Review Scientific Paper/Pregledni naučni rad UDC/UDK: 005.5:316.77]:614.2
Paper Submitted/Rad primljen: 19. 10. 2021.
Paper Accepted/Rad prihvaćen: 23. 12. 2022.
DOI: 10.5937/SJEM2201022K

Upravljanje procesima implementacije kulturne kompetentnosti u zdravstveni sistem

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Apstrakt: Kultura ima značajan uticaj na oblikovanje stavova ljudi o zdravlju, blagostanju i percepciju zdravstvene zaštite. Zdravstvena kulturna kompetentnost je sposobnost da se efikasno funkcioniše kao pojedinac ili organizacija u kontekstu kulturnih verovanja , praksi i potreba pacijenata i zajednica . Kulturna i lingvistička kompetentnost predstavljaju skup ponašanja , stavova i politika koji omogućavaju efikasan rad u interkulturalnim sredinama . Kulturološki različiti pacijenti imaju slabiji pristup zdravstvenim uslugama i suočavaju se sa različitim preprekama. Kulturna kompetentnost zdravstvenih radnika uključuje svest, znanja i kulturne veštine za smanjivanje ovih prepreka. U radu prikazujemo tri modela razvoja kulturno kompetentne zdravstvene zaštite, Campinha-Bacote, Milton Bennett i Darla Deardorff. Modeli se unapređuju u skladu sa novim istraživanjima i saznanjima. Predlaže se da menadžment zdravstvenih ustanova razmotri aspekte kulturne samosvesti, veštine interkulturalne komunikacije i analizu sociokulturnih barijera u zdravstvenoj zaštiti. Obrazovanje i obuka zdravstvenih radnika ka postizanju ravnoteže između interkulturalnog znanja i komunikacijskih veština je najbolji pristup u razvoju kulturnih kompetencija.

Ključne reči: Kulturna kompetentnost, zdravstveni radnici, obrazovanje, globalizacija

Managing the Implementation Processes of Cultural Competency into a Healthcare System

Abstract: Culture has a significant impact on shaping people's attitudes about health, well-being and their perception of health care. Health cultural competence is the ability to function effectively as an individual or organization in the context of the cultural beliefs, practices and needs of patients and communities. Cultural and linguistic competences are a set of behaviours', attitudes and policies that enable effective work in intercultural environments. Culturally diverse patients have poorer access to health services and face different barriers. The cultural competence of health professionals includes awareness, knowledge and cultural skills to reduce these barriers. The paper presents three models of the development of culturally competent health care, Campinha-Bacote, Milton Bennett and Darla Deardorff. Models are being improved in line with new research and knowledge. It is proposed that the management of health institutions consider aspects of cultural self-awareness, intercultural communication skills and analysis of socio-cultural barriers in health care. Education and training of health professionals towards achieving a balance between intercultural knowledge and communication skills is the best approach in the development of cultural competencies.

Keywords: Cultural competency, healthcare workers, education, globalisation

1. Introduction

Culture is a group tool in navigating within the environment. It enables people to create a special world around them, control their own destiny and develop. Sharing the heritage of different cultures promotes our social, economic, technological and human development (Ronra Shimray, 2020). Cultural sensitivity indicates that culture and behavior are relative and that we need to be more careful and less

absolute in interpersonal interactions (Shiraly et al., 2021). Due to globalization, cultures in transition from traditional to western are expected to have poorer health indicators. Faced with unknown environmental, social, economic and physical resources to maintain and improve health, traditional communities are at significantly higher risk of chronic diseases. Local health institutions are not ready to respond to these challenges in a culturally appropriate way (Ratna, 2019).

International literature recognizes the importance of cultural factors on people's attitudes about well-being, holistic health and their understanding of health care. There are pronounced disparities in the perception of health status people living in different cultural and socio-demographic environments (Handtke et al., 2019). Culturally diverse patients as well as those from different language areas have less access to health services than the local population and face different barriers (Stubbe, 2020). It has been proven in the available research about people living in cultural minorities, especially those with language barriers, that they get worse health care compared to ordinary people, experience more accidents and adverse events of treatment during visits to health institutions (Al Shamsi et al., 2020). The authors highlight the same the problem when it comes to all languages, not just English, especially when it comes to health care of immigrants, refugees and ethnic minorities (Szaflarski et al., 2019).

