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EXAMINING THE CROSS-CULTURAL COMPETENCIES OF HEALTHCARE PROFESSIONALS AS A HEALTH MANAGEMENT STRATEGY

ABSTRACT

Objective: A culturally competent health system can help improve health outcomes and quality of care. This competence can contribute to the elimination of racial and ethnic health inequalities. Examples of the health system's strategies to achieve these goals are training of health professionals in cultural competence and intercultural issues, and the establishment of policies that reduce administrative and linguistic barriers to patient care. In this study, it was aimed to examine the intercultural competencies and related factors of health professionals, which are the most important production factors in the management and delivery of health services.

Material and Method: The population of the research was 512 health professionals working in two public hospitals in Istanbul. The sample was 215 people due to voluntary participation and inaccessibility. This descriptive and cross-sectional study was carried out between July 2018 and September 2018. The Cross-Cultural Competence of Healthcare Professionals (CCCHP) was used with the Individual Information Form developed by the researchers to collect the data and the Personal Information Form developed by the researchers. SPPS 25.0 statistical software was used to evaluate the data. Continuous variables were expressed as mean ± standard deviation, categorical variables as numbers or percentages. Kolmogorov-Smirnov test was used to evaluate whether the distribution of variables was normal. It was determined that the variables showed normal distribution. The t-test was used to compare quantitative continuous data between two independent groups, and the One-way Anova test was used to compare quantitative continuous data between two independent groups. After the Anova test, Scheffe test was used as complementary post-hoc analysis to determine the differences.

Results: The average age of the healthcare professional was $33.66 ± 9.65$ 71.6% (n = 154), female, 122 (56.7%) undergraduate, 108 (50.2%) nurses / midwife / health officer, 93 (43.3%) by year of employment in the profession, 191 (88.8%) by ethnicity are Turkish, and 130 (60.5%) have no migration background determined. In addition, the "Intercultural Competence Scale of Health Professionals Scale" total score average is $3,377±0,514$ and it is at the medium level. When the relationship between the factors affecting intercultural competence and the total score of the scale is examined; There was a significant difference ($p <0.05$) according to age, education level, occupation, year of study, and region characteristics lived for a long time.

Conclusion: The intercultural competence levels of healthcare professionals were found to be moderate. It is important that health professionals have the responsibility to communicate effectively with patients of different faiths and cultures and to provide care with a holistic approach. For this reason, trainings can be provided to healthcare professionals about having interpreters in basic health institutions, increasing the diversity of workforce, and healthcare professionals. It may be beneficial to make new arrangements at the organizational and structural level of health systems to effectively respond to the needs of the immigrant population.

Keywords: Culture, intercultural competence, health professionals, health management, strategy

1. INTRODUCTION

The number of immigrants and refugees is increasing worldwide. In Turkey many refugees, asylum seekers, migrants often live and healthcare professionals are faced with individuals from different cultures. Therefore, it is important for healthcare workers to be sensitive and improve their cultural competencies in multicultural societies. Cross-Cultural competence; It is an important component in providing culturally sensitive and effective care in health care services, reducing inequalities, combating racism, improving individuals' care satisfaction and health care outcomes. It is important that health professionals have the responsibility to communicate effectively with patients of different faiths and cultures and to provide care with a holistic approach.

There are many factors that affect the effectiveness and efficiency of health services. Communication, feelings and harmony can be counted among these factors. Correct and effective communication is achieved by providing a true co-sensation and communication to the person in front of us. In order to

realize this, it is necessary to have information about the emotions, thoughts and cultural structure of the person in front of us. The fact that there is an information asymmetry between the service provider and the service provider in the provision of health services also increases the importance of the issue (Guo, Guo, Fang & Vogel, 2017). Due to the increasing cultural differences, health care providers have to encounter and provide care for more than one culture. Not only patients but healthcare providers can come from different cultures (Chen and Wang, 2015). The inability of the health worker to understand the person in front of him due to his cultural disability contributes to health inequalities and poor health outcomes (Gallagher, 2011). Cross-Cultural competence is one of the important components of health care quality and has a healing effect on health care outcomes (So-Yun and Kyung-Sook, 2014; Gallagher and Polanin, 2015). Cross-Cultural competence can be defined as having the knowledge, skill and capacity to meet the demands and expectations of people with different cultures and social groups. In other words, it is the process and ability of the individual or organization to function effectively in different cultural situations (Campinha-Bacote, 2002).

Based on these definitions, cultural competence is stated as making health care services more acceptable and effective for individuals of different ethnic-cultural structures for health institutions. It is stated that it is a factor to increase the efficiency of health and social services by reducing the use of unnecessary and inappropriate services (Kirmayer, 2012). Intercultural competence begins with the desire to recognize and understand people with different cultural characteristics. Healthcare professionals "must strive to ensure the ability and usability of working effectively in a client's cultural context." (Betancourt, Green, Carrillo & Ananeh-Firempong, 2016). When sociocultural differences between patients and service providers cannot achieve a consensus in the clinical encounter, more negative health outcomes occur (Williams and Rucker, 2000).

