

A Comparative Study on Cultural Competence of Healthcare Professionals in Primary and Secondary Healthcare Institutions: A Cross Sectional Study

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Abstract

BACKGROUND/AIMS: It is noteworthy that there are limited studies examining the cultural competence levels of the multidisciplinary team in primary and secondary care. The aim of the study was to compare the level of cultural competence in healthcare professionals working in primary and secondary healthcare institutions and to determine factors related to the level of cultural competence.

MATERIALS And METHODS: A cross-sectional survey design was used to collect data. Totally, 87 healthcare professionals working in primary healthcare services and 348 nurses working in secondary healthcare services between March-May 2018 participated in this cross-sectional study. Data were collected using descriptive information form, the Nurse Cultural Competence Scale form in Turkish, and the Primary Health Care Professionals' Cultural Competency Scale.

RESULTS: Mean score of primary healthcare professionals in terms of cultural competence was found to be 66.58 ± 13.47 while mean score of Secondary Health Care Nurses was 67.44 ± 13.27 . No difference was found between two groups. The level of cultural competence in primary healthcare professionals was increased by factors such as the fact that working time was short in primary healthcare services (odds ratio: 0.81), going abroad for business or touristic purposes (odds ratio: 0.14), meeting individuals/families from different cultures in healthcare services (odds ratio: 0.14), and the satisfaction of providing health service to migrants/asylum seekers (odds ratio: 0.15). The level of cultural competence in secondary care nurses was increased by the satisfaction of working with migrants and asylum seekers.

CONCLUSION: It was found that cultural competence of healthcare professionals in primary and secondary care was at medium level. It might be beneficial to brief healthcare workers during undergraduate study and in-service training on different cultures and to encourage them to meet people from different cultures in order to increase their cultural competence.

Keywords: Cultural competency, culturally competent care, primary healthcare, nurse

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INTRODUCTION

Due to factors such as direct or indirect impact of globalization, poverty, regional conflicts, the concept of migration is rapidly increasing in the world.¹ Nearly 272 million people in the world are international migrants in 2019, and this figure constitutes 3.5% of the global population. The direction of migration is mostly from Asian and African countries where socio-economic conditions are low to European and North American countries where standards of living are much higher.²

Due to its position in the junction between Asia and Europe, Turkey has always been a country of origin, of transit, and of destination. Today, Turkey hosts one of the major migrant populations in the world. In recent years, there has been an increase in migrant population due to the crisis in Syria. Migrants and refugees, nearly 90% of whom are from Syria, come to Turkey from different countries.³ This has become an obligation for healthcare institutions to face different languages, communication styles, attitude, expectations, and perspectives of individuals receiving the services.⁴ Therefore, it is of the utmost importance for healthcare professionals to become sensitive and to improve their cultural competence in order to meet health requirements of individuals from different cultures.⁵

Culturally competent care is defined as a multi-dimensional learning process combining intercultural skills (cognitive, practical, and emotional), including intercultural self-efficacy as an important factor, and aiming to provide culturally suitable healthcare. Moreover, cultural competence is a process requiring constant effort in order to create a working environment suitable for cultural history of individuals, families, and communities receiving professional healthcare.⁶ The acquisition of culturally competent and culturally suitable care depends on improving the cultural competence.^{7,8}

Misunderstandings between people from different cultures and healthcare providers are caused by lack of cultural awareness, cultural knowledge, and flexibility in healthcare providers. Hence, it is rather important for these professionals to be sensitive and to improve their cultural competence in order to meet health requirements of individuals coming from different cultures. Moreover, improvement of cultural competence is a process requiring more than just cultural awareness.⁹ In the qualitative study conducted by Hart and Mareno¹⁰, causes of difficulties in terms of providing culturally efficient care for nurses were defined as the variety of patient population, lack of sources to provide culturally efficient care, and prejudice. Felemban et al.¹¹ stated that nurses without cultural knowledge would cause misunderstandings while providing care; thereby increasing the risk of error and the possibility of causing fatal consequences. In the study conducted by Hendson et al.¹², it was found that providing culturally efficient care became an obligation for nurses due to the reasons such as migrant families having different beliefs and norms and communication obstacles.

