

The intercultural sensitivity levels of primary health care workers in a city in Eastern Turkey

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Abstract

Objective: To assess intercultural sensitivity levels and related factors of primary healthcare workers providing care to a variety of socio-ethnic groups.

Methods: The descriptive cross-sectional study was conducted from March 1, 2019, to February 1, 2020, in the city of Mardin, Turkey, and comprised primary healthcare workers. Data was collected using a questionnaire about socio-demographic characteristics and the Turkish version of the Intercultural Sensitivity Scale. Data was analysed using SPSS 24 software version.

Results: Of the 150 subjects approached, 131 (87.3%) volunteered to participate. Of them, 80 (61%) were females and 51 (39%) were males. The largest age group was 25-34 years having 77 (59%) subjects. The total mean score of the intercultural sensitivity scale was 73.30 ± 16.7 . There was a strong relationship between the subscales of 'Responsibility and Interaction Attentiveness' and 'Respect for Cultural Differences' ($p < 0.01$). Significant difference was found between the sensitivity levels and the job titles of the participants, their status of friendship in different countries, the opportunity to be with people in other cultures for any reason, the status of willingness to work in different cultures and their intercultural sensitivity scale scores ($p < 0.05$).

Conclusions: The level of cultural sensitivity of the healthcare professionals was overall moderate.

Keywords: Culture, Intercultural sensitivity, Healthcare workers, Turkey, Mardin. (JPMA 71: 2554; 2021)

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Introduction

Culture is defined as the set of values, beliefs, attitudes, behaviours, customs and traditions that are learned, shared and passed down from generation to generation by a group of people.¹ Culture is everything that man creates in response to what nature has created.²

In today's world, interrelated concepts, such as multiculturalism, identity, diversity, otherness and globalisation, have become important subjects discussed in different aspects, both scientifically and politically, among the public.³

In addition, rapid developments in communication and transportation technologies have increased the interaction between societies and individuals. These changes and developments at national and international levels have emphasised the concept of 'intercultural communication', thus increasing the need for individuals who recognise, understand and empathise with other individuals from different cultures.⁴

Intercultural communication is all of the interdisciplinary activities that enable two different groups of people to get in touch, recognize each other, understand, accept and respect each other and develop new material and spiritual values with the help of material and spiritual cultural elements.⁵

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It is only possible to maintain effective communication when intercultural communicative competence is promoted. Intercultural communicative competence consists of three dimensions: cognitive (cultural awareness), affective (intercultural sensitivity) and behavioural (intercultural competence) aspects.^{4,6}

In today's multicultural and globalising societies, there is a great deal of interest towards intercultural sensitivity, which is an important element of intercultural communication skills and is defined as "having an active desire to provide one's motivation to understand, accept and appreciate intercultural differences". Interculturally sensitive people have a point of view that prioritises universal values in individualist-socialist environments.⁷

Intercultural sensitivity is expressed as an individual's sensitivity to others and the cultures presented in interaction, and as an understanding of the worldview of others.⁸

It also involves being sensitive to cultural differences and the perspectives of individuals from different cultures.⁹ The emotional aspect of intercultural communicative competence focuses on personal emotions or emotional changes caused by certain situations, people and environments.¹⁰ Intercultural communicative competence can be regarded as an important capability to overcome the obstacles to work effectively with people at both international and domestic cultural borders.¹¹ Intercultural

communicative competence is also defined as people's "active desire to motivate themselves to understand, appreciate and accept the differences between cultures".¹²

In the 21st century, the awareness towards beliefs, values, religion, language and other cultural and socio-economic factors affecting health promotion and help-seeking behaviours have increased among aspiring health professionals, and in recent years, culture-sensitive care has become one of the most important qualifications that graduate students are supposed to possess for professional health applications.¹³

There is a sufficient number of studies on the education of healthcare professionals regarding cultural care, but culturally sensitive care has not been applied enough.^{2,14,15} It has been stated that culturally important aspects are generally neglected in the provision of healthcare. Moreover, cultural issues are usually not emphasised when devising training programmes for healthcare workers (HCWs) and clinical study guides.² On the other hand, the use of cultural models and guides is beneficial to HCWs in evaluating the cultural characteristics of the community they care for, obtaining cultural data in more systematic and standardised ways, and increasing their intercultural knowledge. Culturally appropriate care also requires HCWs to be individually informed and sensitive about cultural differences and similarities. To achieve this goal, a framework of competencies should be developed to provide cultural competence in the training of HCWs in order to ensure that primary healthcare professionals are able to provide intercultural sensitive care to people with different ethnic backgrounds. The current study was planned to examine intercultural sensitivity levels and related factors of primary HCWs providing care to a variety of socio-ethnic groups.