There are many studies showing the relationship between the improvement of patient results due to the increase of cultural competence. In a study, it was emphasized that cultural sensitivity training for healthcare providers increased the social resource utilization and functional capacity of patients (Majumdar, Browne, Roberts and Carpio, 2004). Another study reported that culturally sensitive health policies improve the quality of managed care (Beach et al. 2005; Lie, Lee-Rey, Gomez, Bereknyei & Braddock, 2011; Truong, Paradies and Priest, 2014). Ensuring the cultural competence of health professionals consists of five components that it establishes with the patient. These components are; Cultural awareness is the acceptance and respect of the differences of other people with whom the person interacts, such as tradition, value, and communication style, and to develop and develop experiences related to them. Cultural knowledge is the cultural characteristics that different cultural and ethnic groups learn about worldviews, biological variations, diseases and health conditions and variations. It is the process of searching and finding the right information about different cultures and ethnic groups (Başalan Iz and Bayık Temel, 2009). Nurses who do not have cultural knowledge may lead to misunderstandings and conflicts in care, as well as an increased risk of errors and even a fatal outcome (Felemban, O'Connor and McKenna, 2014). Cultural skills mean being active by using verbal and nonverbal communication skills when interacting with people from different cultures. Cultural encounters refer to the process of interaction with individuals from different cultures and face-to-face encounters (Andrews et al, 2010). In the literature, it has been stated that cultural competence is not an event, but a process, and that cultural competence is an important content. He pointed out that cultural encounter increases cultural sensitivity, cultural awareness, cultural knowledge, skill and desire (Gallagher, 2011). It has also been pointed out that meeting individuals from different cultures in clinics will be effective for a proper cultural approach to the individual (Bahadır Yılmaz,2014; Pearson et al, 2007; Saha, Beach, and Cooper, 2008). Awareness is also important to research and change attitudes and to increase personal prejudices. To provide this awareness, firstly, standard, valid and reliable tools are needed to measure the cultural competence levels of health professionals. In the literature surveys, it has been determined that studies to measure the intercultural competence of health professionals at national level are insufficient. With this study, it was aimed to examine the intercultural competencies and related factors of health professionals, which are the most important production factors in health management and health service delivery. For this purpose, this research is predicted to fill this gap in the literature. The cultural competence of healthcare professionals is thought to play a key role in reducing cultural differences in healthcare, and can contribute to the development of patient care quality.

2.   MATERIALS AND METHODS

2.1.   Objective

This study aimed to examine the intercultural competencies and related factors of health professionals, which are the most important production factors in health management and delivery of health services.

2.2.   The Universe and the Sample of the Research

The universe of the research was 512 health professionals working in two public hospitals in Istanbul. This descriptive and cross-sectional study was carried out between July 2018 and September 2018. Between these dates, 1156 health professionals working in these hospitals constituted the universe of the study. It was determined that the number of samples was 278 by G-Power analysis over the number of universe. However, 215 participants who completed the questions in the scale completely and agreed to participate in the study on a voluntary basis constituted the sample of the study. 63 questionnaires with unanswered and flagged questions were excluded.

2.3.   Collection of Data

In collecting data, "Individual Information Form" created by researchers and "Cross-Cultural Competence Scale of Health Professionals" were used.

Individual Information Form: In this form, it is aimed to evaluate the gender, age, marital status, birthplace, educational status, total working year in the profession, staff status, ethnic origin, the region where he lived for the longest period, the region where his family lived, and the existence of his / her family's migration history. There were 10 questions**.**

Cross-Cultural Competence Scale of Healthcare Professionals (CCCHP): It is a 5-point likert type scale consisting of 5 items with 27 items developed by Bernhard et al. (2015).The sub-dimensions of the scale were named as Cross-Cultural Motivation / Curiosity (9 items), Cross-Cultural Attitude (4 items), Cross-Cultural Skills (5 items), Cross-Cultural Wealth and Diversity (5 items) and Cross-Cultural Emotions / Empathy (4 items). It was stated that the internal consistency reliability for the total score of the scale was 0, 87 and all sub-dimensions of Cronbach's α values ranged between 0.54 and 0.84.Scoring of items in the scale is made as 1 = Strongly disagree, 2 = Disagree, 3 = Undecided, 4 = Agree, 5 = Strongly agree. The scores of the scale's Cross-Cultural Attitude, Cross-Cultural Wealth and Diversity and Cross-Cultural Emotions / Empathy sub-dimensions are calculated by reversing. The lower limit (the lowest score) of the score that can be obtained from the scale is 27, the upper limit (the highest score) is 135 points. These scores are proportional to the number of participants and when the averages are taken, the scores between 1 and 5 indicate that the Cross-Cultural competence level of the health professionals of 3 and above is positive.

