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CROSS-CULTURAL COMPETENCE OF HEALTHCARE PROFESSIONALS WORKING IN PEDIATRIC UNITS: A CROSS-SECTIONAL DESCRIPTIVE STUDY

PEDİATRİK BİRİMLERDE ÇALIŞAN SAĞLIK PROFESYONELLERİNİN KÜLTÜRLERARASI YETERLİLİĞİ: KESİTSEL TANIMLAYICI BİR ÇALIŞMA

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Abstract

Objective: Cultural competence is a skill that healthcare professionals must possess in order to provide effective and safe healthcare services in multicultural societies. Since the pediatric patient population requires special care in terms of cultural diversity, personnel working in pediatric units must have this skill. This study aimed to determine the intercultural competence of healthcare professionals working in pediatric units.

Material- Methods: This study was conducted as a cross-sectional descriptive study in the pediatric units of a city training and research hospital located in the Mediterranean region. It was aimed to determine the intercultural competence of the nurses and doctors (n=157) included in the study. Data were collected using the Personal Information Form and the Cross-Cultural Competence of Healthcare Professionals (CCCHP) scale.

Results: Total mean score of CCCHP is found to be 85.38±10.46 as good and confident in the subdimensions. A statistically significant difference was found between participants' marital status, total working years in their professional life, total working years in their unit, their views on the importance of learning cultures in patient care and the total mean score of the CCCHP scale ($p<0.05$).

Conclusion: In order to sustain the care provided to patients from different cultures, trainings aimed at increasing cultural competence can be provided in undergraduate/graduate education. Transcultural nursing/care courses offered as elective courses in some universities can be made widespread. Healthcare personnel can be encouraged to learn different languages, motivation-enhancing practices can be implemented as the cultural competence scores of healthcare workers decrease as the number of years of service increases, and importance can be given to in-service training programs in providing cultural care in healthcare institutions. Emphasizing intercultural competence in healthcare provides effective care.

Keywords: Cultural competency, Health, Health care professional, Pediatric, Nurse.

Özet

Giriş: Kültürel yeterlilik, çok kültürlü toplumlarda etkili ve güvenli sağlık hizmeti verebilmek için sağlık çalışanlarının sahip olması gereken bir beceridir. Çocuk hasta popülasyonu kültürel çeşitlilik farklılıkları açısından özel bir bakıma ihtiyaç duyduğu için pediatri birimlerinde görev alan personelin bu beceriye sahip olması gerekmektedir. Bu çalışmada da pediatri ünitelerinde görev yapan sağlık çalışanlarının kültürlerarası yeterliliğinin belirlenmesi amaçlandı.

Gereç- Yöntem: Bu çalışma kesitsel tanımlayıcı bir çalışma olarak Akdeniz bölgesinde yer alan bir şehir eğitim ve araştırma hastanesinin pediatri ünitelerinde yürütülmüştür. Çalışmaya alınan hemşire ve doktorların (n=157) kültürler arası yeterliliğini belirlenmesi amaçlanmıştır. Veriler Kişisel Bilgi Formu ve Sağlık Profesyonellerinin Kültürlerarası Yeterliliği Ölçeği (SÇKYÖ) ölçeği ile toplanmıştır.

Bulgular: SÇKYÖ toplam puanının alt boyutlarda iyi ve güvenli olarak 85.8±10.46 olduğu belirlendi. Katılımcıların medeni durumu, mesleki yaşamlarındaki toplam çalışma yılı, birimlerindeki toplam çalışma yılı, hasta bakımında öğrenme kültürünün önemine ilişkin görüşleri ve SÇKYÖ ölçeği toplam puanları arasında istatistiksel olarak anlamlı bir fark bulunmuştur ($p<0.5$).

Sonuç: Farklı kültürlerden gelen hastalara verilen bakımın sürdürülebilmesi için lisans eğitiminde/lisansüstü eğitimde kültürel yeterliliği artırmaya yönelik eğitimler verilebilir. Bazı üniversitelerde seçmeli ders olarak sunulan transkültürel hemşirelik/bakım dersleri yaygınlaştırılabilir. Sağlık personeli farklı dilleri öğrenmeye teşvik edilebilir, çalışma yılı arttıkça sağlık çalışanlarına kültürel yeterlilik puanları azaldıkça motivasyonu artırıcı uygulamalar uygulanabilir ve sağlık kurumlarında kültürel bakım sağlamada hizmet içi eğitim programlarına önem verilebilir. Sağlık bakımında kültürlerarası yeterliliğin vurgulanması etkili bir bakım sunar.

