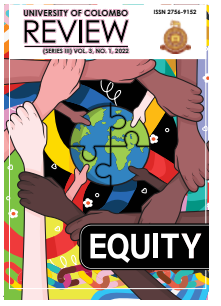

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Cultural competence among student nurses in two selected government schools of nursing in Sri Lanka: A descriptive study

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ABSTRACT

The Cultural Competence of nurses is an important aspect of effective health care. Cultural competency in nursing contributes to equity in health care for culturally diverse patients. Sri Lanka is a plural society and nurses will be serving patients from diverse cultures in their professional contexts. Components of cultural competence are cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire. The purpose of the study on which this article is based was to investigate the level of cultural competence among third-year nursing students in two selected schools of nursing in Sri Lanka. The study was descriptive, cross-sectional, and was conducted in the schools of nursing in Jaffna and Kurunegala among all the schools of nursing. According to the results, all the components of cultural competence were at a moderate level. Based on this finding, the article suggests that cultural competency ought to be improved among student nurses. Moreover, the article suggests that training on components of cultural competence ought to be included in nursing education in Sri Lanka. This would ensure that nurses are equipped to provide culturally competent care. Such nurses would improve equity in health care and enhance patients' satisfaction.

KEYWORDS:

Student nurse, Cultural competence, Cultural awareness, Cultural knowledge, Cultural skill, Cultural encounter, Cultural desire

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Introduction

This article focuses on cultural competence and equity in the provision of health care. It is based on a study among a selected group of student nurses in Sri Lanka. The purpose of the study was to investigate the level of cultural competence among third-year (final year) student nurses in two selected government schools of nursing in Sri Lanka. Cultural competence is "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (individual, family, or community) and the constructs of cultural competence are cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire" (Campinha-Bacote, 2002, p. 181). Understanding the variations across cultures is known as cultural awareness. Cultural knowledge can be defined as the educational foundations of many cultures. Cultural skills are the ability to gather cultural facts relevant to the patient's present health problem, and a cultural encounter is a cross-cultural engagement. Cultural competence is culturally desirable to be willing to provide care to patients of other cultures (Campinha-Bacote, 1999). It is essential to provide equity in health care because the aim of healthcare equity is to ensure that everyone can access affordable, culturally competent health care regardless of race, ethnicity, age, ability, sex, gender identity or expression, sexual orientation, nationality, socioeconomic status, and geographic location.

There is evidence that cultural diversity is increasing worldwide. Black, Hispanic, and Asian populations, for example, are anticipated to increase considerably by 2050. Therefore, healthcare workers all around the world require competence to deliver culturally sensitive care (Reyes et al., 2013) without racial or ethnic discrimination (Marian et al., 2016). The population of around 21 million people in Sri Lanka is culturally, linguistically, and religiously diverse. Providing culturally sensitive health care therefore can pose a challenge for nurses in Sri Lanka. Despite the fact that these principles are taught to students during their training, evidence suggests that their cultural competency is weak even upon completion of their training. Studies have demonstrated that most nurses have poor cultural competence (Sealy, 2003), whereas some have moderate cultural competence (Cicolini et al., 2015; Rew et al., 2003). These studies also demonstrated the need for additional research on cultural competence in areas where ethnic and cultural diversity exists or is developing.

Lack of cultural competence contributes to disparities in the delivery of health care services, poor health outcomes, and lower cost-effectiveness (Betancourt, Corbett & Bandaryk, 2014). It creates a barrier between the patient and healthcare provider and hinders safe patient care (Campinha-Bacote, 1999). Cultural conflicts and non-compliance can occur if professional nursing care is not compatible with the beliefs and values of the care receiver. Therefore, it is essential to identify the level of cultural competence among nurses because it is a component of quality practice that leads to improved health outcomes for patients, families, and the healthcare system. Understanding the levels of cultural competence of the student nurses will lead to educational reforms or curriculum amendments in nursing education. Hence, the purpose of this study was to investigate the level of cultural competence among third-year (final year) student nurses in two selected government schools of nursing in Sri Lanka.

