Nurse Media Journal of Nursing, 8(2), 2018, 58-70
Available Online at http://ejournal.undip.ac.id/index.php/medianers

Behavior, Awareness, and Sensitivity of Healthcare Providers in a Multicultural Environment

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ABSTRACT

Background: The healthcare workforce of Saudi Arabia is characterized by diverse cultural backgrounds as a consequence of the employment of expatriate workers from various countries. The heterogeneity of both providers of health services and clients results in cultural barriers that affect the delivery care. It is paramount to evaluate the cultural competence of healthcare providers (HCPs) to maintain quality holistic care.
Purpose: This study aimed to assess the cultural diversity experience, cultural competence behavior (CCB) and cultural awareness and sensitivity (CAS) of HCPs in a hospital setting of Saudi Arabia.
Methods: This was a cross-sectional study involving a survey of 104 HCPs from medical, nursing and laboratory technology disciplines that were taken based on a total sampling procedure. Data collection was conducted using the Cultural Competence Assessment (CCA) tool that measured cultural diversity experience, CCB, and CAS. Data analysis was performed and presented in descriptive statistics, and significant findings were computed using independent samples t-test, analysis of variance (ANOVA), and Pearson correlation coefficient.
Results: The characteristics of the respondents resulted in mean age of 38.7±10.4 who were predominantly Asians and nurses. The majority had working experience of 10 years and below, with more than half who had prior diversity training. Reported cultural diversity experience included all HCPs caring for Arab Middle Easterners and Asians and encountering at least one or more special population groups. There was an overall high cultural competence (5.28±0.46), high CCB (5.84±0.56) but only moderately high CAS (4.72±0.35). Significant differences were only identified between CCB scores and three demographic variables (racial/ethnic identification, the area of discipline and years of experience). No significant result was found between CAS scores and demographic variables as well as between CCB and CAS scores.
Conclusion: Despite high CCB, the HCPs responded with lower CAS scores. Interventions should be initiated to increase CAS such as cultural diversity training and availability of cultural care resources.

Keywords: Cultural competence; cultural awareness and sensitivity; cultural competence behavior; healthcare providers; Saudi Arabia

BACKGROUND

Culture and health are two essential dimensions of a person's well-being. Culture, which is often reflected in a population's behavior, attitudes, practices, and ideologies, is described by Schein (2010) as stable and rigid that has resulted from the social order formed from the perception, feelings, and actions of society through various socialization experiences. Culture, according to Davey (2018), is "a framework of behavioral patterns, values, assumptions, and experiences shared by a social group" (p. 1). Whereas, health is defined by Bircher (2005) as "a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility" (p. 336). The connection between culture and health had been immensely recognized especially in culture-centered approaches to health communication and health care delivery.

In a more complex scenario, health care is delivered in a multicultural setting with carers from diverse cultural backgrounds. Expanding globalization and movement of people whether because of education, pleasure, health reasons or job opportunities had consequently exposed healthcare workers to culturally different patients or vice versa. A closer look at the Kingdom of Saudi Arabia, for example, depicts a multicultural pool of people in almost all sectors. From Saudi Arabia's 31.5 million inhabitants in 2015, one-third of them were foreign workers (Ministry of Health [MOH], 2015). There are around 85.6% of the expatriates who came from the countries of India, Pakistan, Bangladesh, Egypt, Philippines, Yemen, Indonesia, and Sudan. A few numbers of these expatriates originated from other South Asian, Middle-East Asian and African countries as well as from the United States and Europe (Saudi Gazette, 2014). When it comes to healthcare, 60% of the country's health services are provided by the Ministry of Health through 274 hospitals and 2282 primary health care (PHC) centers. Pharmacists (79%), physicians (74%), and nurses (61.7%) comprise the large percentage of expatriates in hospitals and health centers with Saudi Arabian occupying more allied health positions (74.3%) (MOH, 2015).