Anahtar Kelimeler: Kültürel yeterlilik, Sağlık, Sağlık bakım çalışanı, Pediatri, Hemşire.

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INTRODUCTION

Minority population growth requires cross-cultural care to multicultural society groups by healthcare professionals due to social differences, cultural conflicts, racism, increases in health care expenditures, inequalities, changes in gender roles and discrimination that has emerged in the world with globalization (1,2). Cultural values, attitudes, behaviors, beliefs of the individuals and society shape people's lifestyles and may affect health care and clinical decision making of health care professionals. Cultural and linguistic differences between patients and healthcare professionals can lead to lack of communication in patient care, inequalities in healthcare, and inadequate care outcomes (2-8). Since culture plays a pivotal role in determining medical care and its outcomes, health care professionals must develop their cross-cultural approach competencies and sensitivities to understand the need of individuals from different cultures and to provide culturally congruent services. Besides, culture plays a cruial role in people's perception of their health, health behaviors, utilization of health services and responses to treatment. Therefore, health care professionals should know the patient population and their culture closely in order to provide effective health services (1).

Cultural competence as a crucial element of healthcare excellence is the ability of health care professionals to understand how individuals' health and disease situations are affected by social and cultural factors (9). This skill is necessary for professional healthcare professionals to provide reliable and influential healthcare services to individuals with different cultural backgrounds (10,11). Cultural competence encompasses a suite of academic and interpersonal skills that enable individuals to comprehend and value the divergences and commonalities across diverse cultural groups, and it is an intricate and perpetual process (12). According to the researches, although the concept of competence is a rather abstract concept in terms of evaluation and measurement (13); cultural competence of medical care workers is a necessity and a desired priority in a multicultural world (1).

Cultural characteristics affect the health and illness of individuals, especially children (14). Good care for children not only protects them from danger and harm, but also ensures the child's growth, psychosocial development and a healthy environment (15). Therefore, health professionals have important duties in knowing cultural characteristics (14). Cultural differences among health care providers can cause problems, and when people's needs are not understood, problems such as the inability to provide appropriate care or difficulties in communication may arise (16). Article 24 of UNICEF's Convention on the Rights of the Child declares that “States Parties shall take all appropriate and effective measures to abolish traditional practices harmful to the health of children.” (17). Here, too, the best interests of the child are considered according to cultural characteristics. As of 2020, it is reported that Turkey has the highest rate of child population with rate of 27.2% compared to European Union member countries while the mean is 18.2% in EU-27 member countries. Rate of child population compared to all aged population is stated between 28.1%-34.0% in the city which the study performed in (18). Since Turkey is a country of immigration, statistics on foreign people have been performed. As of 07.07.2021, the total number of foreigners in Turkey with a residence permit is calculated as 1.166.378, in the city which the study performed in as 6.566 and in the surrounding cities which have potential to have patients to come from as 24.839 (19). Data on how much of this proportion is the child population could not be reached. In the view of such information and the children having different culture who have not been reached data of, children rates could be considerable.

In the literature, there are studies that look at the cultural competencies of nursing students, nurses or health professionals in a general field (20-23). Studies in the field of pediatrics are

rarely (24,25). This study was conducted to determine the cross-cultural competencies of healthcare workers working in pediatric units of a hospital having International Health Tourism Unit in Turkey.

Research questions

1. What are the crosscultural competence mean scores of healthcare professionals?
2. Is there a significant relationship between the intercultural competence scores of healthcare professionals and the identifying characteristics?

MATERIAL- METHODS

Design

To assess the cross-cultural competence of nurses and doctors in pediatric units, the research was carried out as a descriptive cross-sectional study.

Participants

The study population consisted of 242 participants (nurses (n=174) and doctors (n=68) working in the pediatric units of the City Training and Research Hospital of a province in Mediterranean Region in Turkey.

The study included those working as nurses and doctors in pediatric units, who agreed to participate in the study and those working on the dates between September 1, 2020 and August 1, 2020. In the power analysis performed according to the sample population with a known population, the sample size was found to be at least 150, based on a Type 1 error of 0.05 and 95% power. Considering the data losses, an attempt was made to reach 10% more. One doctor passed away due to COVID-19, 12 individuals declined to participate, 26 were on leave during data collection, and 47 could not be contacted. Finally, the study was completed with 157 participants taking into account data loss.