Methodology

This study used a descriptive cross sectional study design. The study population was the third-year student nurses in two purposively selected government nursing schools in Sri Lanka, Kurunegala, and Jaffna. The researcher selected two nursing schools to include culturally diverse students as participants in this study. The recommended sample size, according to the Raosoft online sample size calculator, was 171. A proportionate number of 124 students from the School of Nursing in Kurunegala and 47 students were chosen from the School of Nursing in Jaffna. The systematic random sampling technique was undertaken using the student register in each school to select the sample. All the third-year students were included and students who were sick at the time of the data collection were excluded.

Data collection was carried out through a self-administered questionnaire. It is a researcher designed instrument that includes items developed by the researcher as well as items adapted from the literature (Rakesh, 2012; Sealy, 2003; Sealy, et al.,2006; Suaez Balcazar et al., n.d). The instrument is designed specifically to measure the cultural competence of student nurses and encompasses five of the constructs based on the Campinha-Bacote model (1999): cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire. The instrument consisted of two sections. The first section (Part A) of the questionnaire included items on demographic data. The second section (Part B) included 42 items on subscales of cultural competence, and respondents were asked to rate their level of agreement on a Likert scale. Reliability was confirmed by Cronbach's alpha. (Table 1).

Table 1
The reliability coefficient for the items of the questionnaire

Scale	Number of items	Cronbach's Alpha coefficient
Cultural awareness	13	0.70
Cultural knowledge	9	0.69
Cultural skill	6	0.80
Cultural encounter	8	0.73
Cultural desire	6	0.76
Cultural competence	42	0.90

Every response receives a point value. Strongly agree -5 points, agree -4 points, 3 points for neutrality, 2 points for disagreement, and 1 point for strong disagreement. The level of cultural competence can be determined after the value of a student's responses has been established. The mean of the part B scores is used to calculate the cultural competence score. The values for each level of cultural competence are listed below, with higher scores indicating greater cultural competence: The values are based on previous studies.

1–1.99 indicates a low level of competence, 2–2.99 indicates a mild level of competence, 3–3.99 indicates a moderate level of competence, and 4–5 indicates a high level of competence.

Initially, the questionnaire was pretested to 10 selected third-year student nurses from the School of Nursing, Kurunegala, who were not selected as the participants. During the pre-test, special emphasis was given to the recruitment process of participants, the introduction and consent obtaining process, the administration of the questionnaire, the understandability of the questionnaire, and the

time taken to complete one questionnaire. Also, emphasis was given to the identification of questions that were difficult to understand, confusing, or offensive.

Microsoft XL and Statistical Packages for Social Sciences (SPSS) version 21 were used for descriptive statistical analysis. The researchers obtained informed written consent from the students before data collection and ensured voluntary participation in the study. Administrative clearance was obtained from the principals of the School of Nursing in Jaffna and Kurunegala. Ethical clearance was obtained from the Ethics Review Committee of the International Institute of Health Sciences, Welisara, Sri Lanka.

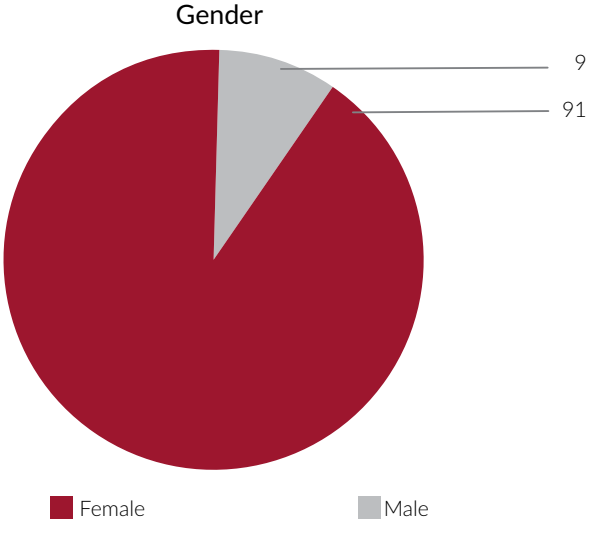
Limitations

The researcher had hoped to include culturally diverse participants from two intentionally selected schools, but the random sampling of the students did not yield this goal. Rather than observing actual behavior, data was obtained through a self-administered survey. It may have allowed participants to provide socially acceptable responses rather than share their honest views. In addition, questionnaire items were selected from the literature, and the required validation procedure was not followed. Due to the insufficient sample size, the researchers were unable to establish correlations between gender, ethnicity, religion, and cultural competency in this study.