Providing culturally competent care requires having and using necessary cognitive, affective, and psychomotor skills in order to fill the gaps often occurred while interacting with culturally different individuals.¹³ Culturally competent care requires having and using necessary cognitive, affective, and psychomotor skills in order to fill the gaps often occurred while interacting with culturally different individuals. There are different scales used for determining cultural competence of healthcare professionals.¹⁴ These tools that can be applied to individuals

from different cultures and healthcare professionals have been used in order to evaluate the cultural competence of healthcare professionals and nurses in primary and secondary healthcare services.¹⁵⁻¹⁸

The frequency of encountering individuals from different cultures for healthcare professional has increased due to intense migration in Turkey in recent years.³ The number of refugees is remarkably high in Adiyaman province, bordering Syria in the southeastern part of Turkey. It is required to understand and explain factors affecting cultural competence of healthcare professionals encountering these disadvantaged individuals from a different cultural history. This study aimed to evaluate and compare level of cultural competence in healthcare professionals in primary and secondary healthcare services in Adiyaman city center.

In this study, the following questions were asked:

1. What are the cultural competence levels of primary health care professionals (PHCP) and secondary health care nurses (SHCN)?

Is there a difference between the cultural competence levels of primary health care professionals (PHCP) and secondary health care nurses (SHCN)?

2. Which demographic factors and cultural experiences are associated to the level of cultural competence of PHCP and SHCN?

MATERIALS AND METHODS

Study Design

This cross-sectional study was conducted in Adiyaman province, bordering Syria in the southeastern region of Turkey, between March–May 2018.

Setting and Sample

The universe for primary healthcare was composed of healthcare professionals working as nurse, midwife, and health officer in all primary healthcare institutions in the city center affiliated with Adiyaman Provincial Health Directorate (Public Health Services Presidency, Family Health Centers, Healthy Life Centers, and Homebased Healthcare Services) (n=90). The sample size for this group was calculated using G*Power 3.1.10 program (Aichach, Germany). The sample size was found to be 62 at 0.95 power, 0.5 effect size (d), and with a confidence interval (CI) of 95%. Totally 87 healthcare professional working in primary healthcare services and having volunteered to take part in the study constituted the sample (Figure 1).

Data Collection

The universe for secondary healthcare was composed of 500 nurses working in Adiyaman University, Adiyaman Training and Research Hospital between March–May 2018. The healthcare institution classified as secondary healthcare center at the time of research ethics committee approval of the study was transformed into tertiary healthcare institution after data collection process. Therefore, the secondary healthcare term was used throughout the study. The sample size for secondary healthcare was found to be 342 at 0.95 power, 0.5 effect size (d), and with a CI of 95%. 348 nurses working in secondary healthcare institutions were included in the study. Of the participants, 46 of them were not included due to their working in operation room, 83 due to having official leave or medical reports, and 23 due to not willing to

fill the questionnaires (Figure 1). The fact that the study sample was composed of 87 healthcare professionals for primary healthcare and 348 healthcare professionals for secondary healthcare provided a higher strength level for the study.

Measurements

For collecting the research data, a “Descriptive Information Form”, “Nurse Cultural Competence Scale (NCCS)”, and the “Primary Health Care Professionals’ Cultural Competency Scale (PHCP-CCS)” were used.

Descriptive Information Form

Form based on the literature and prepared by researchers¹⁵⁻¹⁸ questions evaluating demographic characteristics and cultural history of participants were included. In the demographic features section, age, gender, working year, current institution and for how long they have been working in that institution were questioned. In the cultural history section, whether they knew any languages other than Turkish, whether they had living-working-studying experience abroad, whether they had been to abroad for business or touristic purposes for a short period of time, whether they had a training on providing care for different cultures in vocational or in-service training, the frequency of interacting with foreign friends or neighbors from different cultures, the frequency of encountering individuals/families from different cultures in healthcare services, and the level of satisfaction while providing service for migrants/asylum seekers were questioned.