In this study, firstly, the language equivalence was made for the validity of the Turkish form of the scale, and then Lawshe method was used for expert opinions in the scope validity of the scale (Lawshe, 1975). The reliability of the scale was assessed by internal consistency, item analysis, and time invariance (test-retest).Turkish adaptation of the scale was tested by confirmatory factor analysis and exploratory factor analysis. The repetition of the test was repeated twice in 30 participants in a total of 2 weeks. As a result of factor analysis, it was determined that the total explained variance of the variables was 58.635% and 20 items under 4 factors. 7 items were excluded from the scale since it was determined that the item load and factor load were below 0.4 in the scale. The overall reliability of the scale was found to be very high as alpha = 0.85. Reliability values of the sub-dimensions of the scale are alpha = 0,90 for F1 = 8 items (Cross-Cultural Motivation/Curiosity), alpha = 0,66 for F2 = 5 items (Cross-Cultural Attitudes), alpha = 0 for F3 = 3 items (Cross-Cultural Emotions/Empathy), It was found that alpha = 0.62 for 69, F4 = 4 items (Cross-Cultural Wealth and Diversity). The fit indexes of the scale are CFI = 0.71; NNFI = 0.96; RMR = 0.10 and RMSEA = 0.11, AGFI = 0.67, GFI = 0.73.

2.4.   Data Collection Method

Health professionals working in hospitals were informed about the research and their consent was obtained without distributing questionnaire forms in the institutions they work. The "Personal Identifying Characteristics Form" and " Cross-Cultural Competence Scale of Health Professionals" were

distributed to the participants who agreed to participate in the research. An explanation about filling in the data collection forms was made. It took about 5-7 minutes to respond to the research under the control and collect method.

2.5. Statistical Analysis of Data

SPPS 25.0 statistical software was used to evaluate the data. Turkish adaptation of the scale was tested by confirmatory factor analysis and exploratory factor analysis. The reliability of the scale was calculated with Crombach Alpha. The distribution of the questions in the Personal Information Form was evaluated as frequency, percentage, and scale scores as mean, standard deviation. Before the analysis, the normal distribution of the data was analyzed with the Kolmogorov-Smirnov test or it was determined that it showed a normal distribution. In the case of two groups in the comparison of quantitative data, the "t" test was used for independent samples (Independent samples) for comparison of parameters. In case of more than two groups in comparing quantitative data, one way (Oneway) Anova test was used for comparing parameters between groups and Scheffe test was used in determining the group causing the difference. The results were evaluated a 95 percent confidence interval and $p < 0.05$ significance level.

2.6. Ethical Aspect of the Research

In conducting the study, the managers of both hospitals were informed about the study and their written permissions were obtained. Written and verbal approvals of participants that they volunteered to participate in the study were obtained. The research was carried out in accordance with the Helsinki Declaration Principles.

2.7. Limitations of the Study

Research; The year 2018 is limited to the opinions of 215 health professionals working in two public hospitals in Istanbul and the data obtained from the scale items.

3. RESULTS

In this section, for the solution of the research problem, the findings obtained as a result of the analysis of the data collected through the scales of the employees participating in the research are included. Characteristics of health professionals participating, 63 (29.3%) aged 25 and under, 41 (19.1%) 26-30, 17 (7.9%) 31-35, 27 by age (12.6%) 36-40, 48 (22.3%) 41-45, 19 (8.8%) 46 and over. According to marital status, 124 (57.7%) are married, 91 (42.3%) are single, 29 (13.5%) are high school and associate degree, 122 (56.7%) are 64 (29.8%) are distributed as postgraduate. According to the staff, 108 (50.2%) are distributed as nurses / midwives / health officers, 73 (34.0%) as general practitioners / specialists, 34 (15.8%) as other healthcare professionals. According to the year of employment in the profession, 93 (43.3%) 1-3, 21 (9.8%) 4-6, 16 (7.4%) 7-10, 21 (9%, 8) 11-15, 64 (29.8%) are distributed as 16 and above. According to the place of birth of employees, 21 (9.8%) Mediterranean region, 20 (9.3%) Aegean region, 36 (16.7%) Central Anatolia, 9 (4.2%) Güneyanadol region 17 (7.9%) are distributed in Eastern Anatolia, 45 (20.9%) in the Black Sea and 67 (31.2%) in Marmara. According to ethnicity, 191 (88.8%) of the employees are distributed as Turkish and 24 (11.2%) as other. Employees 21 (9.8%) Mediterranean region, 14 (6.5%) Aegean region, 39 (18.1%) Central Anatolia, 3 (1.4%)) The southeastern region is distributed as 16 (7.4%) Eastern Anatolia, 23 (10.7%) Black Sea, 99 (46.0%) Marmara. According to the region where the family lives, 19 (8.8%) Mediterranean region, 16 (7.4%) Aegean region, 36 (16.7%) Central Anatolia, 16 (7.4%) East Anatolia is distributed as 31 (14.4%) Black Sea and 97 (45.1%) Marmara. Employees are distributed as 85 (39.5%) yes and 130 (60.5%) no according to the presence of migration history.