Results

Demographic results of the participants

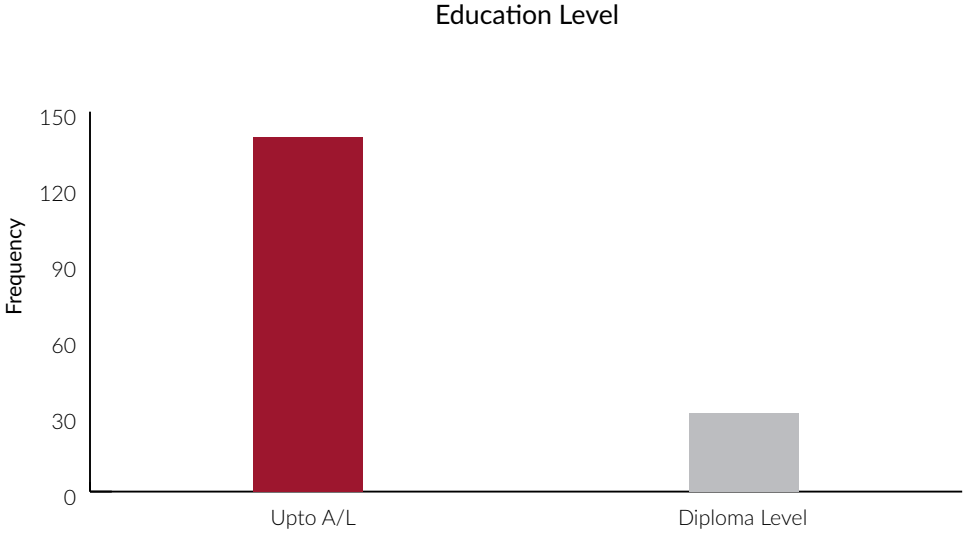
Figure 1 -Gender distribution of the participants



The response rate was 99.8%. All of the participants (n = 171) were between the ages of 20 and 30. The majority of the participants (n = 156, 91 %) were women, as expected because nursing is a female dominant profession. Males made up about 9% of the respondents (n = 15, 6.85 %) (Figure 1).

Education

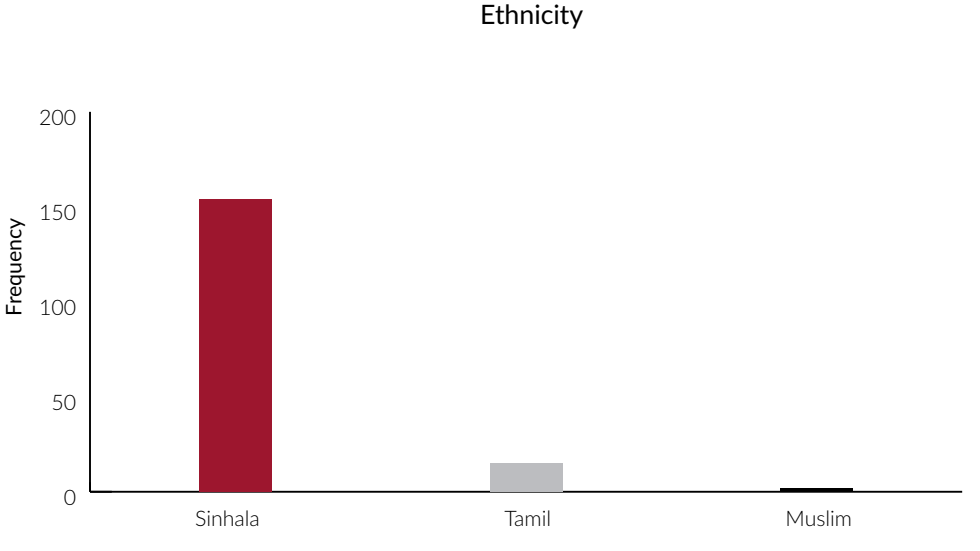
Figure 1 -Gender distribution of the participants



The majority of the sample were educated up to Advanced Level (n=140, 81.8%).31 participants (18.2%) had received education up to diploma level after passing the Advanced Level examination (Figure 2). Passing the Advanced Level examination is the minimum recruitment qualification for the nursing profession.