The current composition of the health workforce is a challenge in delivering quality health care services to culturally diverse consumers. More than managing the illness itself, restoration of health in all its aspects is a preferable way of treating a patient as health transcends from curability to wellness. Usually, medical care aims for the promotion of health, prevention of disease, palliation, and treatment but cultural care is trained to provide a culturally sensitive, culturally appropriate and culturally competent approach to holistic care (Hanson & Callahan, 1999). Achieving such a goal corresponds to the profound understanding of the patient's culture. In as much as cultural diversity is dealt with by "knowing the values, beliefs, practices, customs, racial classification and national origin" it also addresses a person's "religious affiliation, language, physical size, gender, sexual orientation, age, disability (both physical and mental), political orientation, socioeconomic status, occupational status, and geographical location" (Campinha-Bacote, 2003, p. 1). Moreover, health is also affected by cultural phenomena as identified by Giger and Davidhizar (2008) such as environmental control (traditional health practices, folk medicines, healers), biological variations (body structure, skin color, genetic variations), social organization (family-type, religious/ethnic group), communication, space and time orientation. HCPs and patients' cultural conflicts are

believed to arise from these cultural phenomena that are apparent in most multicultural health settings (Spector, 2017).

Studies had been continuously pursued to find solutions to current issues surrounding the diversified health care environment. Certain situations tend to interpose with discernment of cultural differences. Thinking that own beliefs and practices are the right ways, ethnocentrism exhibits influence on one's behavior to render care (Riley, 2017). Each health professional has individual and personal view as he was raised in his culture that may affect his judgments and create biases on his decisions when it comes to the patient's care, the same as the patient has unique understanding on his illness, its cause, treatment and expectations from the healthcare services (Klein, 2004). In another point, a lesser quality of care, poor comprehension, and unsatisfied patients may result from difficulty in language and communication between the healthcare provider and patient (Georgetown University, 2004). Aldossary, While and Barriball (2008) believed that impedance to the delivery of holistic care includes difficult health education due to the absence of a shared culture and language. Communication patterns also vary to a great extent from one culture to another in respect to personal space, touch, eye contact and methods of greetings (Riley, 2004). Religion is also a significant determinant of one's behavior and beliefs where problems surface from lifestyle, the manner of dressing, modesty values, prayer practices, food choices and use of medications (Harvey & Allard, 2015; The Royal Australian College of General Practitioner, 2011). Other cultural barriers to effective delivery of care are gender concern and familial structure. Different cultures present gender differences in role activities and expectations from essential aspects such as decision-making, family roles and employment opportunities (Bird & Rieker, 2008).

Health in the midst of all of these different cultural concerns brings about challenge to all healthcare professionals' capabilities to heal beyond the physical boundaries of medicine. Saudi Arabia which is dominated by Muslims (96%) is strictly governed by the teachings of Islam (D'Avanzo, 2008). Dilemmas occur as interactions between HCPs and patients transpire in a different ethical perspective brought by their differences in culture and practice of faith. There were studies reviewed related to cultural competence in Saudi Arabia. However, to the best of knowledge of the researchers, there were limited local studies that focused on cultural diversity experience and specific aspects of cultural competence of HCPs. Thus, this study intended to reduce this knowledge gap through appraisal of HCPs working in Saudi Arabia, who came from different nations and races, with different religious affiliations and beliefs, and with distinct cultures and languages, in catering to the medical needs of a heterogeneous population.

PURPOSE

This study aimed to assess the cultural diversity experience, cultural competence behavior (CCB) and cultural awareness and sensitivity (CCA) of health care providers in a government hospital setting.

METHODS

Research design

This study was tailored in a descriptive research design through a cross-sectional study.

Samples and setting

Participants were recruited from a government hospital situated in Riyadh Province of Saudi Arabia. These were comprised of and limited to HCPs who were frequently in contact with patients such as doctors, nurses and laboratory technologists. The total sampling procedure was applied including all willing and available HCPs without any restrictions to age, gender, nationality/ethnicity/race, and religion. HCPs who belonged to the professions mentioned above but with decreased to no contact with patients were excluded from the study (e.g., assigned to administrative positions and hospital support units such as a dispensary, medical records, supply office, and others). Of the 121 eligible respondents, there were a total of 104 HCPs who participated in this study with 24 doctors, 76 nurses and four laboratory technologists. Others were either unable to complete the survey or did not participate due to lack of time and conflict of schedules (e.g., vacation, night shift).