Table 1. Identifying Characteristics

Identifying Characteristics	Frequency (n)	Percentage (%)
Age		
25 Years And Under	63	29,3
26-30	41	19,1
31-35	17	7,9
36-40	27	12,6
41-45	48	22,3
46 and over	19	8,8
Marital status		
The married	124	57,7
Single	91	42,3
Education status		
High School and Associate Degree	29	13,5
License	122	56,7
Graduate	64	29,8
Staff		
Nurse / midwife / health officer	108	50,2
Practitioner / uzmandokt is	73	34,0
Other Health Worker	34	15,8
Working Year in Profession		
1-3	93	43,3
4-6	21	9,8
7-10	16	7,4
11-15	21	9,8
16 and above	64	29,8
Place of birth		
The Mediterranean Region	21	9,8
The Aegean Region	20	9,3
The Central Anatolia	36	16,7
The Southeastern Anatolia	9	4,2
The Eastern Anatolia	17	7,9
The Black Sea Region	45	20,9
The Marmara	67	31,2
Ethnicity		
Turkish	191	88,8
Other	24	11,2
Long lived region		
The Mediterranean Region	21	9,8
The Aegean Region	14	6,5
The Central Anatolia	39	18,1
The Southeastern Anatolia	3	1,4
The Eastern Anatolia	16	7,4
The Black Sea Region	23	10,7
The Marmara	99	46,0
Family Lived Region		
The Mediterranean Region	19	8,8
The Aegean Region	16	7,4
The Central Anatolia	36	16,7
The Southeastern Anatolia	16	7,4
The Eastern Anatolia	31	14,4
The Black Sea Region	97	45,1
Existence of the Migration History		
Yes	85	39,5
No	130	60,5

The average of "Cross-Cultural Motivation/Curiosity" of the employees is 3.580 ± 0.794 (Min = 1.25; Max = 5), the average of "Cross-Cultural Attitudes" is average 3.027 ± 0.699 (Min = 1.4; Max = 5), the average of "Cross-Cultural Emotions/Empathy" is 2.817 ± 0.827 (Min = 1; Max = 4.67), "Cross-Cultural Wealth and Diversity" average high 3,827 ± 0,596 (Min = 2; Max = 5), "Cross-Cultural Competence Scale of Healthcare Professionals" mean medium 3,377 ± 0,514 (Min = 1.9; Max = 4.45), detected (Table 2).

Table 2. Cross-Cultural Competence Scale of Healthcare Professionals Mean Scores

	N	Mean±SD	Min.	Max.	Scale Ranges
Cross-Cultural Motivation/Curiosity	215	3,580±0,794	1,250	5,000	1-5
Cross-Cultural Attitudes	215	3,027±0,699	1,400	5,000	1-5
Cross-Cultural Emotions/Empathy	215	2,817±0,827	1,000	4,670	1-5
Cross-Cultural Wealth and Diversity	215	3,827±0,596	2,000	5,000	1-5
Cross-Cultural Competence General	215	3,377±0,514	1,900	4,450	1-5

SD: standard deviation

The cross-cultural empathy subscale and cross-cultural competence scale total scores of health professionals participating in the study differ significantly according to the age variable (F = 9,384; p = 0 <0.05).The reason for the differences is that the mean ranges between the ages are higher than each other (p <0.05). The cross-cultural empathy rank mean of the married professionals was lower than the mean cross-cultural empathy rank of singles (t = -2.824; p = 0.003 <0.05).The mean of cross-cultural wealth and diversity of married people was lower than the mean of cross-cultural wealth and diversity of singles (t = -2.345; p = 0.02 <0.05). In addition, cross-cultural cohesion, intercultural attitude and cultural adequacy scores do not differ significantly according to marital status variable (p> 0.05) (Table 3).

Cross-Cultural Motivation scores of health professionals differ significantly according to the education level variable (F = 6,523; p = 0.002 <0.05).The reason for the difference is that the Cross-Cultural Wealth and Diversityof those with an undergraduate education is higher than the Cross-Cultural wealth and diversity of those with a postgraduate degree (p <0.05). The Cross-Cultural attitude scores of health professionals differ significantly according to the education level variable (F = 4,760; p = 0.01 <0.05). The reason for the difference is that the Cross-Cultural attitude average of those whose education level is high school and associate degree is higher than the intercultural attitude average of those whose education level is undergraduate (p <0.05).The Cross-Cultural attitude average of those with a high school or associate degree is higher than the intercultural attitude average of those with a postgraduate degree (p <0.05). Cross-cultural empathy scores of health professionals differ significantly according to the educational background variable (F = 6.445; p = 0.002 <0.05).

The reason for the difference is that the cross-cultural empathy rank average of those whose education level is undergraduate is higher than the i cross-cultural empathy rank average of those whose education level is high school and associate degree (p <0.05).Cross-cultural competence general scores differ significantly according to the educational status variable (F = 3,890; p = 0.022 <0.05).The reason for the difference is that the overall rank average of the cross-cultural competence scale of those whose education level is undergraduate is higher than the general rank average of the cultural qualification of graduate students (p <0.05).In addition, cross-cultural wealth and diversity scores do not differ significantly according to the educational background variable (p> 0.05) (Table 3).