Ethnicity

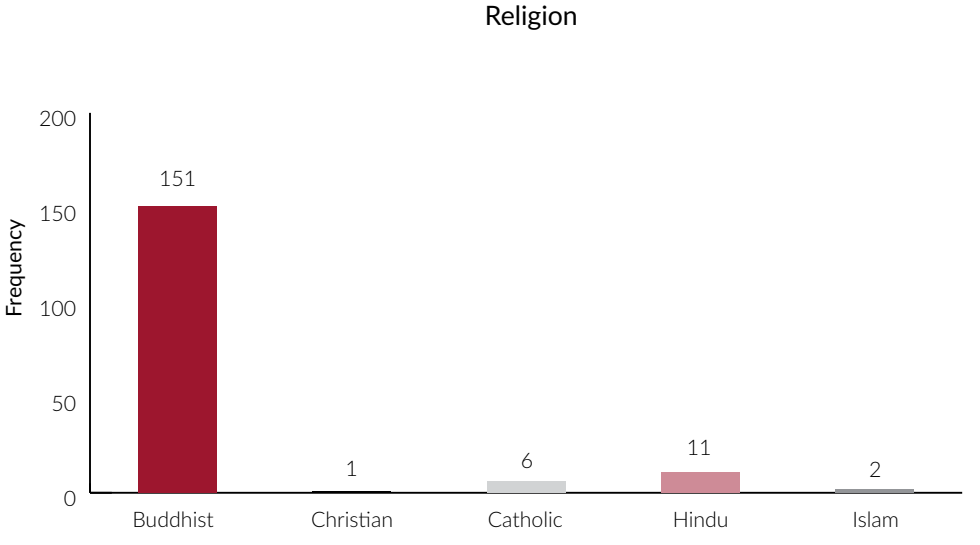
Figure 3 - Distribution of participants' ethnicity



According to the findings, the majority of the participants identified as Sinhalese (n=154, 90%), followed by Tamil (n=15, 8.77%), and Muslims (n=2, 1.2%) (Figure 3). In the nursing school in the Jaffna district, there were students of various ethnicities (Sinhala, Tamil, and Muslim). However, there were only Sinhala students in the Nursing school in the Kurunegala district.

Religion

Figure 4 - Distribution of participants' religion



The majority of the participants in the sample (n = 151, 88.4%) identified as Buddhists. Hinduism (n=11, 6.4 %), Catholicism (n=6, 3.5 %), Islam (n=2, 1.2 %), and Christianity (n=1, 0.5 %) were the next most popular religions respectively (Figure 4).

Comfortable languages of participants

The majority of students (n = 155, 90.64%) spoke Sinhala, and 79 students (46.19%) stated that they could speak English. 12.2 percent of the sample stated that they were fluent in Tamil. The majority of the sample stated that they most frequently care for patients who self-identified as Sinhalese (n = 127, 74.26 %).

Constructs of cultural competence

Cultural awareness

The cultural awareness sub-scale items assessed respondents' awareness and appreciation of cultural diversity through the use of these ideas (Table 2 and Figure 5). Nursing students rated their cultural awareness as moderate (M = 3.76).

Table 2- Level of agreement with statements regarding cultural awareness

Serial No	Variable/item on cultural awareness	Mean	SD
1.	Should make friends with people from various cultural backgrounds	4.40	0.61
2.	Aware of the other culture's cultural values and beliefs	3.75	0.84
3.	Be aware of the meaning of body language in different cultures	3.29	0.95
4.	People should not be stereotyped.	3.13	1.05
5.	Examine my own racial and cultural biases that may influence my nursing behavior.	3.76	1.06
6.	Understand my racial and cultural prejudices	3.60	1.00
7.	Be aware that male-female roles can differ depending on the culture.	3.63	0.93
8.	Believe that everyone, regardless of their cultural background, should be treated with respect.	4.61	0.63
9.	Consider their perspectives on health, illness, and the differences between them.	4.09	0.73
10.	My culture has influenced my views on health and illness.	3.47	1.15
11.	Aware of some of the attitudes that are stereotyped (prejudices)	3.5	0.94
12.	Aware that perceptions about biological differences in different cultures	3.74	0.98
13.	Aware that when caring for others, the same approach should not be used.	3.83	1.06

Cultural knowledge

The mean score on cultural knowledge level was 3.83, indicating that the participants agreed they had a moderate level of cultural knowledge.

