Positive attitude toward cultural differences leads to a desire to acquire cultural knowledge and skill, which are the essence of CC.

Educational preparation

Experience in taking courses and workshops related to cultural competent care is a significant factor that influences cultural competency levels (Kawashima, 2008). The finding is correlated with a study on cultivating cultural competence through education in China in 2007 which discovered that nurses who received a cultural competence educational program obtained significantly higher scores on cultural knowledge, cultural sensitivity, and cultural skills than the others (Perng, Lin, & Chuang, 2007). Furthermore, the educational level of the provider was associated with differences in knowledge of cultural patterns and attitudes toward clients of diverse ethnic backgrounds (Jones & Bond, 1998).

Being a woman

Women have a greater aptitude at developing cultural sensitivity than men. According to a study by Lee and Coulehan in 2006 that aimed to assess the cultural attitudes of medical students toward racial diversity and gender equality and to identify groups within this population that differed in cultural sensitivity, women scored higher than men. Similarly, a study found that female doctors exhibit more empathy and engage in more co-operative, partnership-building relationships with clients than male doctorsw.ebscohost.com,july22,09.

Being a minority

In a study on students learning cultural differences, it was found that the combined score of minorities was substantially higher than that of the majority. Over a 2-year period, the same test was given and it was found that minority group students (Asian, Hispanic, and black) showed a significant increase in mean score ($P = 0.001$) compared with the white group, which did not change ($P = 0.34$) (M. Lee & Coulehan, 2006). It was suggested that minority students may recognize the significance of cultural studying and upholding cultural attitude more than majority students.

Barriers to cultural competence

Lacking cultural knowledge and its application in practice

Since current health care practices are structured in a more or less neutral approach to acknowledging the cultural differences, a low level of self-confidence in cultural knowledge is an evident barrier to acquiring cultural competence. The confidence in cultural knowledge is influenced by the lack of exposure to minority

people, prejudice and stereotype, or it may reflect less information in today's literature about that minority culture (Kardong-Edgren, et al., 2005). Therefore, any minority group with a lack of literature explaining their own culture to other people is at an obvious disadvantage. The chances of being understood and of suitably interacted with by others are diminished for both parties. Hence nurses avoid contact with the Other and have negative attitudes toward them sometimes. Similarly, another study about exploring the barrier in the implementation of diversity in health care practices among health care professionals including nurses shown that there was a lack of awareness and knowledge regarding dimensions of diversity in health care partly due to the unfamiliarity with the impact of dimensions of diversity on patients' health (Celik, Abma, Widdershven, Wijmen Van, & Klinge, 2008). Therefore, nurses who have less experience in interacting with diverse populations will not feel comfortable being among them due to the cultural dissimilarities.

> Although nurses have cultural knowledge, they may not know how to utilize the knowledge in practice. Several reasons were identified such as ingrained habits, the expectation to conform to standard health care procedure, time pressure, lack of confidence, or directives from superiors (Kumas-Tan, et al., 2007). In addition, a lack of opportunity for students or health care providers to operate their cultural knowledge in the context of actual client care with the other population will decrease the opportunities for improving cultural skills (Kardong-Edgren, et al., 2005).

Discriminatory attitudes

Discriminatory attitude certainly affects cultural attitude; consequently, such an attitude decreases the effectiveness of care for clients. According to Kumas-Tan and his colleagues, ethnocentrism and racism are the result of individual ignorance and individual prejudice as their study shows that the scores of ethnocentric prejudice and discriminatory attitude were high (2007). Even though some people are aware of their own prejudice and remind themselves not to feel that way, they just cannot help it sometimes. Similar findings were supported in another study that described nursing faculty attitudes, perceived cultural knowledge, and cultural skills in caring for clients from Hispanic, African American, Southeast Asian, and Anglo communities (Jones & Bond, 1998). Moreover, attitudes or uneasiness that denies the larger structural and systemic realities of racism, ethnocentrism, and other forms of social inequality create cultural incompetence (Kumas-Tan, et al., 2007). Not only denial, but also a closed minded attitude may lead people to gain more negative attitudes toward culturally different people (Ruiz, 1981). However, we all are aware that these issues exist but for a person who is not interested in the existence of the Other, the cultural attitude, the willingness to learn, and the application of knowledge are not likely to occur. Although some practitioners have good knowledge of the Other, they may not utilize it because of their closed-mindedness and ignorance (Kumas-Tan, et al., 2007).