Research instrument and data collection

The primary approach for data gathering was the survey method. The Cultural Competence Assessment (CCA) tool (Doorenbos, Schim, Benkert, & Borse, 2005) was utilized to collect data from the participants. To answer the objectives of the study, the three original cultural competence dimensions (cultural diversity experience, CCB, and CAS) were included in the latest version. The cultural diversity experience was assessed by the number of racial/ethnic groups and special populations that the respondents had cared for the last 12 months. The CCB subscale is measured using a 7-point Likert scale described as always, often, somewhat often, often, sometimes, few times and never. Meanwhile, the CAS subscale was also responded through a 7-point Likert scale described as strongly agree, agree, somewhat agree, neutral, somewhat disagree and strongly disagree. Both scales were described with the following equivalent ratings of cultural competence: very high, high, moderately high, moderate, moderately low, low and very low. The demographic characteristics of the HCPs consisted of information about their age, racial/ethnic identification, the area of discipline, years of experience and training on cultural diversity.

Data collection was initiated through the personal distribution of the questionnaires with clear instructions to the participants in each unit of the hospital. Recollection of the questionnaires was carried out after they completed answering which took around 20 to 30 minutes.

Data analysis

Microsoft Excel 2010 and IBM Statistical Package for Social Sciences (IBM SPSS) v.20 were utilized for data analysis. Frequencies and percentages computed most demographic characteristics and items on cultural diversity scales. Age, CCB and CAS were presented in means and standard deviations (*SD*). Independent samples t-test and analysis of variance (ANOVA) were applied to determine significant differences, and the Pearson correlation coefficient was performed to measure associations.

Ethical consideration

The ethical review and approval were sought from the hospital administration. A letter addressed to the participants was attached to inform the purpose of the study and ensure

the anonymity and confidentiality of their identity and responses. Both implied and verbal consent were elicited from them with clear information about their right to participate voluntarily, withdraw or decline and with emphasis that their completion of the survey indicated their informed consent to participate. The utilization of the questionnaire was obtained for permission and approval from the original authors via email. All necessary ethical practices were undertaken in the completion of this study.

RESULTS

Demographic characteristics

Characteristics of the HCPs were detailed in Table 1. The mean age of 38.7 years (*SD*±10.4) was found among the participants. More than two-thirds (73.1%) identified themselves as Asian consisting of Filipinos, Indians, and Indonesians. Middle Easterners such as Saudi Arabians, Egyptians, and Syrians comprised 21.2% of the samples. There were very few Black Africans (4.8%) and only one percent of the HCPs were of European origin. Nurses represented the largest number of participants with 73.1% followed by 23.1% doctors and 3.8% laboratory technologists. Regarding experience, the majority (67.3%) was working for ten years and less while 32.7% was in service for more than ten years. Attendance to cultural diversity training was expressed by over half of the respondents (55.8%) with others without prior training (44.2%).

Table 1. Demographic characteristics of the healthcare providers (n=104)

Demographic Characteristics	*n* (%)
Age (in years), mean (*SD*)	38.7 (10.4)
Racial/Ethnic Identification	
Asian	76 (73.1)
Middle Eastern	22 (21.2)
European	1 (1)
Black African	5 (4.8)
Area of Discipline	
Medicine	24 (23.1)
Nursing	76 (73.1)
Laboratory	4 (3.8)
Years of Experience	
10 years and less	70 (67.3)
>10 years	34 (32.7)
Training on Cultural Diversity	
No	46 (44.2)
Yes	58 (55.8)

Cultural diversity experience

The cultural diversity experience of the HCPs as summarized in Table 2 indicated that all of them had at least came across people from different racial or ethnic groups for the last 12 months. All participants (100%) reported having cared for Arab Middle Easterners and Asians (e.g., Asian Indian, Filipino, Pakistani, Nepalese and other Asians). Nearly three-quarters (71.6%) managed care for Africans and very few numbers (3.8%) with White Europeans/Americans. Similarly, the entire samples had contact with special population

groups for the past 12 months. This had varied from people who were physically challenged/disabled (76.9%), mentally or emotionally ill (38.5%) and with the different religious/spiritual background (42.3%).