Nurse Cultural Competence Scale (NCCS)

The scale was developed by Perng and Watson¹⁸ in 2012. The Turkish version of the scale was published by Gözüml et al.¹⁵ There are three

dimensions and 20 items evaluating cultural competence (12 items), cultural knowledge (6 items), and cultural sensitivity (2 items) in the scale. The scale is evaluated using answers such as “strongly agree”, “agree”, “indecisive”, “disagree”, and “strongly disagree”. Scores in the scale vary between 20–100, and the level of cultural competence increases as the total score increases.¹⁸ The reliability coefficient of Turkish version of NCCS was 0.96,¹⁵ whereas the reliability coefficient of NCCS used in this study was 0.94.

Primary Health Care Professionals’ Cultural Competency Scale (PHCP-CCS)

The Turkish version of NCCS was adapted to be applied to primary healthcare professionals by Gözüml et al.¹⁶ While adapting the scale, some terms in items were modified. There are three dimensions and 20 items evaluating cultural competence (12 items), cultural knowledge (6 items), and cultural sensitivity (2 items) in the scale. The scale is evaluated using answers such as “strongly agree”, “agree”, “indecisive”, “disagree”, and “strongly disagree”. Scores in the scale vary between 20–100, and the level of cultural competence increases as the total score increases.¹⁶ The reliability coefficient of PHCP-CCS was 0.84¹⁶ whereas the reliability coefficient of the scale used in the study was 0.93. Data were collected using face-to-face interview method with healthcare professional in the units they were assigned to within approximately 15–20 minutes.

Data Analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS) 23.0 package program (IBM SPSS Corp., Armonk, NY, USA). In descriptive statistics, continuous variables were defined as mean ± standard deviation (SD) whereas categorical variables were defined as frequency and percentage. The comparison of demographic features, cultural history, and cultural competence mean scores of both groups was carried out using chi-square and *T-test*.

In examining the relationship of demographic features and cultural experiences with the level of cultural competence using single variable analyses, *t-test*, Mann–Whitney U test, Kruskal–Wallis Analysis, One-Way ANOVA and Dunn–Bonferroni tests were used. In multivariate analysis, possible factors confirmed in previous analyses were examined using multivariate logistic regression analysis in order to determine independent predictors of cultural competence. Hosmer–Lomeshow test was used for the model fit. All independent variables were included in logistic regression model. As the dependent variable, the level of cultural competence was the continuous variable. Mean cultural competence scores of two groups were dichotomized in order to conduct multivariate logistic regression analysis. Mean cultural competence score was 66.58 in PHCP whereas it was 67.44 in SHCN. Accordingly, the level of cultural competence was categorized as “below average” in 66 or below, and “above average” in 67 or above. Due to the low number of those stating, “*I am (very) satisfied*” and “*It does not matter*” in the evaluation of factors related to PHCP-CCS and not being able to establish a proper logistic regression model, the ones giving these answers were combined. Moreover, another criterion for this decision was that those choosing both of these answers had similar cultural competence scores.