Cultural and linguistic competence in the provision of health care are two inseparable entities and represent a set of behaviors, attitudes and policies within the system and employees and enable effective work in intercultural circumstances (Gulati et al., 2022). Cultural competence is not determined only by the knowledge acquired during education and training, although the importance of this form of knowledge acquisition cannot be disputed, but it represents a constant commitment and awareness of cultural factors that influence attitudes about health and disease (Abubakar et al., 2018). Knowledge from this field helps healthcare workers to understand how the patient perceives his illness and how he feels, perceives and reacts to the disruption of his health. It should be emphasized the importance of knowing the most diverse practices of traditional medicine, which are often practiced among different ethnic groups and which should be understood because they are important for the patient who seeks health care (Abubakar et al., 2018). The essential importance of health workers' own beliefs, attitudes and values towards health, ethnic heritage and own cultural heritage is essential (Abubakar et al., 2018).

The essence of understanding cultural competence is not the acquisition of knowledge about different ethnic groups, but rather the developed awareness of the health worker, his skill and attitude that he should approach the patient in such a way as to overcome all ethnic barriers. With this approach, the patient's perception of the cultural competence of the health care provider is improved, his desirable health behavior is improved, and thus the treatment outcome is better, as well as the reduction of disparities. An important strategy for improving care for racial and ethnic minorities is empowering them to actively participate and communicate actively during health visits (Williams et al., 2019).

In the study of Govere et al (2016), training on cultural competencies had a positive effect on the cultural competence of health professionals and was significantly associated with increased patient satisfaction. Patient-centered communication is an important segment during examination and treatment, as it is necessary to harmonize all aspects in the context of different norms and values perceived by the healthcare professional and the patient (Handtke et al., 2019). Intercultural and patient-centered communication are not formally integrated into medical education, although their function is to improve the quality of health care, and both of these skills show similarities (Handtke et al., 2019).

The world is becoming increasingly diverse. Diversity affects all areas of functioning and work, and it is necessary to adequately respond to all the challenges that diversity brings. Diversity and globalization have not spared the health system either and affect its efficient functioning.

2. Models of intercultural competence development

Culture refers to integrated patterns of human behavior that include language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. Cultural and linguistic competencies are a set of matching behaviors, knowledge, attitudes, and policies that are embedded in a system, organization, or among professionals and enable effective work in intercultural environments. Healthcare competence is the ability to function effectively as an individual or organization in the context of the cultural beliefs, practices and needs of patients and their communities. The goal of

intercultural competence in health care is to acquire specific knowledge and skills that enhance its ability to provide quality service (Chauhan et al., 2020).

We single out three earlier models of development of culturally competent health care.

3.1. Campinha-Bacote's model

The Campinha-Bacote's (2002) model of culturally competent health care was developed specifically for this sector. In this model, cultural competence consists of cultural awareness, cultural knowledge, cultural skills and cultural encounters. This combination offers culturally responsible assessments that will in turn provide culturally relevant interventions. The health care workers constantly achieve the ability to work effectively in the cultural context of an individual or community of different cultural/ethnic backgrounds. Cultural awareness requires recognition and sensitivity of the patient's perspective, especially when patients from different cultures are from the culture of service providers. Exploring one's own beliefs, in order to fully understand how it can have an impact on the relationship with patients from different ethnic and linguistic minorities, is necessary to further develop awareness of the importance of cultural awareness (Campinha-Bacote, 2002).

Campinha-Bacote (2001) states two basic approaches in the work of health workers, namely the culturally sensitive and culturally responsible attitude. The first approach refers to the sensitization of the individual in accordance with the perceived beliefs, lifestyles and sensitive style of work, while the second includes the application of all factors that influence a responsible attitude providing a mutually acceptable relationship towards the patient, including diagnosis, treatment and his monitoring.