Subject and Methods

The descriptive cross-sectional study was conducted from March 1, 2019, to February 1, 2020, in the city of Mardin, Turkey. Mardin, located in southeastern Turkey, plays host to different socio-ethnic groups because of migrants from strife-torn Syria. After approval from the Non-Interventional Researches Ethics Review Committee of the Mardin Artuklu University, the sample was raised without using any sampling method as all healthcare workers were approached in line with the full count method.

The sample comprised all primary HCWs, including doctors, nurses, midwives, and others, working at the family health centre for at least the preceding six months and who were present at the time of data-collection. Those who were on leave or not willing to participate were excluded.

Data was collected after taking verbal informed consent from the volunteers.

Data was collected through face-to-face interviews using a questionnaire with the help of nursing students of the Faculty of Health Sciences of Mardin Artuklu University. The questionnaire form had two sections. The first section comprised a predesigned sheet with 20 open-ended and multiple choice questions (MCQs) targeting the socio-demographic characteristics of the subjects. The second section comprised 24-item Intercultural Sensitivity Scale,¹⁶ which has been shown to be a psychometrically valid and reliable tool translated into Turkish.⁴

The scale has five emotional subscales explaining the aspects of intercultural sensitivity. The interaction engagement subscale consists of seven items (items 1, 11, 13, 21, 22, 23 and 24). The respect for cultural differences subscale includes six items (items 2, 7, 8, 16, 18 and 20). The interaction confidence subscale includes five items (items 3, 4, 5, 6 and 10). The interaction enjoyment subscale contains three items (items 9, 12 and 15), and the interaction attentiveness subscale has three items (items 14, 17, and 19). Also, items 2, 4, 7, 9, 12, 15, 18, 20 and 22 of the scale are reversely evaluated. The scale is scored using a 5-point Likert rating, ranging from 1 = strongly disagree, to 5 = strongly agree. The lowest total score that can be obtained from the scale is 24, while the highest total score is 120. A score of 72 points is considered sufficient. The scale does not have any cut-off points. Higher total scores indicate higher levels of intercultural sensitivity.⁴

Data was analysed using SPSS 24 software version. Continuous variables were expressed as mean and standard deviation, while categorical variables were described as frequencies and percentages. Kolmogorov-Smirnov test was used to evaluate data distribution. The variables with normal distribution in the statistical comparisons were evaluated using independent sample t tests and one-way analysis of variance (ANOVA), while the variables without normal distribution were evaluated using Kruskal Wallis, Mann-Whitney-U and Spearman's rho correlation tests. $P < 0.05$ was considered statistically significant.

Results

Of the 150 subjects approached, 131(87.3%) volunteered to participate. Of them, 80(61%) were females and 51(39%) were males. The largest age group was 25-34 years having 77(59%) subjects. Among the HCWs, there were 43(32.8) doctors, 64(48.9%) nurses/midwives and 24(18.3%) other staff. Of the total, 21(16%) had received training on providing care for patients from other cultures, and 30(22.9%) had experience of working and training in

different cultures (Table 1).

Mean total score of the sample on the Intercultural Sensitivity Scale was 73.35 ± 16.74 . Subscale mean scores

Table-1: Socio-demographic and cultural characteristics of the sample.