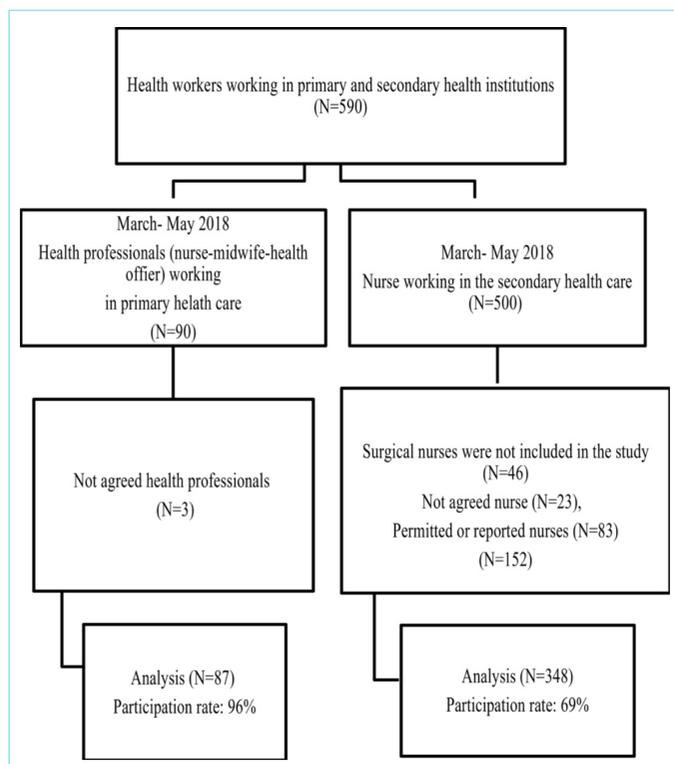


Figure 1. It shows the sample of the study and explains the reasons for those who did not participate in the study.

RESULTS

Mean age of those taking part in the study was 33.22 (± 7.88) in primary healthcare, and 33.11 (± 7.64) in secondary healthcare services. The majority of participants in both groups were women, and 59.8% of those in primary care and 64.9% of those in secondary care had undergraduate level or higher education. Of the participants, 54% of them in primary care and 63.5% of them in secondary care had a professional experience less than 10 years ($p > 0.05$, Table 1).

The frequency of encountering individuals/families from different cultures was found to be higher in SHCN than in PHCP ($p < 0.05$; Table 1). The rate of those who had not had any experience about the satisfaction of providing services for migrants/asylum seekers was found to be higher in PHCP than in SHCN. Moreover, the rate of those stating they were not satisfied, or it did not matter was found to be higher in secondary healthcare compared to primary healthcare ($p < 0.05$, Table 1).

Mean score of PHCP-CCS was 66.58 (± 13.47), and mean score of nurses in secondary healthcare was 67.44 (± 13.27). There was not any difference between cultural competence scores in primary and SHCN ($p > 0.05$). It was found that mean scores of PHCP-CCS were not related to age, gender, education, and duration of working in primary healthcare services ($p > 0.05$). It was found that the level of cultural competence of those working for less than 10 years was higher than those working for 10 years and more ($p < 0.05$). It was found that mean scores of PHCP-CCS were not associated with factors such as speaking a foreign language, having a living-working-studying experience abroad, having been abroad for business or touristic purposes for a short period of time, the presence of and close interaction with foreign friends-partners-relatives-neighbors from different cultures in their private life, and the satisfaction of providing services for migrants and asylum seekers ($p > 0.05$). It was found that the mean score of PHCP-CCS in those having frequent and very frequent interactions with foreign friends or neighbors from different cultures was higher than those having no or rare interaction with individuals from different cultures ($p < 0.05$). The rate of those encountering individuals/families from different cultures in healthcare services “frequently and very frequently” was found to be higher than those encountering these individuals “never and rarely” ($p < 0.05$).

It was found that the mean scores of NCCS in the secondary health services were not related to age, gender, the year of work in the profession, the period of work in education and secondary health care ($p > 0.05$). Moreover, it was found that the mean scores of NCCS were not associated with factors such as speaking a foreign language, having living-working-studying experience abroad, having been abroad for business or touristic purposes for a short period of time, the frequency of interaction with foreign friends or neighbors from different cultures in private life, and the frequency of encountering individuals/families from different cultures in healthcare services ($p > 0.05$). However, a significant difference was found between the level of satisfaction in providing services for migrants and asylum seekers and the mean of NCCS. It has been found that the mean of NCCS of those stating, “I am satisfied/very satisfied” about providing care for migrants and asylum seekers was higher than those who were “not satisfied at all/were not satisfied” ($p < 0.05$).