Table 2. Cultural diversity experience

Variable	*n* (%)
Racial/ethnic groups of people encountered in the past 12 months	
Arab Middle Easterner	104 (100)
Asian	104 (100)
African/Black	74 (71.6)
White European/American	4 (3.8)
Special population groups encountered in the past 12 months	
Physically Challenged/Disabled	80 (76.9)
Mentally/emotionally ill	40 (38.5)
Different religious/spiritual background	44 (42.3)

Cultural competence behavior

The findings on the cultural competence behavior translated an overall high competence of the HCPs with a mean of 5.84 (*SD*±0.56). They specifically displayed very high practice on *acting to remove obstacles for people of different cultures when clients and families identify such obstacles and welcoming feedback from co-workers on how to relate to others with different cultures* with the highest means of 6.69 (*SD*±1.05) and 6.23 (*SD*±1.00), respectively. Lowest means were computed from responses on *having resource books and other materials available to help learn about clients and families from different cultures* (*M*=5.38, *SD*±1.01) and *use a variety of sources to learn about the cultural heritage of other people* (*M*=5.38, *SD*±1.01). In most items, culturally related behaviors were practiced very often demonstrating high competence as delineated in Table 3.

Table 3. Cultural competence behavior

	Indicators	Mean	*SD*
1.	I include cultural assessment when I do client or family evaluations.	5.92	1.09
2.	I seek information on cultural needs when I identify new clients and families in my practice.	5.90	1.10
3.	I have resource books and other materials available to help me learn about clients and families from different cultures.	5.31	1.09
4.	I use a variety of sources to learn about the cultural heritage of other people.	5.38	1.01
5.	I ask clients and families to tell me about their own explanations of health and illness.	6.02	1.03
6.	I ask clients and families to tell me about their expectations for care.	5.77	0.92
7.	I avoid using generalizations to stereotype groups of people.	5.88	0.96

	Indicators	Mean	*SD*
8.	I recognize potential barriers to service that might be encountered by different people.	6.04	0.86
9.	I act to remove obstacles for people of different cultures when I identify such obstacles.	5.94	0.93
10.	I act to remove obstacles for people of different cultures when clients and families identify such obstacles to me.	6.69	1.05
11.	I welcome feedback from clients about how I relate to others with different cultures.	6.12	0.94
12.	I welcome feedback from co-workers about how I relate to others with different cultures.	6.23	1.00
13.	I find ways to adapt my services to client and family cultural preferences.	6.13	0.81
14.	I document cultural assessments.	5.52	1.12
15.	I document the adaptations I make with clients and families.	5.50	1.07
16.	I learn from my co-workers about people with different cultural heritages.	6.12	0.85
	Overall CCB	5.84	0.56

Cultural awareness and sensitivity

Further results (Table 4) described the HCPs with a moderately high level of cultural awareness and sensitivity with a mean of 4.72 (*SD*±0.35). The highest score was drawn from the respondents' *enjoyment of working with people who are culturally different from them* with a mean of 6.10 (±0.93). Although the majority of the items showed a high level in the CAS subscale, the respondents displayed the lowest level of cultural awareness and sensitivity in two statements. They believed that *race is the most important factor in determining a person's culture* (*M*=2.46; *SD*±1.17) and that *people with a common cultural background think and act alike* (*M*=2.58; *SD*±0.84). Finally, no significant relationship was derived between the means of CCB and CAS subscales with *r*=0.19, *p*=.053.

Table 4. Cultural awareness and sensitivity

	Indicators	Mean	*SD*
1.	The race is the most important factor in determining a person's culture.*	2.46	1.17
2.	People with a common cultural background think and act alike.*	2.58	0.84
3.	Many aspects of culture influence health and healthcare.	5.98	0.98
4.	Aspects of cultural diversity need to be assessed for each individual, group, and organization.	5.87	0.92
5.	If I know about a person's culture, I do not need to assess their personal preferences for health services.*	3.17	1.06
6.	Spirituality and religious beliefs are important aspects of many cultural groups.	6.06	1.07
7.	Individuals may identify with more than one cultural group.	5.52	0.98
8.	Language barriers are the only difficulties for recent expatriates to Saudi Arabia.*	2.29	0.97