Data Collection

Data was collected from participants working in clinics, policlinics, emergency units, intensive care units in person meetings. The interviews were held in the health care personnels' rooms when the they were not caring for patients and were convenient. Each interview lasted an average of 10 minutes.

Instruments

Data were collected using the Personal Information Form and the Cross-Cultural Competence of Healthcare Professionals (CCCHP) scale. "Personal Information Form" which consisted of 22 questions and including participants' socio-demographic characteristics (age, marital status, educational status, economic status, homeland) and questions that were thought to affect cross-cultural competency (caring for/treating patients from different cultures, having been abroad, having any foreign friends, ability for speaking foreign language). was used to collecting data. In data collection forms "abroad" meant to be another country except of Turkey, "foreign"meant to be any person who lives in another region in Turkey and/or does not have Turkish citizenship.

It was used a scale called "Cross-Cultural Competence of Healthcare Professionals" (CCCHP) which measures the cross-cultural competence. This scale was developed by Bernard et al (26) in German as a 5-point Likert-type scale consisting of 27 items and 5 dimensions. The Turkish validity and reliability of the scale was performed by Çınar et al (27). Sub-dimensions of the scale were called Cross-Cultural Motivation / Curiosity (9 items-1, 2, 3, 4, 5, 6, 7, 8, 9), Cross-Cultural Attitude (4 items-10, 11, 12, 13), Cross-Cultural Skills (5 items) - 14, 15, 16, 17, 18), Cross-Cultural Knowledge/ Awareness (5 items-19, 20, 21, 22, 23) and Cross-Cultural Emotions/Empathy (4 items-24, 25, 26, 27). Internal consistency reliability for the total score of the scale was 0.87, and Cronbach's α values for all sub-dimensions ranged between 0.54 and 0.84. The items in the scale are scored as 1=Strongly disagree, 2=Disagree, 3=Undecided, 4=Agree, 5=Strongly agree. The scores of the Cross-Cultural Attitude, Cross-Cultural Knowledge/Awareness, and Cross-Cultural Emotions / Empathy sub-dimensions of the scale are calculated by reversing. The lowest score that can be obtained from the

scale is 27, and the highest score is 135 points. When these scores are compared with the number of participants and the means are taken, when the scores between 1 and 5 are evaluated, it shows that the cross-cultural competence level of health professionals with 3 points and above is good. In the present study Cronbach's α values for all sub-dimensions ranged between 0.66 and 0.85.

Data Analysis

Statistical analyses were carried out using the SPSS software (IBM SPSS Statistics 24). To interpret the findings, frequency tables and descriptive statistics were utilized. It was checked whether the data were normally distributed or not with the Shapiro Wilk test. For measurement values that did not follow a normal distribution, non-parametric methods were applied. Specifically, the "Mann-Whitney U" test (Z-table value) was used to compare the measurement values of two independent groups, while the "Kruskal-Wallis H" test (χ2-table value) was employed for comparing measurement values among three or more independent groups. Bonferroni correction was applied for pairwise comparisons of variables showing significant differences in groups of three or more. Cronbach-α coefficients were calculated to assess the reliability of the scale and its sub-dimensions. Since the mean scores of the scale do not show a normal distribution, it would be sufficient to give the median, min and max scores, but the mean scores are also given in the table to be used in future studies.

Ethical considerations

Before conducting the research ethical consent from the Ethics Board in Faculty of Medicine, Çukurova University (number / date: 101 / 3 July 2020) and institutional permissions in which the study was to be performed were obtained. Participants provided informed consent and the consents were verbal in the person meeting. All participants were informed that study permits were obtained, their names would be kept confidential, anonymity would be considered, and the data would be used for scientific purposes only.

RESULTS

Of participants 59 (37.6%) were in the <30 age group. It was determined that 128 participant (81.5%) were women, 104 (66.2%) were married, 104 (66.2%) were nurses, 94 (59.9%) were graduated, and 112 (71.3%) were born in the Mediterranean region. 128 people (81.5%) lived in the Mediterranean region the longest (where the study performed), 117 (74.5%) did not have a migration background, 72 (45.9%) worked in the pediatric clinics, 68 (43.3%) had a total of >10 years and 66 (4%) 42.0) has been working in the unit for 2-5 years. Among the participants, four people who wrote their profession as midwives in the questionnaires were included in the number of nurses because they worked as a nurse in their units. Four participants working in COVID-19 units included in the participants working in clinics (Table 1).