Language barrier and poor communication

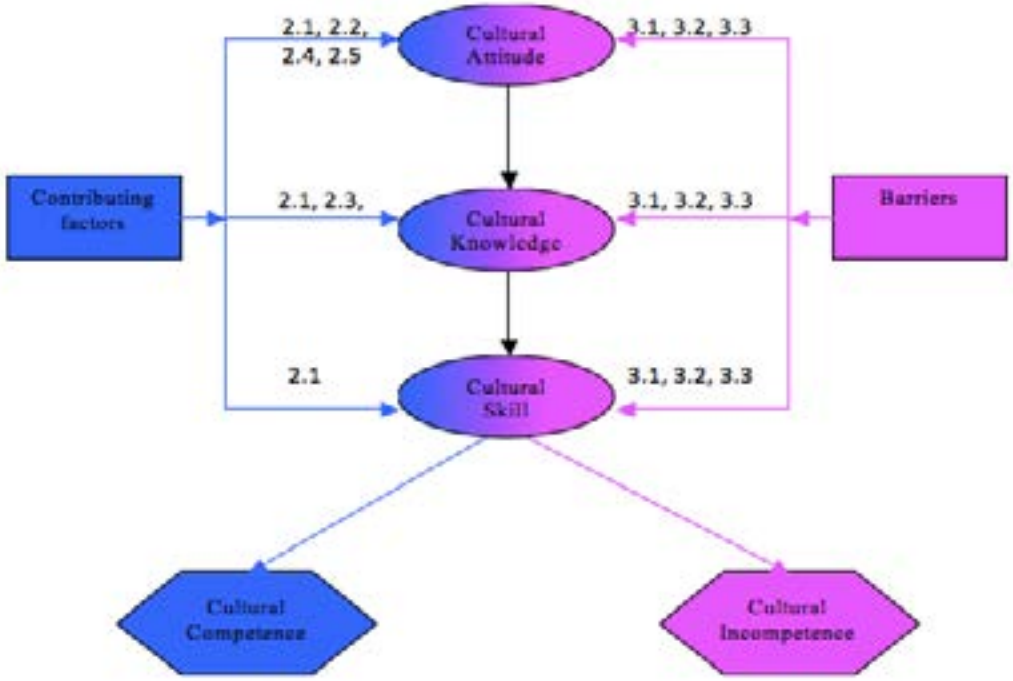
Cultural competence depends on increased familiarity through increased contact or communication with diverse individuals (Kumas-Tan, et al., 2007). One study revealed that students felt more confident in their ability when using interpreters and their CC increased significantly with bilingual and culturally appropriate personnel providing the treatment services (Kulwicki & Boloink, 1996). This reflects the issues that even though an individual has cultural attitude and knowledge, cultural skill cannot be learnt or given effectively due to the inefficient language skill of providers. Therefore, problems occur between providers and clients because of obstacles in communication. This is similar to another study which reported that poor information and communication can be an important barrier of mutual understanding between client and health care professionals (Celik, et al., 2008).

Outcomes

Outcomes of the interaction among those who are acquiring processes of cultural competency can be classified into: (1) cultural competence, and (2) cultural incompetence. An individual who achieves this status is the one who acquires a strong foundation in cultural attitude, cultural knowledge, and cultural skill. They are commonly equipped with any of the contributing factors to CC. Hence, they are capable of assessing cultural needs, planning proper care, and providing cultural care proficiently to the other in any situation. However, some scholars disagree and point out that whether practitioners applied what was taught, or whether what was taught had any impact on service processes and outcomes, remains unclear (Kumas-Tan,

et al., 2007). In contrast, a cultural incompetent individual is the one who is not equipped with cultural attitude, cultural knowledge, cultural skill, or any of these components. Not surprisingly, this person bears some type of CC barriers. Therefore, it is impossible for this individual to understand, interact and care for the Other appropriately.

It is mandatory that people have all of these three components in acquiring CC skill. Unfortunately, the transformation of knowledge received into cultural skill may not occur due to some CC barriers. The more strength in each component people have, the more proficient in cultural competency they will be. Therefore, people are encouraged to advance their ability of all components continuously. In acquiring CC, both contributing factors and barriers must be taken into account as well. The relationship among these five elements of CC can be demonstrated in Figure 1.



Note: Numbers representing each contributing factors and barriers in the content

Figure 1 Concept of Acquiring Cultural Competence, Contributing Factors and Barriers, and Outcomes

Measurement and Instrumentation of CC

The knowledge of psychometric evaluation in measurement is the foundation in examining an appropriate tool for cultural competence studies. Since cultural competence study in Asia is in its early stage of development, it will be beneficial to study tools that are developed earlier from various resources. Moreover, if professional nursing is to evaluate cultural competency, we need to identify existing tools and be able to determine their quality from their psychometric properties (see Table 1).