Table 3 - Level of agreement with statements regarding cultural knowledge.

	Cultural knowledge	Mean	SD
1	Different cultures have their own unique characteristics.	4.5	0.58
2	Can recognize the obstacles to caring for cultural/ethnic groups	4.2	0.65
3	I would like to learn about the healthcare beliefs of a different cultural group than mine.	3.47	0.90
4	Understand the socioeconomic and environmental risk factors that contribute to major health issues.	4.19	0.65
5	Some religious and cultural groups believe that supernatural forces can cause illness.	3.98	0.82
6	Have a clear understanding of what culture means	3.64	0.87

	Cultural knowledge	Mean	SD
7	Knowledgeable about diseases that are prevalent among cultural, racial, and ethnic groups in our service area	3.40	0.88
8	Understand the dominant cultural beliefs, customs, norms, and values in my service area.	3.61	0.80
9	Becoming familiar with the diseases that originated in the native countries of recent immigrants.	3.38	0.90

Cultural skill

Participants had the lowest mean score on cultural skills (M = 3.50). They agreed that they were not comfortable communicating, assessing, and interacting with people because they lacked confidence in using a variety of cultural assessments (Table 4 and Figure 7)

Table 4 - Level of agreement with statements regarding cultural skill

	Cultural skill	Mean	SD
1	When interacting with culturally/ethnically diverse clients, I am aware of my limitations.	3.98	0.86
2	Know how to assess a client's cultural components	3.36	1.04
3	Skilled and comfortable with a variety of ethnic groups	3.56	1.08
4	To communicate with clients from various cultural backgrounds, use the appropriate communication style.	3.33	1.11
5	Feel comfortable utilizing a variety of cultural assessment tools in a healthcare setting.	3.16	1.10
6	I use a cultural assessment tool to elicit information about my clients' dietary habits, health beliefs, and social structure.	3.6	0.94

Cultural encounter

The mean level of cultural encounter score in this study was M = 3.51, indicating that students were unsure about their encounter with culturally diverse patients. (Table 5 and Figure 8).

Table 5 - Level of agreement with statements regarding cultural encounter

	Cultural encounter	Mean	SD
1	I enjoy interacting (meeting) with people from various cultures.	4.46	0.65
2	I enjoy having friends from various cultural backgrounds.	4.31	0.9
3	I am effective at communicating with clients from cultures other than my own.	3.39	1.06
4	I have spent at least seven days at a time among people from cultural, racial, and ethnic groups other than my own.	3.19	1.52

	Cultural encounter	Mean	SD
5	I look for clinical opportunities to work with culturally, racially, and ethnically diverse clients.	3.55	1.11
6	I work with people who provide health care to people from a variety of cultural, racial, and ethnic backgrounds.	3.11	1.19
7	My workplace does not encourage or support the development of cultural competence.	2.55	1.09
8	Peers have provided me with opportunities to learn culturally responsive behaviors.	3.54	1.29

Cultural desire

The results of this study indicated high competence in cultural desire, with a score of 4.23, the highest in the study.

Table 6 - Level of agreement with statements regarding cultural desire

	Cultural desire		
1	I enjoy interacting with people from various cultures.	4.39	0.69
2	I like to care for clients from various backgrounds	4.21	0.85
3	I would like to further my education, training, and experience to improve my ability to care for clients who are culturally and ethnically diverse.	4.43	0.69
4	I am personally and professionally committed to providing culturally competent nursing care	4.22	0.79
5	I would like to include more cultural and cultural competence content in my curriculum.	3.78	0.99
6	Individuals must be motivated to become culturally competent.	4.35	0.70

Cultural competence

According to the findings, the mean score for overall cultural competence (M =3.76). This was a combination of the indexes of five cultural components of cultural competence. It indicates that most of the participants considered themselves to be moderately culturally competent with regard to cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire (Table 7).