Factors related to the mean of PHCP-CCS were analyzed using logistic regression analysis. It was found that the mean of PHCP-

CCS was increased by shorter working hours in primary care 0.81 times, by having been abroad for business or touristic purposes for a short period of time 0.14 times, and frequently and very frequently encountering individuals/families from different cultures in healthcare services 0.14 times ($p < 0.05$; Table 2). It was also found that the mean of PHCP-CCS of those stating that they “were not satisfied at all/were not satisfied” on the level of satisfaction in providing care for migrants and asylum seekers was decreased 0.15 times ($p < 0.05$, Table 2).

It was found in logistic regression analysis that the mean of NCCS in secondary healthcare institution was not related to demographic factors ($p > 0.05$). It was also found that the cultural competence of those stating that they “were not satisfied at all/were not very satisfied” on the level of satisfaction in providing care for migrants and asylum seekers was decreased 0.53 times ($p < 0.05$). In addition, it was also found that being satisfied with providing care for migrants and asylum seekers was significant with the mean of NCCS ($p < 0.05$, Table 3).

DISCUSSION

Comparing the Level of Cultural Competence in PHCP and SHCN

It was concluded in this study that the level of cultural competence in PHCP and SHCN was at medium level and that there was not any difference between the level of cultural competence in PHCP and SHCN. In three similar studies, it was found that the level of cultural competence in nurses was at medium level.^{18,19} In a study conducted by Gözümlü et al.¹⁵ at a hospital in Turkey, it was observed that the level of cultural competence in nurses was higher than the level found in this study. In a study conducted in primary healthcare services in Turkey, it was found that the level of healthcare professionals was at medium level and that it was in consistency with the results obtained in this study.¹⁶ The fact that the level of cultural competence in healthcare professionals was found to be lower than the level found in the aforementioned study conducted in Turkey¹⁵ is believed to be caused by factors such as intense migration to Adiyaman only from Syria and the fact that healthcare professionals encounter a certain migrant group in healthcare services.

Comparing the Cultural Experiences in PHCP and SHCN

The rate of those frequently encountering individuals/families from different cultures was 24.1% in primary healthcare, and 37.6% in secondary healthcare in this study. A significant difference was found between these two groups. In two different studies conducted in secondary healthcare in Korea, the frequency of encountering patients from different cultures was found to be 81.6% and 94.3%.^{20,21} It was found that 73.5% of nurses in secondary healthcare provided services for patients from different cultures in Thailand²² and that the majority of nurses (91%) provided care for patients from different cultures in Taiwan.²³ In studies conducted in primary and secondary healthcare in Turkey, it was observed that the frequency of providing services for individuals from different cultures in nurses varied between 71% and 94%.^{14,24,25} The fact that PHCP in this study encountered individuals from different cultural history than SHCN may be explained by the presence of migrant health centers and refugee camps in the region where the study was conducted. Since basic healthcare services are provided in migrant health centers and camps, PHCP encounter refugees less in healthcare services.