According to Kumas-Tan and colleagues, several tools are utilized as cultural competence measures (Kumas-Tan, et al., 2007). The most commonly used measures of multicultural competency are Cultural Self-Efficacy Scale (CSES), Multicultural Counseling Inventory (MCI), Cross-cultural Counseling Inventory (CCCI), Multicultural Counseling Awareness Scale (MCAS), and Multicultural Awareness Knowledge Skills Scale (MAKSS) (Dunn, Smith, & Montoya, 2006). Among those scales, CSES and MAKSS have the highest psychometric properties. However, a minimum of two types of reliability and two types of validity tested was suggested (Waltz, Strickland, Lenz, & Soeken, 2005). Therefore, further studies on CC measures are highly obligatory and encouraging.

In addition to studying psychometric properties of the tools, identifying important components is crucial for constructing other measures in the future. This study will use the method of defining components for CC measure from Walker and Avant (2005). All of the components from these seven tools were analyzed to identify the most commonly used components of the CC tool (Table 2)**.** Among the three most important components for CC measure, cultural awareness ranks the highest under the category of cultural attitude in accordance to the meaning as defined by the concept of CC. Moreover, measuring the cultural knowledge is not a problem in and of itself; rather, it becomes problematic when measures of knowledge are used as stand-ins for cultural competence, of which knowledge is only a part (Kumas-Tan, et al., 2007). Therefore, investigators must bear this in mind when constructing a tool or choosing an appropriate tool to assess CC.

Another important aspect that any investigator needs to be aware of is the effect of social desirability toward the response. Multicultural competency tools, such as MCI, MAKSS, and CCCI-R, were linked with social desirability accounted of average correlation coefficients ranging from .21 to .24. Therefore, it is suggested by many scholars to concurrently administer measures with social desirability questionnaires (Dunn, et al., 2006).

According to Meleis' criteria to analyze the rigor and creditability of research process of CC (Meleis, 1996), some studies utilize it for assessing measurement scale (Im, Meleis, & Lee, 1999; Im, Page, Lin, Tsai, & Chen, 2004). Even though these studies apply only some criteria in evaluating their tools, they are valuable criteria for CC study. Furthermore, CC has changed over time due to changes in health care delivery systems, culture, people, beliefs, and etc. Therefore, it remains unclear whether measures of CC tools which were developed in western countries can be utilized in non-western countries including Thailand since CC is influenced by the culture to which people adhere.

For Thais, collectivism is demonstrated in their way of living and working. Thais, generally, live in an extended family systems composed of immediate family members and close family members residing together in one house. Helping, caring, and sharing among members are common practices which is called "Nam Jai". Hence, Thais tend to have more sensitivity toward and tolerance of the Other. Hence, CC measures that take into consideration cultural practices and values of nurses within the appropriate context of the population in their own country are necessary. A suggested example of the items measuring the cultural attitude component for Thai nurses should include the statement "I feel comfortable being around Caucasian, Burmese, Islamic, Karen, African, Chinese, Indian, and the Other". Suggested examples of the items in the cultural knowledge component should include "I know that I should not make eye contact with older Chinese or Korean when talking to them because it is impolite in their culture" or "I should leave more space when approaching Caucasians because they are highly individualistic". Some items in the cultural skill component can be "I am flexible with time when rendering my care to Muslim clients because they have to pray 5 times a day".