There was no statistically significant difference in the total scores of the CCCHP scale according to the gender, age groups, occupation, education level, immigration background, working unit and speaking foreign language ($p>0.05$). A statistically significant difference was found in terms of the CCCHP scale total mean scores according to the marital status of the participants. The CCCHP scale total mean scores of singles are statistically significantly higher than those of married ones ($Z=-1.988$; $p=0.047$). It was found to be a significance in terms of the total mean scores of the CCCHP scale according to the total working years of the participants ($\chi2=7.529$; $p=0.023$). As a result of pairwise comparisons with Bonferroni correction made to determine which group the significant difference originated from; a significant difference was found between those who have worked totally for <5 years and those who have worked for >10 years. CCCHP scale total mean scores of participants working totally for <5 years were significantly higher than those working for >10 years. There was a significant difference between total mean scores of the CCCHP scale

and the working time of the participants in the present unit they were working. ($\chi 2$=7.496; p=0.024). As a result of pairwise comparisons with Bonferroni correction made to determine which group the significant difference originated from; a significant difference was found between those who worked in the unit for ≤1 and those who worked in the unit for >5 years; who worked 2-5 years and >5 years. Total mean scores of the CCCHP scale of those working in the unit for ≤1 year and 2-5 years were significantly higher than those who have worked for >5 years (Table 1).

Table 1. Comparison of CCCHP scale total mean scores according to participants' findings

Variable (n=157)	n (%)	CCCHP – Total		Statistical analysis*
		$\bar{X} \pm S.D.$	Median (Min.-Max.)	
Gender				
Male	29	86.8±10.97	87.0 (53.0-105.0)	Z=-0.962
Female	128	85.17±10.37	85.0 (58.0-113.0)	p=0.336
Age groups(year)				
<30	59	87.25±10.98	86.0 (66.0-110.0)	χ^2=3.302
30-40	58	85.12±10.53	87.0 (53.0-113.0)	p=0.192
>40	40	82.98±9.19	84.0 (58.0-98.0)	
Marital status				
Married	104	84.03±9.20	85,0 (53.0-102.0)	Z=-1.988
Single	53	88.01±12.22	87.0 (60.0-113.0)	**p=0.047**
Occupation				
Nurse	104	86.82±10.08	86.5 (66.0-113.0)	Z=-1.909
Doctor	53	82.34±10.67	85.0 (53.0-101.0)	p=0.056
Education level				
H.school/A.degree	12	84.50±6.42	85.0 (70.0-96.0)	χ^2=0,843
Graduate	94	86.38±10.69	86.0 (66.0-113.0)	p=0.656
Postgraduate	51	83.73±10.71	86.0 (53.0-101.0)	
Migration				
Yes	40	85.18±12.44	87.0 (58.0-113.0)	Z=-0.085
No	117	85.44±9.75	86.0 (53.0-110.0)	p=0.933
Work unit				
Clinic	72	85.90±10.16	86.5 (53.0-108.0)	
Policlinic	27	83.48±9.95	85.0 (58.0-101.0)	χ^2=1.134
Emergency unit	11	86.00±15.87	83.0 (66.0-113.0)	p=0.769
Intensive care unit	47	85.51±9.91	86.0 (67.0-110.0)	
Total working time				
Less than 5 years (1)	41	89.54±11.73	91.0 (66.0-110.0)	χ^2=7.529
Between 5-10 years (2)	48	84.25±10.64	85.5 (53.0-113.0)	**p=0.023**
More than 10 years (3)	68	83.67±8.86	84.5 (58.0-98.0)	**(1-3)**
Time for present unit				
≤1 (1)	58	87.12±10.81	87.0 (60.0-110.0)	χ^2=7.496
2-5 (2)	66	85.53±11.33	87.0 (53.0-113.0)	**p=0.024**
>5 (3)	33	82.00±6.84	83.0 (670-95.0)	**(1,2-3)**

*p<0,05, β: In Bonferroni correction; The difference was due to the difference between groups (1) and (3), ¥: The difference in Bonferroni correction was due to the difference between groups (1) and (3) and the difference between groups (2) and (3).