Table 1. Comparison of demographic characteristics and cultural experiences of PHCP and SHCN						
Demographic characteristics and cultural experiences	PHCP (n=87)		SHCN (n=348)		Analysis	
	n	%	n	%	χ^2	p
Age, years						
<35	45	51.7	213	61.2	2.593	0.107
≥35	42	48.3	135	38.8		
Age (mean ± SD)	33.22	7.881	33.11	7.643	0.994***	0.321
Gender						
Female	80	92.0	292	83.9	3.638	0.056
Male	7	8.0	56	16.1		
Total working period in professional						
<10 years	34	39.1	169	48.6	2.515	0.113
≥10 years	53	60.9	179	51.4		
Education level						
High school and associate degree	35	40.2	122	35.1	1.121	0.571
Undergraduate and graduate	52	59.8	226	64.9		
Working period in primary and secondary health care						
<10 years	47	54.0	221	63.5	2.646	0.104
≥10 years	40	46.0	127	36.5		
Speaking a foreign language						
No	54	62.1	182	52.3	2.677	0.102
Yes	33	37.9	166	47.7		
Living-working-education experience in abroad						
No	85	97.7	332	95.4****	0.547
Yes	2	2.3	16	4.6		
Traveling abroad for business or touristic purposes for a short period of time						
No	66	75.9	284	81.6	1.462	0.227
Yes	21	24.1	64	18.4		
Having friends, spouses, relatives and neighbors from different cultures in private life						
No	57	65.5	233	67.0	0.065	0.799
Yes	30	34.5	115	33.0		
Frequency of interaction with friends or neighbors from different cultures in private life						
No-rarely	73	83.9	291	83.6	0.004	0.948
Often-very often	14	16.1	57	16.4		
Frequency encountering individuals/families from different cultures in healthcare services						
No-rarely	66	75.9	217	62.4	5.585	0.018*
Often-very often	21	24.1	131	37.6		
Satisfaction of providing services for immigrants/asylum seekers						
I have no experience	45	51.7	83	23.9	27.225	0.000**
I am not satisfied at all- I am not satisfied	26	29.9	164	47.1		
I am satisfied-I am very satisfied	6	6.9	23	6.6		
It does not matter to me	10	11.5	78	22.4		

p<0.05*, p<0.001**, t-test***, Fisher's exact test****.

PHCP: primary health care professionals, SHCN: secondary health care nurses, SD: standard deviation, n: number.

It was found in this study that the rate of PHCP who did not have any experience in terms of providing services for migrants/asylum seekers was higher than that of the rate of SHCN. Moreover, the level of dissatisfaction in SHCN was found to be higher compared to PHCP. In a study, it was concluded that the level of satisfaction in providing

care for different individuals from their own culture in healthcare professionals was higher and that having sufficient information on different cultures increased the level of satisfaction.²⁶ In another study, it was observed that 19.4% of nurses were satisfied with providing care for foreign patients and that 32.5% of them were willing to do

Table 2. Logistic regression analysis: factors that may be associated with PHCP-CCS score mean (n=87)						
	β	SE	p	OR	95% CI	
					Lower	Upper
Age, years	0.18	0.01	0.067	1.19	0.99	1.45
Gender						
Male: 1						
Female: 0	1.94	1.51	0.200	6.92	0.36	133.39
Working period in profession	0.10	0.13	0.420	1.11	0.87	1.41
Education level						
High school and associate degree: 0						
Undergraduate and graduate: 1	0.57	0.60	0.340	1.77	0.55	5.71
Working time in primary health care	-0.21	0.11	0.047	0.81	0.66	0.99
Speaking a foreign language						
Yes: 0						
No: 1	-0.17	0.64	0.787	0.84	0.24	2.93
Traveling abroad for business or touristic purposes for a short period of time						
Yes: 0						
No: 1	-2.00	0.81	0.013*	0.14	0.03	0.65
Having friends, spouses, relatives and neighbors from different cultures in private life						
Yes: 0						
No: 1	-0.18	0.70	0.800	0.84	0.21	3.32
Frequency of interaction with friends or neighbors from different cultures in private life						
Often-very often: 0						
No-rarely: 1	-1.11	1.11	0.318	0.33	0.04	2.92
Frequency encountering individuals/families from different cultures in healthcare services						
Often-very often: 0						
No-rarely: 1	-2.01	0.86	0.020*	0.14	0.03	0.73
Satisfaction of providing services for immigrants/asylum seekers						
I am satisfied-I am very satisfied- It does not matter to me: 0			0.133			
I am not satisfied at all- I am not satisfied: 1	-1.87	0.94	0.046*	0.15	0.02	0.97
I have no experience: 2	0.46	0.62	0.459	0.63	0.19	2.13
Constant	-6.06	3.23	0.061	0.00		
p<0.05*						
PHCP-CCS: Primary Health Care Professionals' Cultural Competency Scale, SE: standard error, OR: odds ratio, CI: confidence interval, n: number.						