The cross-cultural motivation, cross-cultural attitude, cross-cultural competence and scores of health professionals differ according to the staff variable (p = 0 <0.05).The reason for the difference is that the cross-cultural cohesion average of those who are staff nurses / midwives / health officers is higher than the intercultural cohesion mean of those who are staff practitioners / specialists (p <0.05). Cross-cultural motivation average of those who have a staff nurse / midwife / health officer is higher than the mean of intercultural motivation among staff of other healthcare professionals (p <0.05).The Cross-cultural empathy, cross-cultural wealth and diversity scores do not differ significantly according to the staff variable (p> 0.05) (Table 3).

The cross-cultural attitude, cross-cultural attitude empathy, and scores of health professionals differ according to the variable of working year in the profession (p <0.05).The reason for the differences arises from the fact that the average ranks between working years in the profession are higher than each other (p <0.05). The cross-cultural motivation, cross-cultural wealth and diversity, cross-cultural competence scores do not differ significantly according to the working year variable in the profession (p> 0.05) (Table 3).The cross-cultural competence general scores and cross-cultural motivation scores of health professionals differ significantly according to the birthplace variable (p <0.05). The differences are due to the higher mean rank between birth places compared to each other (p <0.05). The cross-cultural competence general scores do not differ significantly between employees' cross-cultural attitude, intercultural empathy, intercultural wealth and diversity scores by birthplace variable (p> 0.05).

The overall scores of health professionals in cross-cultural motivation cross-cultural attitude, cross-cultural empathy, cross-cultural wealth and diversity, cross-cultural competence do not differ significantly according to ethnicity variable (p> 0.05) (Table 3). The cross-cultural motivation, intercultural attitude, cross-cultural empathy, cross-cultural wealth and diversity, cross-cultural competence scores of health professionals differ significantly according to the region variable experienced for a long time (p <0.05). The reason for the differences is that the average of the ranks among the regions experienced are higher than each other (p <0.05).The cross-cultural adaptation, cross-cultural empathy, cross-cultural wealth and diversity, cross-cultural competence scores of health professionals differ significantly according to the region variable in which the family lives (p <0.05). The differences are due to the higher mean rank between the regions where the family lives (p <0.05). The overall scores of health professionals in cross-cultural motivation, cross-cultural attitude, cross-cultural empathy, cross-cultural wealth and diversity, cross-cultural competence do not differ significantly according to the presence of migration history (p> 0.05), (Table 3) (Table 3).

Table 3. Comparison of Identifying Characteristics and Cross-Cultural Competence Scale Scores of Health Professionals

Identifying Characteristics	n	Cross-Cultural Motivation	Cross-Cultural Attitudes	Cross-Cultural Emotions	Cross-Cultural Wealth and Diversity	Cross-Cultural Competence General
Age		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
25 Years And Under	63	3,76±0,491	3,02±0,679	3,09±0,597	3,97±0,508	3,51±0,305
26-30	41	3,57±0,845	2,82±0,777	2,76±0,739	3,70±0,662	3,29±0,464
31-35	17	3,29±0,901	3,27±0,685	3,13±0,635	3,82±0,611	3,37±0,516
36-40	27	3,55±0,818	3,29±0,547	2,85±0,844	3,82±0,686	3,43±0,597
41-45	48	3,38±0,939	2,98±0,784	2,21±0,921	3,68±0,610	3,17±0,644
46 and over	19	3,78±0,865	2,96±0,412	3,19±0,772	3,98±0,429	3,53±0,527
F=		1,979	1,970	9,384	1,999	3,349
p=		0,083	0,084	0,000	0,080	0,006
PostHoc=				1>2, 6>2, 1>5, 2>5, 3>5, 4>5, 6>5 (p<0.05)		1>2, 1>5, 4>5, 6>5 (p<0.05)
Marital status		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
The married	124	3,58±0,868	2,99±0,731	2,68±0,948	3,74±0,616	3,33±0,592
Single	91	3,57±0,684	3,07±0,655	3,00±0,582	3,93±0,552	3,43±0,379
t=		0,052	-0,778	-2,824	-2,345	-1,444
p=		0,957	0,438	0,003	0,020	0,125
Education status		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
High School and Associate Degree	29	3,62±0,570	3,39±0,613	2,33±0,926	3,75±0,598	3,40±0,351
License	122	3,72±0,608	2,97±0,716	2,93±0,669	3,88±0,553	3,44±0,390
Graduate	64	3,29±1,078	2,96±0,662	2,81±0,974	3,75±0,667	3,23±0,720
F=		6,523	4,760	6,445	1,269	3,890
p=		0,002	0,010	0,002	0,283	0,022
PostHoc=		2>3 (p<0.05)	1>2, 1>3 (p<0.05)	2>1, 3>1 (p<0.05)		2>3 (p<0.05)

Table 3. Comparison of Identifying Characteristics and Cross-Cultural Competence Scale Scores of Health Professionals (*Cont*.)