In addition, it was found to be 133 (84.7%) have no experience of living abroad, 92 people (58.6%) do not speak a foreign language, 151 (96.2%) have no experience of working abroad, 88 (56.1%) of them did not have business/tourism experience in abroad, 107 people (68.2%) had friends from different cultures, 86 (54.8%) had caregiving experience

in abroad, 138 (87.9%) had experience of caring for patients from different cultures in the country, and 149 (94.9%) of them did not receive training in caring for different cultures. 107 people (68.2%) thought it was difficult to care for different cultures, 79 (50.3%) thought it was necessary to provide care according to culture, and 101 (64.3%) thought it was important to learn about cultures in patient care. It was determined that mean scores for both total scale and of sub-dimensions were generally at a reliable level. There was no statistically significant difference between total mean scores of the CCCHP scale and the participants' living abroad, working abroad, abroad business/tourism visiting, having friends from different cultures, giving care abroad, having experience of caring for different cultures at home, receiving training on caring for different cultures, caring for different cultures, whether considering the necessity of cultural care ($p>0.05$). A statistically significant difference was found in terms of total mean scores of the CCCHP scale according to the participants' views on the importance of learning cultures in patient care. ($\chi^2=13.021$; $p=0.001$). As a result of pairwise comparisons with Bonferroni correction made to determine which group the significant difference originated from; a significant difference was found between those who think it is important and those who think it is not important and say it is neither important / nor important. The total mean scores of the CCCHP scale of those who think it is important to learn about cultures in patient care were significantly higher than those who think it was not important and say neither important / nor was it important (Table 2).

Table 2. Comparison of CCCHP scale total mean scores according to participants' findings which predicted to effect cross-cultural competence

Variables (n=157)	n	CCCHP – Total		Statistical analysis*
		$\bar{X} \pm S.D.$	Median (Min.-Max.)	
Living abroad				
Yes	24	86.75±11.16	87.0 (60.0-113.0)	Z=-0.757
No	133	85.13±10.35	85.0 (53.0-110.0)	p=0.449
Foreign language				
Yes	65	85.00±11.89	87.0 (53.0-113.0)	Z=-0.282
No	92	85.64±9.38	85.5 (66.0-110.0)	p=0.778
Working experience abroad				
Yes	6	84.50±9.09	83.0 (72.0-100.0)	Z=-0.499
No	151	85.41±10.53	86.0 (53.0-113.0)	p=0.617
Business/tourism experience abroad				
Yes	69	85.29±10.35	87.0 (53.0-113.0)	Z=-0.480
No	88	85.44±10.60	85.0 (58.0-110.0)	p=0.631
Friend from different culture				
Yes	107	85.60±11.20	87.0 (53.0-113,0)	Z=-0.822
No	50	84.90±8.74	84.0 (58.0-108.0)	p=0.411
Caregiving experience in abroad				
Yes	86	84.51±9.31	84.5 (60.0-105.0)	Z=-1.248
No	71	86.42±11.68	86.0 (53.0-113.0)	p=0.212
Caregiving to patient with different culture				
Yes	138	85.24±10,56	86.0 (53.0-113,0)	Z=-0.399
No	19	86.36±9.81	86.0 (67.0-102.0)	p=0.690

Table 2. Continued. Comparison of CCCHP scale total mean scores according to participants' findings which predicted to effect cross-cultural competence

Variables (n=157)	n	CCCHP – Total		Statistical analysis*
		$\bar{X} \pm S.D.$	Median (Min.-Max.)	
Receiving training in caring for different cultures			87.0 (60.0-113.0) 85.0 (53.0-110.0)	
Yes	8	92.25±8.63		Z=-1.801
No	149	85.01±10.44	87.0 (53.0-113.0) 85.5 (66.0-110.0)	p=0.072
Caregiving to patient with different culture				
Difficult	107	84.64±10.37	85,0 (53.0-108.0)	χ^2=1.471
Easy	31	8.69±10.64	86.0 (66.0-113.0)	p=0.479
No caregiving	19	87.60±10.71	88.0 (67.0-102.0)	
Requirement for caring according to cultural charecteristics				
Yes	79	88.20±9.22	87.0 (70.0-110.0)	Z=-1.383
No	78	84.78±8.88	86.0 (63.0-108.0)	p=0.167
Learning cultures in caregiving				
Important[1]	101	87.56±10.33	87.0 (58.0-113.0)	χ^2=13.021
Not important[2]	13	79.61±8.59	81.0 (66.0-96.0)	**p=0.001***
Neither important nor important[3]	43	81.98±9.87	84.0 (53.0-100.0)	**(1-2,3)** ¥

p<0,05, ¥ (1-2,3): The difference in Bonferroni correction was due to the difference between groups (1) and (2) and the difference between groups (1) and (3)