Table 7 -Mean competence level of sub scales and overall mean of the cultural competence

	Mean	Std. Deviation	Variance
Cultural awareness	3.76	0.44	0.19
Cultural knowledge	3.83	0.43	0.18
Cultural skill	3.50	0.73	0.54

	Mean	Std. Deviation	Variance
Cultural encounter	3.51	0.67	0.45
Cultural desire	4.23	0.53	0.29
Cultural competence	3.76	0.42	0.18

Discussion

Cultural awareness

Cultural awareness is the deliberate, cognitive process by which health care providers appreciate and become sensitive to the cultures, values, beliefs, ways of life, practices, and problem-solving strategies of their clients (Campinha-Bacote, 1999). It is the concept of having a basic understanding, acceptance, respect, and valuing of differences that exist between cultures (Sealey, 2003). The cultural awareness sub-scale items assessed the awareness and appreciation of cultural diversity of respondents through the use of these ideas (Table 2 and Figure 5). Nursing students rated their cultural awareness as moderate (M = 3.76). This result is comparable to those found in Sealey's (2003) study, where participants rated themselves highly in the cultural awareness (M = 4.14) sub-scale, and Dutcher's (2012) study (M=4.34). According to the findings of the current study, nursing students agreed to be culturally aware of different cultural groups, and the participants agreed to be appreciative and knowledgeable about cultural diversity issues. However, the majority of the participants in the current study were unable to avoid stereotyping. This is an issue that may have a negative impact on equity in the delivery of health care.

Cultural knowledge

Cultural knowledge is the process of seeking and obtaining a solid educational foundation concerning various worldviews of different cultures (Campinha-Bacote, 1999). It is also a process of learning about the differences that exist between culturally diverse individuals and knowing how to apply this knowledge in practice. Healthcare providers who lack cultural knowledge are unable to comprehend the behavior of their patients. The mean score on the cultural knowledge level was 3.83, indicating that the participants agreed they had a moderate level of cultural knowledge. M = 3.65 (Sealey, 2003) and M = 3.67 (Haller, 2018) were found to be nearly identical to previous studies. In contrast to this study, Gwanmesia's study in 2017 (M = 2) and Dutcher's study in 2012 (M = 3.51) both revealed low cultural competence levels in cultural knowledge. However, cultural knowledge was identified to be a critical component of cultural competence that was consistently associated with overall levels of cultural competence (Sealey, 2003). It is important to build a knowledge base about different cultures so that practice can be informed and stereotyping can be eliminated. A variety of teaching strategies may be applied to improve cultural knowledge such as the use of case studies from different cultures.

Cultural skill

"Cultural skill" is the ability to collect relevant cultural data about the client's health history and current problems, as well as the capacity to accurately perform a culturally specific physical assessment (Campinha-Bacote, 1999). To reduce misdiagnosis and provide competent care, healthcare providers must collect relevant information using a tool and conduct an appropriate cultural assessment. But participants had the lowest mean score on cultural skills (M = 3.50). They agreed that they were not comfortable communicating, assessing, and interacting with people because they lacked confidence in using a variety of cultural assessments in the healthcare setting and did not know how to assess a client's cultural components (Table 4). Most of the previous studies found that the participants had low mean scores on cultural skills M=3.65 (Sealey, Burnett, Johnson, 2006), M= 2 (Gwanmesia, 2017) M=3.41 (Dutcher, 2012), M=3.09 (Haller, 2018). Therefore, students must acquire the necessary skills to be culturally competent. There are cultural assessment tools in the literature that can be used with minor modifications to assess patients in Sri Lanka. Tools that are relevant to the curricula should be identified and introduced. Furthermore, nurse educators can provide opportunities for clinical experience with patients from diverse backgrounds. They may use role-plays to improve cultural skills, use simulation to practice cross-cultural communication among students, and provide opportunities for continuous professional development in the form of workshops and knowledge development sessions.