Table 1 *Comparing Cultural Competence Measures*

Cultural Competence Measures	Purpose	Components	Reliability	Validity	Additional information
1. Cultural self-efficacy scale (CSES), 1987 and revised in 1993 (Bond, Kardong-Edgren, & Jones, 2001; Suzan Kardong-Edgren et al., 2005; Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007)	For use in nursing	1.Knowledge of cultural concepts 2.Knowledge of cultural patterns 3.Skills in performing transcultural nursing functions	-Good reliability	-Good validity	Assumes behavior is positively associated with an individual's level of confidence. Constructed to assess Puerto Ricans, African Americans, South-east Asians, Hispanic, Anglo, Islamic, and Native American cultures.
2. Inventory for assessing the proves of cultural competence among health professionals (IAPCC and IAPCC-R), 1998 and revised in 2003 (S Kardong-Edgren, 2004; Kawashima, 2008; Kumas-Tan et al., 2007; Sargent, Sedlak, & Martsolf, 2005)	For use in nursing, medicine, and pharmacy	1.Cultural awareness 2.Cultural knowledge 3.Cultural skill 4.Cultural encounters 5.Cultural desire	-Good internal consistency	-Content and construct validity were done but no result shown	
3. Culture Attitude scale or ethnic attitude scale (CAS/EAS), 1979 and revised in 1993 (Bond et al., 2001; Suzan Kardong-Edgren et al., 2005; Kumas-Tan et al., 2007)	For use in nursing	1.Nurisng care-patient interaction 2.Cultural health behavior 3.Cultural health attitudes and beliefs	-Poor reliability -Relatively low Cronbach Alpha	-Not known	Consists of four vignettes describing four ethnic groups (Anglo, African American, Asian, and Hispanic). Each vignette assesses family members, type of employment, church preference, and health care practices.

4. Multicultural counseling inventory (MCI), 1994 (Kumas-Tan et al., 2007; Ponterotto, Rieger, Barrett, & Sparks, 1994)	For use in counseling psychology	-One general multicultural competency factor -Four specific factors 1. Multicultural counseling skills 2. Multicultural awareness 3. Multicultural counseling relationship 4. Multicultural counseling knowledge	-Unknown result of test-retest stability	-Good face validity -Good content validity -Moderate relationship among subscales -Four-factor model accounts for 36% of variance	
5. Multicultural awareness, knowledge, and skills survey (MAKSS and MAKSS-CE-R), 1991 and revised in 2003 (Kumas-Tan et al., 2007; Ponterotto et al., 1994)	For use in counseling psychology	1.Awareness-revised 2.Knowledge-revised 3.Skills-revised	-Adequate reliability	-Acceptable construct validity -Acceptable criterion-related validity -MAKSS-CE-R accounts for 1/3 of the variance that the original MAKSS had accounted for (29.8%)	
6. Cross-cultural counseling inventory (CCCI and CCCI-R), 1983 and revised in 1991 (Kumas-Tan et al., 2007; Ponterotto et al., 1994)	For use in counseling psychology	1.Cross-cultural counseling skill 2.sociopolitical awareness 3.Cultural sensitivity	-Questionable test-retest -Questionable Interrater reliability	-Factor structure remains in question	
7. Multicultural counseling knowledge and awareness scale (MCKAS), 1991 and revised in 2002 (Kumas-Tan et al., 2007; Ponterotto, Rieger, Barrett, & Sparks, 1994)	For use in counseling psychology	1.Knowledge 2.Awareness	-Not known	-Moderate convergent validity with MCI -Questionable criterion validity	Results of psychometric evaluation are preliminary

Components	Number of times used as CC components among 7 tools	Ranking
Knowledge of cultural patterns (#1), Knowledge of cultural concepts (#1), Cultural Knowledge (#2), Multicultural counseling knowledge (#4), Knowledge-revised (#5), Knowledge (#7)	6	2
Skills in performing transcultural nursing functions (#1), Cultural skill (#2), Multicultural counseling skills (#4), Skills-revised (#5), Cross-cultural counseling skill (#6)	5	3
Cultural awareness (#2), Cultural health attitudes and beliefs (#3), Multicultural awareness (#4), Awareness-revised (#5), Sociopolitical awareness (#6), Cultural sensitivity (#6), Awareness (#7)	7	1
Cultural encounters (#2)	1	
Cultural desire (#2)	1	
Nursing care-patient interaction (#3)	1	
Cultural health behavior (#3)	1	
Multicultural counseling relationship (#4)	1	

Table 2 *Components of Cultural Competence Measures*
Note: (#) Representing tool number in **Table**

Inevitably, a standard CC measure, both psychometric properties and the content that fit circumstances to the population of the practice sites are important. It is suggested that more CC tools development and more utilization of CC measures in CC research are required.

Clinical Practice Issues

Thai nurses' way of rendering care to the Other originates not only from their cultural awareness, cultural knowledge, and cultural skill, but also from their own culture belief, background and experiences. This section will describe clinical practice issues regarding cultural care.