The findings regarding the employees' answers to the scale are given below. It was determined that the answers given by the employees to the scale were generally reliable (Table 3)

Table 3. Distrubutions of CCCHP scale and subdimensions' definitive findings and Cronbach-α coefficients

Subdimensions (n=157)	Mean	S.D.	Median	Min	Max	*Item number*	*Cronbach α*
Cross-Cultural Motivation	30.80	6.73	32.0	9.0	45.0	9	0.846
Cross-Cultural Attitudes	10.15	3.14	10.0	4.0	20.0	4	0.671
Cross-Cultural Skills	18.43	2.81	19.0	10.0	25.0	5	0.665
Cross-Cultural Awareness	15.03	3.70	15.0	5.0	23.0	5	0.685
Cross-Cultural Emotions	10.95	2.20	11.0	6.0	16.0	4	0.705
CCCHP - Total	85.38	10.46	86.0	53.0	113.0	27	0.729

DISCUSSION

The increase in cultural diversity also affects nursing care (28). Nurses must take their culture into consideration when providing care to patients, and cultural competence is an essential part of health care (29) This hospital was preferred to carry out the study due to reasons such as accepting patients from the surrounding provinces located in South, North, West and East of Turkey and/or who having different cultures, having an International Health Tourism Unit, and being the only City Training and Research Hospital in the city. Furthermore, Adana is among the Turkish cities with the largest Syrian refugee populations (30). According to another report, out of the 3.6 million Syrian refugees living in Turkey, 1.2 million are children, many of whom have experienced severe emotional and psychological trauma (31). Therefore, it was predicted that healthcare professionals working in this hospital may give care to the patients having different cultures.

It is stated in the literature that cultural competence can be affected by many characteristics such as age, gender,

socioeconomic status, race, spiritual dimension, ethnic characteristics, and education (32). In this study, significant differences were found in the cultural competence scores of the participants according to their marital status, total years of work, and whether they found it important to provide care to someone from a different culture. These findings show similarities and differences with the literature. A study found that single nurses had high cultural awareness (33). High cultural awareness may explain the high intercultural competence score in our study. Kıvrak et al.'s (34) study examining the intercultural competence of pediatric nurses found significant differences between the CCCHP and gender, education level, willingness to provide care to patients from different cultures, and willingness to communicate with patients from different cultures ($p<0,05$). In the study by Yılmaz and Kuğuoğlu (35), a significant difference was found between the willingness to provide care to patients from different cultures, foreign language proficiency, education level, the willingness to be together with patients from different cultures and cultural competence scores. Even though cross-cultural competence is mentioned as competence in communication (36), in the present study there was no significiance diffrence between speaking foreign language and the CCCHP scale mean scores contrary to the literature. Using natural foreign language translaters for communication with patients having foreign language may cause this outcome. Communication barriers could be solved with translaters, that's why sometimes healthcare professionals may not feel any need to learn foreign language. According to the Intercultural Competence Pyramid Model developed by American Council on International Intercultural Education, some of required attitudes for cultural competency are cultural awareness and experiences (37). At the same time, the difficulties experienced by nursing students in terms of language while providing care to patients from different cultures (difficulty in providing care, inability to educate the patient, inability to communicate with the patient, experiencing anxiety and fear) and the solutions offered (learning cultural competence, transferring experiences to the nursing curriculum, increasing community sensitivity, providing education to the community to break prejudice, teaching the native language of the place where they are located in a different culture, states controlling people from different cultures, training health workers to break prejudices, adding courses to the curriculum that teach how to provide care to people from different cultures in nursing education) are given in the literature (38,39). Determining Cross-Cultural Competency in healthcare professionals is crucial. It should be given more importance to cross-cultural competence particularly in countries having multicultural citizens. For maintaning the cross-cultural competent care giving, it should be given importance to in service training programs, lectures for enhancing cultural competency could be given in graduation / post graduation education. The differences between the studies in the literature and the current study may be due to cultural differences or similarities among healthcare professionals, the policies of the institutions where the studies were conducted, the cultures of the regions where the study was conducted, nurses providing care to patients from different cultures, differences in the courses taken during nursing education to develop skills in intercultural competence, differences in scales measuring intercultural competence, and individual differences.