Cultural encounter

A process that encourages health care providers to interact directly with clients from culturally diverse backgrounds is known as a cultural encounter (Campinha-Bacote, 1999). The mean level of cultural encounter score in this study was M = 3.51, indicating that students were unsure about their exposure (Table 5 and Figure 8). Researchers found a low level of cultural encounter at 3.56 (Seley, Burnett, & Johnson, 2006), 2.6 (Gwanmesia, 2017), 3.44 (Dutcher, 2018), and 3.43(Haller, 2018) in previous studies similar to the current study. Nurse educators can provide the students with the opportunity to interact with clients from culturally different backgrounds to enhance opportunities for cultural encounters.

Cultural desire

Cultural desire is the motivation of healthcare providers who "wish to" participate and improve their cultural competence. The foundational and pivotal construct of cultural competence is cultural desire. It is the willingness and commitment to understanding others while respecting differences and building on commonalities. It encompasses concepts such as caring, love, sacrifice, social justice, and humility (Campinha-Bacote, 2003). Healthcare providers who lack cultural desire are culturally incompetent because they may exhibit dissatisfaction when caring for culturally diverse patients.

The results of this study indicated a high level of cultural desire, with a score of 4.23, the highest in the study. The majority of the participants (M = 4.43) agreed that they needed more education, training, and experience to improve their ability to care for culturally and ethnically diverse clients (Table 6 and Figure 9). Participants in Sealey's (2003) study (M = 3.65), Dutcher's study in 2012 (M = 4.12), and Haller's study in 2018 (M = 3.7) all rated themselves highly in the

culture desire sub-scale, similar to how participants rated themselves in this study. Participants in the Gwanmesia study, on the other hand, rated their cultural desire as low (M = 2.75).

Those with a higher level of cultural desire are more likely to be motivated to genuinely seek to expand their knowledge, improve their skills, and engage in cultural encounters (Campinha-Bacote, 2003), but they will need their employer's support to receive training on cultural competence.

Cultural competence

According to the findings, the mean score for overall cultural competence was M=3.76. It was a combination of the indexes of five components of cultural competence. The mean score indicated that most of the participants agreed themselves be moderate in cultural competency with regard to cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire (Table 7). It is essential to find the reasons for moderate cultural competence because similar findings were in the previous studies as well (Sealey, 2003, M=3.73: Cicloni et al., 2015, M=4.8: Dutcher, 2012, M=3.75, Haller, 2018, M=3.66). A study revealed that the teaching strategies using international service-learning immersion projects (in service-learning type healthcare-focused trips to culturally different areas or countries) contribute to students' cultural encounters, knowledge, skills, awareness, sensitivity, self-efficacy, and understanding of cultural barriers (Kohlbry, 2016). Therefore, it may be useful to introduce international service learning immersion projects to the curriculum if possible.

Conclusion and recommendations

Nursing students reported high levels of cultural desire but low levels of cultural awareness, cultural encounters, cultural skills, and knowledge. The mean overall cultural competence score was 3.76, which means that the cultural competence of participants is moderate and ought to be raised to the highest level because patients in Sri Lanka are culturally diverse. In addition, it is necessary to identify the causes of moderate cultural competence. These findings can be considered when revising or reforming the nursing education system. Components of cultural competence may be included in the curricula and may result in improving the culturally competent care of nurses. This would enhance the satisfaction of patients and improve equity in the provision of health care.

To provide empirical findings on cultural competence among nursing students in Sri Lanka, further research is needed. While this study only examined students at two nursing schools, future studies including other nursing schools are required to ensure that the findings can be applied to nursing schools and programs across the country. A subsequent qualitative research study with the same population could also be valuable. Conducting a qualitative study provides an opportunity to learn more about the cultural competency experiences of nursing students. While the researchers in this study did not look into the correlations between the subscale and demographic factors and the level of cultural competence in nursing schools, further research is required to identify the correlations between demographic factors and professional characteristics (if any). Furthermore, because the cultural competence of nurse educators has a direct influence on the cultural competence of students, research is necessary to determine their level of cultural competence, and to identify methods for enhancing the cultural competence of nurse educators in addition to that of student nurses.

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