When nurses first meet clients, their initial response is to observe the language, appearance, odor, costume, and manner of that client in order to assess similarities and differences between themselves and their clients. According to a study on Cultural Awareness Competency of Thai Nursing Students and Faculties in giving care to multicultural client (Hiranchunha, Sangchan, Songwattana & Phetphichetchean, 2009), students who have less experience in contacting the Other sometimes avoid contact with the clients who are different from them. Students are afraid of and do not participate in any activities with other students who wear Muslim outfits because of the possible connections with the terrorist acts in the three southernmost provinces of Thailand. At the same time, Muslim students do not participate in Wai Kru ceremony because it is against their religious teaching and some do not understand this. The similar scenario also happen in a hospital when nurses are afraid of Muslim clients and do not attend to them as much as they should because of poor understanding in cultural care. Furthermore, less language skills to communicate with clients who speak a different language may obstruct nursing care. A previous study found that nursing students from other parts of Thailand had difficulty and were uncomfortable in doing clinical practice especially when taking clients' history and writing care plans because of their inability to speak the southern Thai dialect or Malayan language (Hiranchunha, et al., 2009). Fortunately, Thais have Nam Jai and a tradition of respecting powerful and privileged persons in the society. Hence, nurses try to communicate, assist, and especially, tend to give special attention to the client who appears to be superior. Therefore, strategies to enhance progression in cultural competency skills are essential to generate equal treatment among clients.

Strategies in Enhancing Cultural Competency of Professional Nurses in Thailand

According to the concept, the strategies to increase CC in nurses are categorized into two main levels: (1) nursing student level, and (2) professional nurse level.

Nursing student level

This level of preparation is considered the most important foundation of CC care. Cultural diversity education is essential and recommended to be included into all nursing programs. However, the implementation of the plan has to be executed appropriately. Thais observe a large power distance cultural practice. They are more accepting of unequal distribution of power and privileges within hierarchical organizational systems (Ralston, 2005). The large power distance culture creates centralization of decision-making power mainly at the top level; therefore, this change in educational system will need to be accomplished by the Ministry of Education and Thai Nursing Council. The question may be raised on what degree CC concept should be included in nursing curricula. The answer depends on how serious the gaps in the provider and client relationship are. A minimum of 1-hour lecture and 2-hour lab/practice may be integrated into the content throughout the program. The issue may be raised in post case conference discussions or seminars when encountering the Other in clinical practice (Songwathana, 2010)

In CC education, students may acquire knowledge and skill in small increments thus enhancing competency as time goes by through repeated exposure to the real practice situation in clinical sites. A clinical evaluation may be designed to ensure an increasing complexity of the three areas of CC – attitude, knowledge, and skill – year by year. For example, the evaluation criteria purposed by Kent State University College of Nursing are worth considering. The first year students are expected to "discuss cultural influences on the discipline of nursing and health care practice". The second year level, students are expected to "discuss characteristics and components of culture and identify behaviors reflective of a culture/ethnic group as related to health care". At the third year level, students are expected to "explore the influence of culture on nursing care". At the fourth year level, students are expected to "critically examine cultural factors related to current challenges in the profession of nursing emphasizing international/global perspectives" (Sargent, et al., 2005). In this study, they found that fourth year students were more culturally competent than first year students. The finding is supported by Reeves (2001) who described a curriculum revision that enhanced knowledge about transcultural nursing.

For a clinical evaluation, it is recommended that students are allowed to do self-assessment in conjunction with faculty evaluation in order to promote students' cultural self awareness. In addition, Songwathana's model (2010) for integration of CC training in nursing education for preparing Thai nursing students also supported the idea that third and fourth year of students should learn and use cultural understanding to identify clients' problems, nursing intervention and improve patient education. Experiential learning can assist students to practice what they have learnt in class.

Furthermore, persons with greater exposure to cultural experiences through international travels are more culturally competent than those who have never been exposed. Similarly, a study where nursing students and faculty members of state university in a Midwestern American small city were asked to complete an inventory for assessing the process of CC (IAPCC). The result showed a positive correlation between the numbers of foreign countries they visited and the cultural competence score (Sargent, et al., 2005). Hence, faculty members are encouraged to obtain an international experience and be a key person to bring back an expertise to help their students. Furthermore, Sargent and colleagues also encouraged the use of immersion experience as a tool to increase students' knowledge of health care needs among various cultures. The cultural immersion, besides assisting faculty members in gaining CC, will also improve personal adjustment, language acquisition, and culture learning for students regardless of the length of stay (2-10 weeks) (Jones & Bond, 2000). Therefore, educational institutions are strongly encouraged to establish student exchange programs with institutions abroad in order to broaden, not only their perspective on nursing care and education in other countries, but their cognitive maturation as well (Lee, Pang, & Wong, 2007).