Identifying Characteristics	n	Cross-Cultural Motivation	Cross-Cultural Attitudes	Cross-Cultural Emotions	Cross-Cultural Wealth and Diversity	Cross-Cultural Competence General
Staff		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
Nurse / midwife / health officer	108	3,79±0,611	3,18±0,739	2,81±0,852	3,90±0,562	3,51±0,395
Practitioner / uzmandokt is	73	3,31±0,998	2,94±0,622	2,81±0,940	3,76±0,667	3,23±0,673
Other Health Worker	34	3,47±0,625	2,70±0,595	2,83±0,396	3,70±0,513	3,23±0,308
F=		8,745	7,284	0,009	2,119	8,484
p=		0,000	0,001	0,991	0,123	0,000
PostHoc=		1>2, 1>3 (p<0.05)	1>2, 1>3 (p<0.05)			1>2, 1>3 (p<0.05)
Working Year in Profession		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
1-3	93	3,66±0,629	3,07±0,691	3,05±0,634	3,92±0,529	3,47±0,372
4-6	21	3,74±0,812	2,61±0,832	2,57±0,634	3,65±0,777	3,26±0,531
7-10	16	3,40±0,830	3,31±0,704	2,79±1,067	3,85±0,508	3,38±0,615
11-15	21	3,44±0,908	3,35±0,629	1,98±0,703	3,61±0,701	3,23±0,531
16 and above	64	3,49±0,942	2,91±0,611	2,83±0,920	3,80±0,592	3,31±0,631
F=		1,026	4,352	8,831	1,727	1,772
p=		0,395	0,002	0,000	0,145	0,136
PostHoc=			1>2, 3>2, 4>2, 3>5, 4>5 (p<0.05)	1>2, 1>4, 2>4, 3>4, 5>4 (p<0.05)		
Place of birth		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
The Mediterranean Region	21	3,89±0,511	3,16±0,871	3,00±0,675	4,03±0,614	3,60±0,341
The Aegean Region	20	3,93±0,570	3,19±0,631	3,16±0,644	4,02±0,544	3,65±0,494
The Central Anatolia	36	3,57±0,856	2,89±0,573	2,98±0,898	3,76±0,570	3,35±0,574
The Southeastern Anatolia	9	3,80±0,688	3,02±0,628	2,85±0,377	3,86±0,220	3,47±0,314
The Eastern Anatolia	17	3,71±0,842	3,44±0,776	2,96±1,006	4,07±0,440	3,60±0,453
The Black Sea Region	45	3,60±0,760	2,95±0,738	2,68±0,701	3,77±0,683	3,33±0,407
The Mediterranean Region	67	3,30±0,843	2,94±0,657	2,61±0,906	3,70±0,596	3,19±0,561
F=		2,898	1,805	2,015	1,952	4,087
p=		0,010	0,100	0,065	0,074	0,001
PostHoc=		1>7, 2>7, 6>7 (p<0.05)				2>3, 1>6, 2>6, 1>7, 2>7, 5>7 (p<0.05)
Ethnicity		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
Turkish	191	3,56±0,792	3,04±0,699	2,83±0,845	3,82±0,608	3,37±0,521
Other	24	3,74±0,803	2,85±0,691	2,70±0,676	3,84±0,499	3,38±0,468
t=		-1,078	1,317	0,682	-0,148	-0,087
p=		0,282	0,189	0,423	0,882	0,930
Long lived region		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
The Mediterranean Region	21	3,89±0,511	3,16±0,871	3,00±0,675	4,03±0,614	3,60±0,341
The Aegean Region	14	4,14±0,470	3,24±0,521	3,45±0,464	4,08±0,362	3,80±0,328
The Central Anatolia	39	3,52±1,068	2,62±0,492	2,85±0,939	3,81±0,633	3,25±0,717
The Southeastern Anatolia	3	4,25±0,000	3,60±0,000	3,00±0,000	3,75±0,000	3,80±0,000
The Eastern Anatolia	16	3,91±0,789	3,21±0,859	3,104±0,727	4,12±0,438	3,65±0,426
The Black Sea Region	23	3,38±0,953	2,92±0,992	2,696±0,688	3,66±0,562	3,22±0,473
The Mediterranean Region	99	3,42±0,648	3,10±0,591	2,650±0,855	3,74±0,615	3,29±0,433
F=		3,677	3,610	2,799	2,260	5,110
p=		0,002	0,002	0,012	0,039	0,000
PostHoc=		2>3, 1>6, 2>6, 5>6, 1>7, 2>7, 5>7 (p<0.05)	1>3, 2>3, 4>3, 5>3, 7>3 (p<0.05)	2>3, 2>6, 2>7, 5>7 (p<0.05)	1>6, 2>6, 5>6, 1>7, 2>7, 5>7 (p<0.05)	1>3, 2>3, 5>3, 1>6, 2>6, 5>6, 1>7, 2>7, 5>7 (p<0.05)

Table 3. Comparison of Identifying Characteristics and Cross-Cultural Competence Scale Scores of Health Professionals (*Cont*.)