so.²⁷ In a study conducted in Turkey, it was found that the majority of nurses (83.6%) did not face any problems due to cultural and religious values while providing care for patients.²⁸ In a study, 69.4% of nurses working at a hospital in the western part of Turkey and 74.2% of nurses working at a hospital in the eastern part of Turkey stated that cultural background of patients was important in terms of providing nursing services.²⁹ The fact that the level of dissatisfaction in providing care for individuals from different cultures was found to be higher in secondary healthcare than in primary healthcare may have been caused by the frequent encounters of SHCN with refugees and asylum seekers from Syria.

The Relationship of Demographic Characteristics and Cultural Experiences in PHCP and SHCN with the Level of Cultural Competence

When the relationship between demographic characteristics of PHCP and their cultural competence was analyzed, it was observed that shorter

working hours in primary healthcare increased cultural competence. On the contrary, in a study conducted in Taiwan,²⁷ it was found that working hours of nurses at hospitals was not associated with the level of cultural competence. The fact that the level of cultural competence decreased in the present study as working hours increased in primary healthcare may have been caused by longer encounters of healthcare professionals with refugees only from Syria.

It was concluded that PHCP frequently encountering individuals/families from different cultures in healthcare services increased their cultural competence, and this was found to be suitable with two studies conducted in Turkey.^{15,16} Similarly, in a study conducted in Taiwan, it was concluded that the most important indicator of the level of cultural competence was the frequency of providing care for different cultures and that cultural competence of those frequently providing care for these individuals increased.²³ On the contrary, in a study conducted in primary healthcare services in

Table 3. Logistic regression analysis: factors that may be associated with NCCS score mean (n=348)						
	β	SE	p	OR	95 % CI	
					Lower	Upper
Age, years	0.05	0.04	0.152	1.05	0.98	1.13
Gender						
Male: 1						
Female: 0	-0.40	0.32	0.211	0.67	0.36	1.26
Working period in profession	-0.21	0.04	0.587	0.98	0.91	1.06
Education level						
High school and associate degree: 0						
Undergraduate and graduate: 1	0.31	0.26	0.227	1.37	0.82	2.28
Working period in secondary health care institution	-0.05	0.03	0.132	0.95	0.90	1.01
Speaking a foreign language						
Yes: 0						
No: 1	0.33	0.23	0.154	1.39	0.88	2.20
Traveling abroad for business or touristic purposes for a short period of time						
Yes: 0						
No: 1	-0.01	0.62	0.984	0.99	0.29	3.34
Having living-working-studying experience abroad						
Yes: 0						
No: 1	0.37	0.34	0.281	1.44	0.74	2.82
The presence of friends, spouses, relatives, neighbors from different cultures in your private life						
Yes: 0						
No: 1	0.44	0.28	0.079	1.55	0.90	2.66
Frequency of interaction with friends or neighbors from different cultures						
Often-very often: 0						
No-rarely: 1	-0.06	0.36	0.877	0.95	0.47	1.92
Frequency encountering individuals/families from different cultures in healthcare services						
Often-very often: 0						
No-rarely: 1	0.21	0.25	0.396	1.24	0.76	2.02
Satisfaction of providing services for immigrants/asylum seekers						
I am satisfied-I am very satisfied-It does not matter to me: 0			0.046*			
I am not satisfied at all- I am not satisfied: 1	-0.63	0.28	0.023*	0.53	0.31	0.92
I have no experience: 2	-0.50	0.29	0.084	0.61	0.35	1.07
Constant	-1.72	1.14	.133	0.18		
p<0.05*						
NCCS: Nurse Cultural Competence Scale, SE: standard error, OR: odds ratio, CI: confidence interval, n: number.						

Portugal, the level of cultural competence was found to be higher in healthcare professionals with less interaction with migrants than in those with frequent interactions.³⁰ The fact that frequent encounters with individuals from different cultures in healthcare delivery has a positive impact on the level of cultural competence is an expected result of the present study.