Socio-demographic and cultural characteristics (n=131)		n (%)
Age (years)	18-24	11 (8.4)
	25-34	77 (58.8)
	35-44	27 (20.6)
	45-54	11 (8.4)
	55 and above	5 (3.8)
Gender	Male	51 (38.9)
	Female	80 (61.1)
Marital status	Married	92 (70.2)
	Single	39 (29.8)
Professional title	Doctor	43 (32.8)
	Nurse/Midwife	64 (48.9)
	Other healthcare staff	24 (18.3)
Income status	Less income than expenses	53 (40.5)
	More income than expenses	26 (19.8)
	Equal income and expenses	52 (39.7)
Language spoken at home	Turkish	71 (54.2)
	Kurdish	34 (26.0)
	Arabic	26 (19.8)
Status of choosing the profession	Willingly	108 (82.4)
	Unwillingly	23 (17.6)
Reason for choosing the profession	Easy to get a job	49 (37.4)
	Ideal job	54 (41.2)
	Family's request	23 (17.6)
	Teacher's advice	5 (3.8)
Residence until the age of 12	Metropolitan city	10 (7.6)
	Province	76 (58.0)
	District	33 (25.2)
	Village	12 (9.2)
Opinion about the job during university education	Changed positively	80 (61.1)
	Changed negatively	41 (31.3)
	No idea	10 (7.6)
Able to speak a foreign language	Yes	52 (39.7)
	No	79 (60.3)
Frequency of following the mass media in different countries	Never	29 (22.1)
	Rarely	35 (26.7)
	Occasionally	58 (44.3)
	Usually	9 (6.9)
Status of having friends from different countries	Yes	45 (34.4)
	No	86 (65.6)
Status of ever having been abroad	Yes	32 (24.4)
	No	99 (75.6)
Willingness to live in a country with a different culture	Yes	25 (19.1)
	No	106 (80.9)
Opportunity to be around people from different cultures for any reason	Yes	86 (65.6)
	No	45 (34.4)
Status of having received training on providing care for patients from other cultures	Yes	21 (16.0)
	No	110 (84.0)
Experience in working and training in different cultures	Yes	30 (22.9)
	No	101 (77.1)
Willingness to work in different cultures	Yes	97 (74.0)
	No	34 (26.0)
Total		131 (100)

Table-2: The total mean scores of the participants on the Intercultural Sensitivity Scale and its subscales.

	n	Min	Max	Mean $\pm$ SD
Intercultural sensitivity level	131	28.00	107.00	73.35 $\pm$ 16.74
Interaction engagement	131	7.00	35.00	22.33 $\pm$ 6.94
Respect for cultural differences	131	6.00	30.00	21.79 $\pm$ 4.56
Interaction confidence	131	5.00	25.00	15.87 $\pm$ 4.17
Interaction enjoyment	131	5.00	15.00	11.51 $\pm$ 2.44
Interaction attentiveness	131	3.00	15.00	9.54 $\pm$ 3.37

SD: Standard deviation.

were also computed (Table 2).

The strongest relationship was between the interaction engagement subscale and the respect for cultural differences subscale ($p < 0.01$). A moderately positive significant relationship was found among the subscales of interaction engagement, interaction confidence and interaction attentiveness ($p < 0.01$). The lowest positive significant relationship was found between the interaction enjoyment and the interaction confidence subscales ($p < 0.01$) (Table 3).

No significant difference was found between the scores in terms of gender ($p > 0.05$). There was a significant difference in terms of the friendship status in different countries, the opportunity to be with people from other cultures for any reason, and willingness to work in different cultures ($p < 0.05$) (Table 4).

The overall mean score of the doctors was 78.34 ± 15.26 , while the mean score of the nurses / midwives was 75.51 ± 16.52 and it was 58.62 ± 11.24 for the other HCWs. There was a significant difference in the scores in terms of professional titles ($p < 0.05$) (Table 5).

Discussion

The present study was carried out in a city that has a multicultural environment and consists of individuals of many different ethnic backgrounds.

The Intercultural Sensitivity Scale total mean score of HCWs was 73.3 ± 16.7 . For the doctors it was 78.34, for nurses / midwives 75.51, and for other staff 58.62. A similar study with nurses / midwives working in a family health centre in two districts in Izmir, the total mean score was 77.1 ± 5.4 .¹⁷ Another study comprising nursing students¹⁸ reported high score of 91.20 ± 13.78 . The mean scores of other similar samples were 90.48 ± 15.14 ¹⁹ and 89.42 ± 13.55 .²⁰ In a study conducted with pharmacy students in the United States, the mean total score was 94.00, whereas it was 76.33 among Japanese nurses.^{21,22} Since other healthcare staff were also included in the current study, it may have lowered the total mean scores.