	Indicators	Mean	*SD*
9.	I understand that people from different cultures may define the concept of ‘‘healthcare’’ in different ways.	5.92	0.92
10.	I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.	6.00	0.92
11.	I enjoy working with people who are culturally different from me.	6.10	0.93
	Overall CAS	4.72	0.35

*Reversely-coded items

Differences and relationship between cultural competence variables and characteristics of HCPs

The comparison of mean scores of the samples' CCB and CAS according to their characteristics generated varied findings (Table 5). Significant differences were computed when CCB scores were compared among and between racial/ethnic identification ($p<.05$), the area of discipline ($p<.01$) and years of experience ($p<.001$) variables. Asian participants responded with the highest mean score (M=5.93, SD±0.55) in CCB than HCPs from other racial/ethnic groups. Nurses scored higher in CCB (M=5.94, SD±0.52) than HCPs from laboratory and medicine. Meanwhile, more experienced HCPs (M=6.11, SD±0.42) behaved more culturally competent than those with lesser years of experience. On the other hand, no significant result was generated between demographic variables and CAS subscale.

Table 5. Cultural competence mean scores across characteristics of healthcare providers

Characteristics	CCB		CAS	
	Mean (*SD*)	*p*	Mean (*SD*)	*p*
Age (*r*, *p)*	0.028	*0.18*	0.779	*0.067*
Racial/Ethnic Identification[a]				
Asian	5.93 (0.55)		4.76 (0.34)	
Middle Eastern	5.68 (0.57)	*0.007*	4.56 (0.35)	*0.053*
Black African	5.23 (0.31)		4.80 (0.19)	
Area of Discipline				
Medicine	5.52 (0.64)		4.72 (0.35)	
Nursing	5.94 (0.52)	*0.005*	4.74 (0.34)	*0.055*
Laboratory	5.91 (0.11)		4.32 (0.16)	
Years of Experience				
10 years and less	5.71 (0.58)	*0.000*	4.71 (0.41)	*0.676*
>10 years	6.11 (0.42)		4.74 (0.17)	
Training on Cultural Diversity				
No	5.79 (0.47)	*0.383*	4.75 (0.37)	*0.449*
Yes	5.89 (0.63)		4.70 (0.33)	

a. One ethnic group (White European/American) was excluded in the computation because of only one participant.

DISCUSSION

Cultural components of health delivery support the holistic approach to patient care. With this study, outcome found diversified HCPs who deliver care to an equally heterogeneous

group of patients. High CCB level was observed with the participants, but CAS was identified at a moderately high level. Nonetheless, this resulted in an overall high cultural competence. Racial/ethnic identification, area of practiced discipline and length of experience were significant factors on CCB whereas, CAS was uninfluenced by any demographic characteristics.

Culture in Saudi Arabia is dominated by Islamic practices where The Two Holy Mosques are located (Saudi Arabian Cultural Mission [SACM], 2017). However, more than 30% of the population are expatriates from Philippines, India, Pakistan, other Asian countries and some from US, UK, EU, and Canada (MOH, 2015), who have different religious beliefs and cultural practices. This was reflected in the findings of the study that the largest groups of HCPs identified themselves from the Asian region and who were predominantly Christians and Muslims. The composition of the HCPs in this study was consistent with the previously discussed report that physicians and nurses were among the most numbered foreign professionals in the health sector of the country (MOH, 2015).

There was an evident diversity in the types of patients the HCPs had encountered in this study. Hence, there was a considerable experience with cultural diversity as attested by caring for people from at least one or more different races and delivering health services to special groups who were either sick physically, mentally or emotionally as well as patients with varying religiosity. Such multiculturalism within the clinical workplace had existed both locally (Almutairi, McCarthy, & Gardner, 2015) and in many parts of the world like in Africa, Canada, Mexico, and United States which are recognized with diverse cultures (Almutairi, Adlan, & Nasim, 2017; Morin, 2013).