Identifying Characteristics	n	Cross-Cultural Motivation	Cross-Cultural Attitudes	Cross-Cultural Emotions	Cross-Cultural Wealth and Diversity	Cross-Cultural Competence General
Family Lived Region		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
The Mediterranean Region	19	3,93±0,521	3,13±0,914	2,89±0,619	4,09±0,619	3,61±0,359
The Aegean Region	16	4,04±0,579	3,18±0,554	3,29±0,749	4,06±0,413	3,72±0,467
The Central Anatolia	36	3,63±0,838	2,85±0,533	3,00±0,912	3,75±0,582	3,36±0,579
The Southeastern Anatolia	16	3,91±0,789	3,21±0,859	3,10±0,727	4,12±0,438	3,65±0,426
The Eastern Anatolia	31	3,48±0,845	2,91±0,853	2,78±0,753	3,82±0,578	3,30±0,442
The Black Sea Region	97	3,38±0,777	3,05±0,640	2,61±0,835	3,71±0,618	3,25±0,509
F=		3,938	1,151	3,097	2,971	4,814
p=		0,002	0,335	0,010	0,013	0,000
PostHoc=		1>5, 2>5, 1>6, 2>6, 4>6 (p<0.05)		2>5, 2>6, 3>6, 4>6 (p<0.05)	1>3, 4>3, 1>6, 2>6, 4>6 (p<0.05)	2>3, 4>3, 1>5, 2>5, 4>5, 1>6, 2>6, 4>6 (p<0.05)
Existence of the Migration History		Ort±SS	Ort±SS	Ort±SS	Ort±SS	Ort±SS
Yes	85	3,66±0,658	3,01±0,539	2,88±0,774	3,85±0,604	3,42±0,459
No	130	3,52±0,869	3,03±0,789	2,77±0,860	3,80±0,592	3,34±0,547
t=		1,241	-0,257	0,936	0,637	1,052
p=		0,190	0,781	0,350	0,525	0,294

p <0. 05

4. DISCUSSION, CONCLUSION AND SUGGESTIONS

As a result of the globalizing world, many people migrate willingly or unwillingly. As a result, nurses and healthcare providers were required to serve individuals, families or groups whose health beliefs, mother tongue, and life experiences were very different from their own. Culture plays an important role in health perception, health behavior, and all actions of individuals, nurses and other healthcare professionals. It is important to develop intercultural competence and sensitivity to understand individuals from different cultures. The intercultural competence is a process that starts with the individual's willingness to learn cultural issues, progresses with the inclusion of the importance of culture in all care, and provides the necessary adaptation to the services provided to meet culture-specific needs. Raising awareness and accepting cultural differences are considered as the first step in the process of becoming a culturally competent individual. Understanding differences begins with awareness, and healthcare professionals should always be prepared to accept differences and maintain this attitude.

When the total scores of health professionals received from the cross-cultural competence scale were analyzed, it was determined that the cross-cultural competence levels were at a medium level (3,377 ± 0,514), cross-cultural motivation was "average, cross-cultural attitude, intercultural attitude, cross-cultural wealth and diversity were good, cross-cultural empathy" was medium. The cross-cultural competence levels of health professionals were found to be similar and slightly higher than the research findings in the literature, and were determined to be in the desired competence (Aslan, Yılmaz, Kartal, Erdemir & Güleç, 2016; Kılıç and Sevinç, 2017; Meydanlıoğlu, Arıkan and Gözüm, 2015). The research findings could not be adequately discussed with the literature, as the study aimed at determining the cross-cultural competence status of health professionals was almost nonexistent. High intercultural competence scores indicate that they are prone to intercultural sensitive behaviors and attitudes towards patients /relatives from different cultures and their cultural differences (Bok, 2009; Downing, Kowal and Paradies, 2011). The number of studies on determining the intercultural competence levels of health professionals through the literature survey is very limited. There are studies conducted to determine the intercultural sensitivity levels of classroom teachers, nurses or nursing department students as different professional groups. It is thought that this research will contribute to the literature in this aspect.

The cross-cultural competence general scores of health professionals differ significantly according to the place of birth and gender. However, cross-cultural attitude, cross-cultural empathy, cross-cultural wealth and diversity scores do not differ significantly according to the birthplace variable. The overall scores of health professionals in cross-cultural motivation, cross-cultural attitude, cross-cultural empathy, cross-cultural wealth and diversity, cultural competence do not differ significantly according to ethnicity variable. In the studies of Yılmaz and Göçen (2013), it has been found that the cultural sensitivity levels of the elementary teacher candidates do not show a significant difference according to the gender and the one they live in (Yılmaz and Göçen 2013). Again, Bayles (2009), Üstün (2011) and Polat, Barka (2012) stated that gender has no effect on the level of intercultural sensitivity (Bayles, 2009; Polat and Barka, 2012; Üstün, 2011). Our study results are similar to the study results.