It was concluded that having been abroad for business or touristic purposes for a short period of time increased cultural competence of PHCP and that this was in consistency with the results of studies conducted in Japan and South Korea.^{16,31} On the contrary, in another study conducted in South Korea, the experience of having been abroad was not related to the cultural competence of nurses.²⁰ The fact that the level of cultural competence in this study is higher in PHCP

having been abroad may be explained by the fact that interacting with individuals from different cultures has a positive impact on cultural competence.

The level of cultural competence increased in PHCP as the level of satisfaction in providing care for migrants and asylum seekers increased and this was found to be suitable with the study conducted by Gözümlü et al.¹⁶ It was found that the level of cultural competence in SHCN being satisfied or very satisfied for refugees and asylum seekers increased ($p<0.05$), and that this was suitable with two different studies conducted in Thailand and Turkey.^{16,22} On the contrary, in a study with nursing students in Saudi Arabia, it was concluded that there was not any difference between choosing to provide care for patients from different cultures and the level of cultural competence.³² The fact that

the level of competence is high in PHCP and SHCN being satisfied with providing care for individuals from different cultures is an expected result of the present study.

In this study, the level of cultural competence in PHCP and SHCN in a region of intense migration was found to be at medium level. The level of cultural competence in PHCP increased by factors such as shorter working hours in primary healthcare, having been abroad for business or touristic purposes, frequent encounters with individuals/families from different cultures in healthcare services, the level of satisfaction in terms of providing care for migrants and asylum seekers. The level of cultural competence of SHCN increased by the level of satisfaction in providing care for migrants and refugees. It might be beneficial to brief healthcare workers during undergraduate study and in-service training on different cultures and to encourage them to meet people from different cultures in order to increase their cultural competence. Moreover, conducting qualitative studies that can explain the causes of decreases in the level of cultural competence due to longer working years in the profession is of the utmost importance.

Limitations of the Study

The present study has two limitations. The first one is that healthcare professionals in Adiyaman frequently encounter refugees only from Syria. The second one is that data are collected from healthcare professionals in a city center in the southeastern part of Turkey and that results obtained in the present study could not be adapted to the entire country.

CONCLUSION

In this study, the level of cultural competence in PHCP and SHCN in a region of intense migration was found to be at medium level. The level of cultural competence in PHCP increased by factors such as shorter working hours in primary healthcare, having been abroad for business or touristic purposes, frequent encounters with individuals/families from different cultures in healthcare services, the level of satisfaction in terms of providing care for migrants and asylum seekers. The level of cultural competence of SHCN increased by the level of satisfaction in providing care for migrants and refugees. It might be beneficial to brief healthcare workers during undergraduate study and in-service training on different cultures and to encourage them to meet people from different cultures in order to increase their cultural competence. Moreover, conducting qualitative studies that can explain the causes of decreases in the level of cultural competence due to longer working years in the profession is of the utmost importance.

MAIN POINTS

- Cultural competence is an important component in providing culturally sensitive and effective care in healthcare services, reducing inequalities and improving health outcomes.
- Determining the cultural competence levels of healthcare professionals employed at health institutions is important in terms of planning interventional work.
- The findings of this study present the factors that are related to the cultural competence of healthcare professionals employed at primary and secondary health institutions.

ETHICS

Ethics Committee Approval: Official approval for the present study was obtained from the Clinical Research Ethics Committee of Akdeniz University, Faculty of Medicine (approval no: 70904504/38, date: 17.01.2018).

Informed Consent: Written informed consent was obtained from patients who participated in this study.

Peer-review: Externally peer-reviewed.

Authorship Contributions

Concept: A.T., M.S., Design: A.T. M.S., Supervision: A.T., Data Collection and/or Processing: M.S., Analysis and/or Interpretation: A.T., M.S., Literature Search: M.S., Writing: M.S., A.T., Critical Review: A.T.

DISCLOSURES

Conflict of Interest: No conflict of interest was declared by the authors.

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