The present study had substantiated high competence level through the assessment of CCB among the healthcare workers with a mean of 5.84 (*SD*±0.56). This finding was congruent with the results of a study conducted in the US using similar CCA tool (Schim, Doorenbos, & Borse, 2006). Another interesting finding is that the level of CAS was evaluated moderately high with a mean of 4.72 (*SD*±0.35). This mean value was lower than the participants' CCB level. The difference had obtained a significant relationship between the two subscales. Although a comparable result was established in one study (Dabney et al., 2015), the pattern was dissimilar in mostly reviewed cultural studies. There was lower cultural competence in the behavioral domain as investigated in Italy, Canada, Taiwan, Ethiopia and US (Aragaw, Yigzaw, Tetemke, & G/Amlak, 2015; Colini et al., 2015; Debiasi & Selleck, 2017; Lin, Mastel-Smith, Alfred, & Lin, 2015; Starr & Wallace, 2009). This outcome implies that in this current set of health workers, they maintained and conducted actions that were culturally positive when caring for their patients despite decreased CAS. This further highlights the necessity of providing for the training needs of the HCPs to enhance their CAS, whom nearly half of them admitted having not attended any cultural diversity training.

Another key finding in the CCB subscales is that respondents highly acted to remove obstacles identified by the clients and families and welcomed feedbacks from clients, but they are least likely to have reading resources about other's culture. These were identical findings in the previous study of Schim et al. (2006) and a recent study of Debiasi et al. (2017). This translates a desirable characteristic of healthcare workers to maintain the

standard of care by responding to the needs of their patients regardless of cultural difficulties. Moreover, accessibility and availability of materials and resources related to cultural care are paramount in all healthcare facility setting. Meanwhile, in the CAS subscale, the race was connected to essentially predetermine one's culture which had contributed to the low CAS score. This issue occurs when one categorizes a group of people in one culture because they share similar physical traits or biological features. Delivery of health care services should not be attributed based on race alone. Many people nowadays had multiracial and multicultural background brought about by migration and interracial marriages. Therefore, care should be communicated with intercultural competence which is not only effective but also appropriate (Messner & Schäfer, 2012).

Lastly, the researchers identified demographic factors that are essential determinants of CCB scores. In this research work, racial differences had significantly played an influence on CCB. However, the opposite result was reported in the study of Schim et al. (2006). Race/ethnicity was only significant when computed with cultural competence entirely (Almutairi et al., 2017; Lampley, Little, Beck-Little, & Xu, 2008). Thus, further studies are required to achieve generalization which is specific to CCB. Meanwhile, experience had also impacted the CCB in this study. The publication of Cicolini et al. (2015) likewise found an association between length of experience and CCB resulting to more experienced nurses displaying a more favorable behavior culturally. Another study supported the profession of the HCPs as a significant factor, but the result identified physicians as more culturally skillful than nurses (Casillas et al., 2014). Both CCB and CAS mean scores were not significantly associated with age and cultural diversity training variables. In disagreement, results of other works established the relationship of age, and cultural competence that identified older-aged HCPs tend to demonstrate higher competence skills culturally (Almutairi et al., 2017; Bunjitpimol, Kumar, & Somrongthong, 2018). On the other hand, prior cultural diversity training created an effect on CCB scores only (Schim et al., 2006) and both CCB and CAS scores (Starr & Wallace, 2009).

There are certain limitations that necessitate acknowledgment in this study. Some factors can probably restrict the generalizability of the results. First, the setting of the study was conducted in a single hospital facility. Second, the demographic characteristics of the samples included mostly Asians, women, and nurses. Third, the cultural diversity experience was limited to encounter with mostly Middle Easterners and Asians with least to no exposure to other racial/ethnic groups such as White Caucasians/ Europeans/ Americans or Hispanics/ Latinos. Hence, future research works may broaden the setting to collect data from a more diverse group of HCPs.

CONCLUSION

The HCPs were considered highly culturally competent especially in the behavioral aspect. However, crucial interventions should be performed to improve their awareness and sensitivity while working with diverse patients. Hospital management should carefully look into designing and planning effective diversity and culturally care-centered programs for training their health care workers. Availability and accessibility of accurate and updated sources of information related to cultural care are also essential to continuously deliver overall quality healthcare services.

ACKNOWLEDGMENT
The authors extend their gratitude to Dr. Ardith Doorenbos and her co-authors for permission to use the CCA tool and to Ms. Imelda Manding for assistance in data collection.

DECLARATION OF INTEREST
None

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