The total scores of the cross-cultural empathy sub-dimension and the cross-cultural competence scale of the health professionals participating in the study were higher than those aged 46 and over. It was found that the perceptions of married people between cross-cultural empathy and intercultural wealth and diversity were lower than that of singles. Single people have more cross-cultural competence. The average level of cross-cultural integration of those with an undergraduate education is higher than the cross-cultural integration average of those with an undergraduate degree (p <0.05). The cross-cultural attitude scores of healthcare professionals differ significantly according to the education level variable. The cross-cultural attitude of those with high school and associate degree is higher than those of undergraduate and graduate students, and the cross-cultural empathy scores are higher than the cross-cultural empathy average of those with a higher education degree. The average of the cross-cultural competence score of undergraduate graduates is higher than the average of cross-cultural competence score of graduate students. The cross-cultural motivation, cross-cultural attitude, cross-cultural competence, scores of health professionals are higher than the Practitioner / specialist doctor of the staff who are staff nurses / midwives / health officers. Nurses and midwives have more cross-cultural competence than doctors. The cross-cultural attitude, cross-cultural empathy, scores of 1-3 years are higher than those of the profession. Those who have just started the profession are more sensitive. The reason for this is the effectiveness of informing about this subject during undergraduate education. It is emphasized in the literature that these informations are important in undergraduate education (Betancourt and Green, 2010). Festini, Focardi, Bisogni, Mannini & Neri (2009); He stated that there should be a continuing process that gives education to nurses and nurse students in universities and professional working life in the fields of transcultural nursing, cultural difference and cultural competence (Festini et al, 2009).

The cross-cultural motivation, cross-cultural attitude, cross-cultural empathy, cross-cultural wealth and diversity, cross-cultural competence scores of health professionals differ significantly according to the region of the region where the family lives. It was determined that the difference originated from the Aegean region. It is thought that this may be due to the desire of this region's people to know and understand people with different cultural characteristics. In the study of Üstün (2011); cross-cultural sensitivity levels of pre-service teachers trained in the province were significantly higher than pre-service teachers trained in the village and district (Üstün, 2011).

In Yılmaz and Göçen (2013) studies; It has been stated that cross-cultural sensitivity levels of teacher candidates are not affected in terms of settlement (Yılmaz and Göçen, 2013). According to their studies on the problems faced by nurses who care for patients from different cultures, Wong, Murphy and Adelman (2009); 88.3% of the nurses stated that they learned the information about the cultural structures of the patients from their previous experiences and 75.7% of them stated that they learned from their friends. Results are similar to current study findings (Wong, Murphy and Adelman, 2009). In the literature; the most important way in which information about the cultural structures of patients is obtained; He stated that giving care to patients from different cultures in the health and disease process and experiencing this process individually (Plaza Del Pino, Soriano & Higginbottom, 2013).

When the total scores of health professionals from the intercultural competence scale were analyzed, it was determined that the intercultural competence levels were medium, intercultural harmony average was high, intercultural attitude, intercultural wealth and diversity were good, intercultural empathy was medium. It was determined that the intercultural competence levels of healthcare professionals were similar to the research findings in the literature and were slightly higher. It was determined that those

who do the nursing / midwifery profession among health professionals have more cultural competence than physicians and other healthcare professionals. It is thought that this study will be conducted with all healthcare professionals and the results will contribute to the literature and guide health administrators. In order to define the basic differences between the two cultures and the results that can be obtained depending on these differences, it is necessary to take intercultural training on cognitive, emotional and behavioral levels. Thus, individuals who have acquired intercultural competence will be able to gain an objective perspective on different cultures. This perspective not only facilitates its compliance with people from different cultures for healthcare professionals working in healthcare institutions operating in the international field, but also ensures the effective use of knowledge and experience gained in different cultures in business decisions. As a health management strategy, making some changes in order to provide adequate cultural communication and care in healthcare institutions is a necessity in terms of quality of service and meeting the rights of caregivers. Therefore, cultural competence should be the core value of the institution as a health management strategy. In order to meet this qualification in line with the results of the study; Implementing programs to improve the cultural competence of staff in health institutions,

❖ To carry out projects and to closely monitor all developments in order for health professionals to recognize different cultures,

❖ To allocate resources for translation services in health institutions in the development of culturally adequate care and communication,

❖ Considering cultural diversity as a constant variable in evaluating the care services for cultural differences in health institutions in a valid, reliable and correct manner,

❖ Cultural competence of health personnel, training of health personnel for cultural competence, taking into account the experience of giving care to individuals from different cultures, meeting the criteria,

❖ It is recommended to review clinical services in terms of cultural competence, to identify cultural barriers and necessary changes

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