In the current study, the most important factor was

Table-3: Correlation analysis between the subscales of the Intercultural Sensitivity Scale.

Correlations between the factors	Interaction engagement and Interaction attentiveness	Interaction confidence	Respect for cultural differences	Interaction enjoyment
Interaction engagement and Interaction attentiveness	1	0.612**	0.703**	0.184*
Interaction confidence	0.612**	1	0.503**	0.129
Respect for cultural differences	0.703**	0.503**	1	0.384**
Interaction enjoyment	0.184*	.129	0.384**	1

* $p < 0.05$, ** $p < 0.01$ **Table-4:** Comparison of the socio-demographic characteristics and cultural interactions on the Intercultural Sensitivity Scale (n=131)

	Intercultural sensitivity Levels			
	n (%)	Mean±SD	t-test	p-value
Gender				
Female	80 (61.1)	79.00±16.24	0.986	0.95
Male	51 (38.9)	76.11±16.40		
Having Friends from different countries				
Yes	45 (34.4)	80.60±18.42	1.387	0.019
No	86 (65.6)	76.45±14.99		
Opportunity to be with people from other cultures for any reason				
Yes	86 (65.6)	79.23±17.67	1.318	0.015
No	45 (34.4)	75.28±13.10		
Willingness to work with different cultures				
Yes	97 (74.0)	75.13±17.24	1.897	0.012
No	34 (26.0)	68.81±14.13		

SD: Standard deviation.

Table-5: Comparison of the socio-demographic characteristics and cultural interactions on the Intercultural Sensitivity Scale (n=131).

	Intercultural sensitivity Levels			
	n	Mean±SD	F	p-value
Age (years)				
18-24	11	80.36±11.45	1.96	0.111*
25-34	77	74.02±16.43		
35-44	27	73.11±18.02		
45-54	11	61.63±15.35		
55 and above	5	74.60±20.80		
Professional title				
Doctor	43	78.34±15.26	14.08	0.000*
Nurse / midwife	64	75.51±16.52		
Other healthcare worker	24	58.62±11.24		
Income status				
Less income than expenses	53	69.03±18.16	3.22	0.43*
More income than expenses	26	77.84±15.48		
Equal income and expenses	52	75.50±15.05		
Frequency of following the mass media in different countries				
Never	29	68.75±15.67	0.98	0.42*
Rarely	35	74.14±15.04		
Occasionally	58	75.46±17.79		
Usually	8	69.87±19.77		
Always	1	84.00		

SD: Standard deviation; *p-value: Significant.

interaction engagement, followed by respect for cultural differences, interaction confidence, interaction enjoyment

and interaction attentiveness. A similar study²³ reported the most important factor to be interaction enjoyment, followed by interaction attentiveness and interaction confidence. Another study³ showed that the most important factor effective in intercultural sensitivity in communication was interaction engagement and attentiveness.

In the current study, the total mean score of the participants' being careful in interaction was lower than the other subscales, which may be due to the low level of efforts of the participants to understand what is happening in the domain of intercultural interaction.

The current study also conducted correlation tests to assess the relationships between various variables. The findings were similar to those reported earlier.^{3,6,18} Based on these findings, it can be suggested that those who interact with other cultures and have a positive perception of this subject have a higher level of intercultural sensitivity.

According to one study,³ a significant difference in intercultural sensitivity in communication was noted in those knowing a foreign language.³ However, this difference was not statistically significant in the current study. The reason for the absence of this expected relationship in the present study could be attributed to the fact that the city where the study was carried out has a multicultural and multilingual environment and there is a direct and indirect intercultural experience.

The study findings indicate the importance of addressing intercultural sensitivity, which is an important dimension of intercultural communication for HCWs to provide culturally adequate care to individuals from different cultures.

The current study is one of the very few studies conducted to determine the level of intercultural sensitivity in Turkey. Similar studies with individuals from different socioeconomic backgrounds living in different regions of Turkey with larger samples are recommended. Future studies shall explore the impact of other dimensions to better understand the nature of being fully competent in the context of intercultural sensitivity.

Conclusion

The level of cultural sensitivity of the healthcare professionals working in primary care was found to be moderate.

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