In order for nurses to provide culturally adequate care, they need to be knowledgeable, skilled and receive appropriate training for this purpose (1,39). At the same time, healthcare professionals must communicate with and care for different populations in order to empathize and be culturally competent. Because when culturally competent personnel respond to the unique needs of the patient, inequalities in health are eliminated (40). In a qualitative

study conducted with nursing students, it was stated that cultural competence is affected by caring for patients from different cultures and having incomplete knowledge about the culture (39). In the present study, 94.9% of participants mentioned that they did not get any training for caring different cultures and there was no significiant difference between this variable and the total mean score of CCCHP scale (Table 4). It could be due to the large number of participants who did not receive training. However, most of the participants (64.3%) thought learning different cultures in patient care was important and a significant difference was found between those who think it was important and those who think it was not important and say it was neither important / nor important (p=0,001) (Table 3). In this regard, training programs could be included in the graduate and postgraduate curriculum or in-service trainings. In Turkey, "Transcultural Nursing" or "Cross-cultural Nursing" lectures were given as optional lessons in some universities having nursing graduation programs for students to be able to discuss the cross-cultural nursing models and to discuss the integration of cultural competence into nursing education and practice (41,42). "Transcultural Nursing" or "Cross-cultural Nursing" lectures have been for a few years in the some graduation programs in Turkey. This situation may explain one of the rationale of why total CCCHP scale mean score was found higher in participants who have been working totally <5 years although most of participants did not receive any training on caring for different cultures. Besides, a significant difference was found between those who have worked totally for <5 years and those who have worked for >10 years. The other rationale may be that the hospital where the study performed has an International Health Tourism Unit and this hospital started to patient admission upon the opening on September 2017. As a result working for totally <5 years may start working life in that hospital and may experience caregiving to patients having different cultures in accordance with the hospital's policies on providing care to different cultures.

In a conducted qualitative study with nurses caring for Syrian pediatric patients, communication and cultural differences was stated as challenges for caregiving them. Enhancing cultural competence by training programs was suggested to cope with this kind of challenges (43). In the present study of participants 58.6% did not speak foreign language, 94.9% did not receive any training about caring for patients having different culture, 68.2% got it difficult to giving care to the patients with different cultures even though 87.9% had an experience to giving care such that patients. Findings are paralell.

Subdimensions are in that scale as Cross-Cultural Motivation / Curiosity, Cross-Cultural Attitude, Cross-Cultural Skills, Cross-Cultural Awareness, Cross-Cultural Emotions/Empathy. Cross-Cultural Motivation / Curiosity, Cross-Cultural Awareness and Cross-Cultural Skills mean scores were found to be good; and Cross-Cultural Attitudes and Cross-Cultural Emotions/Empathy were not good. The scale scores in our study were found to be higher than the total CCCHP scale score and average total scores in the sub-dimensions in the study by Kıvrak et al. (34). The reason for this may be that although the total scale scores of singles were significantly higher in both studies, the number of singles in the study by Kıvrak et al. (34) constituted approximately one-third of the participants, while in our study they constituted half. Learning cultures in caregiving was found statistically significant. This can refer to the Cross-Cultural Motivation / Curiosity subdimension.

CONCLUSION

Determining Cross-Cultural Competency in healthcare professionals is crucial. It should be given more importance to cross-cultural competence particularly in countries having multicultural citizens. For maintaning the cross-cultural competent care giving, it should be given importance to in service training

programs, lectures for enhancing cultural competency could be given in graduation / post graduation education.

Limitations

The study was limited by being conducted in a single center and only with employees working in pediatric units. In future studies, it is recommended that multicenter studies be conducted that include other units so that the results can be integrated into the general population.

Ethical considerations

Before conducting the research ethical consent from the Ethics Board in Faculty of Medicine, Çukurova University (number / date: 101 / 3 July 2020) and institutional permissions in which the study was to be performed were obtained. Participants provided informed consent and the consents were verbal in the person meeting. All participants were informed that study permits were obtained, their names would be kept confidential, anonymity would be considered, and the data would be used for scientific purposes only.

Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available

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Conflict of interest

No potential competing interest was reported by the authors

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