Professional nursing level

With increasing multicultural and multiethnic background clients, CC is becoming one of the important elements of nursing care. One may be more culturally competent with a certain diverse population (such

as Laotian) but not with another (such as gay and lesbian). Nurses are expected to provide appropriate care for more and more diverse population groups, and to ensure that the human rights of clients from different cultures are respected (Gerrish, 1997). Therefore, as the large power distance cultural practice creates centralization for the process of decision-making, it is suggested that the Ministry of Public Health can establish the CC requirement for hospitals' national policy and Hospital Accreditation (HA) criteria.

At the implementation level, theoretical consideration is recommended to be added. Raynolds and Leininger developed the Sun Rise Model in 1993 which described the theory of Cultural Care Diversity and Universality (Reynolds & Leininger, 1993). The model concerns the context of environment, language, and cultural background. As hospitals accept the national policy to increase CC, creating an environment to support this change is essential. The environmental changes will assist all nurses and other health care personnel to be aware of and sensitive to the issues and promote learning experience in CC. For instance, pictures or reading materials that illustrate people from different cultures and ethnic groups around this region such as Chinese, Indians, Muslims, etc. could be made available in the waiting room and client rooms. Handouts and brochures should be in the main languages of clients that the hospital serves. Health care providers and office support staffs should as far as possible be from the same major ethnic background as clients. Television and radio programs in some channels are in the languages of the major ethnic backgrounds of clients. When this new environment is created, it stimulates cultural sensitivity and cultural awareness which contribute to establishing an important foundation for cultural attitude. Since language is one of the CC barriers, some hospitals may wish to send nurses to learn other languages. Lastly, to avoid miscommunication, utilizing interpreters should be available as an option.

CC training courses is required for nurses to understand clients' cultural background. The training activity can be implemented through cooperation between hospitals and the national policy from the Ministry of Public Health. Administrators may send nurses to learn other cultures and immerse themselves at international experiences. Nurses will gain greater attitude, knowledge and skill in effective CC care as well as technology in nursing from other hospitals. When implemented, such a program which was done at the School of Nursing Polytechnic University in Hong Kong reported significant changes in personal development in relation to gaining a cultural understanding of the host region (Lee, et al., 2007). Moreover, to increase the level of confidence in transcultural care skill, cultural content taught in current nursing program, continuing education courses, and the predominant ethnicity of clients is recommended. These three predictive variables accounted for 33% of the variability in the level of confidence in transcultural care skill (Kardong-Edgren, et al., 2005).

A recent survey on CC of nursing students, nurses, faculty members conducted in southern Thailand where a predominant Muslim population was shown a significant finding. Findings revealed most subjects' CC is interpreted as having cultural awareness. Although the cultural content knowledge was low, the overall cultural attitudes and skills were at a moderate level. Lack of knowledge and language barrier were perceived as the main barriers. The results suggest that teaching and learning through direct experiences and delivering culturally competency care are necessary. Further studies may be required to develop an effective model through the use of the clinical setting within the context of real-world clients in order to facilitate their cultural needs (Songwathana, et al., 2008).

The strategies to increase CC at both student and professional levels are equally important. Hence, the continuation of above strategies will create a consistent CC care outcome.

Conclusions

Health care providers and clients are affected by globalization in the last decade in many aspects. Clients feel uncomfortable in accessing medical care due to being perceived as minorities or different (the Other). Meanwhile, nurses concerns whether cultural care for this special group of clients is efficient. Three processes of gaining CC are cultural attitude, cultural knowledge, and cultural skill. While contributing factors and barriers in CC derive from each individual's background, those are unchangeable; attitude, experience, and knowledge in CC are changeable. Successful outcomes depend mostly on the changeable variables. To fill the gap of knowledge in this area may require further studies in the Thai context in order to capture the concept more completely. Although several tools exist, none of the tools in this study was developed in Asia; therefore, there is a great need for a study to develop a standard CC measure in Asian context that may be utilized suitably for Thai and Asian nurses.

Even though many resources are available for improving CC, it is important to recognize that there is no cookbook approach for teaching cultural sensitivity and competence (Suzan Kardong-Edgren, et al., 2005). Therefore, success in improving our CC in Thailand also depends on the vision and support from involved

government offices. Implementation at all levels is equally important which requires the attention of administrators and staffs as well as financial support from organizations. Our hope in the future is seeing health care personnel from diverse ethnicities effectively serving clients from anywhere in the world, while learning and sharing experiences in life among each other. It is our belief that the process of civilization rooted in our humanity will be enriched by diverse perspectives in the near future.

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