Employees in health care institutions, during their work, encounter different attitudes and beliefs about illness and the concept of health, depending on different cultural affiliations, and this is called cultural knowledge. It can be acquired through individual engagement, professional activities, by attending expert meetings, congresses and conferences and during conversations with people which belong to different ethnic and linguistic minorities. Each patient is an individual and has their own experiences, perceptions and beliefs. Accordingly, healthcare workers should be able to obtain the necessary information during history taking from patients with attitude full of respect and consideration for sensitive issues. These skills prevent cultural knowledge stereotype. The purpose of cultural meetings is to involve health professionals directly in intercultural area. Cultural meetings allow employees in the health system to check their attitudes about the differences that exist in different cultures and avoid stereotypical behaviors.

3.2. Milton Bennett's developmental model

Milton Bennett's (1993) developmental model of intercultural sensitivity consists of six stages and is applicable in a complex health care system. The stages of this model lead through the entire psychological flow of understanding the area of intercultural sensitivity. The model starts from ethnocentrism in which there is denial, defense and minimization of problems. With the acquisition of new knowledge and education, the healthcare worker develops and moves into the field of ethnorelativism when he accepts diversity, adapts in accordance with new knowledge and integrates into a new approach to intercultural competence.

During the period of denial, the employee is unaware that there are any cultural differences between him and the patients at all. The health care professional assumes that the patient shares a belief system about the illness with him and therefore does not notice any signs that the patients view of well-being, illness, and treatment modalities are different. We meet this attitude more often among healthcare workers who do not often meet patients belonging to different cultural groups. After the denial, a period of defense develops, when the healthcare worker begins to recognize the differences, but due to the risk that these new findings will threaten his perceived and established reality, he moves to defend himself from this level of awareness.

The next period the healthcare worker goes through is minimization. Then the employee already starts to admit that there are cultural differences between him and the patient, but minimizes it. At this stage, he understands that there are still more similarities between people than differences. What can lead to poor intercultural communication in this period is the assumption of similarity that is not supported by real differences between the health worker and the patient. This can lead to poor patient cooperation,

because what the doctor suggests, for example, the patient may never accept, especially when it comes to treatment modalities. After that comes the phase of acceptance of differences. The employee starts to recognizes and respects the existence of cultural differences between himself and his patients. At this stage, the healthcare worker has an ambivalent attitude, so he recognizes that there are differences, but he does not evaluate them as either positive or negative. Then switches to ethnorelativism, starting to respect intercultural differences and their values.

The next phase is the period of adaptation, while the healthcare worker develops communication skills for better interaction with members of other cultures. There is a perspective adaptation and the ability to see the world through different eyes. The sixth stage, the last one, is integration, when employees appreciate cultural differences, values and different behaviors and improve their identity. They manage to overcome the limitations of the intercultural context and are able to integrate their own cultural perspective with other cultures they encounter during their professional work.

3.3. Darla Deardorff's model

The Darla Deardorff's (2006) model is a process model of intercultural competence. The main topic that arises when analyzing the intercultural competence of healthcare workers is their ability to understand the perceived perspective of the patient. Deardorff created the model based on the contributions of leading experts in intercultural communication, and the only element of intercultural competence understands right on perceived perspective of the patient. Deardorff (2006) presented the model consists of four categories, with skills and behaviors spanning the domain of intercultural competence. Those categories are attitudes, knowledge, skills and outcome. "Attitudes include respect, which is defined as valuing other cultures; openness, which refers to refraining from judgment; curiosity and discovery, so it includes tolerance" (Deardorff, 2006).

The model suggests, as a first step in providing culturally competent treatment, the adoption of these attitudes as they ensure respect for different belief systems about health and illness. Knowledge and understanding in this model implies the existence of self-awareness, both at the cultural and at the socio-linguistic level. When it comes to skills, as the third component of the model, they refer to the ability to listen carefully to the patient, observe him and professional assessment, and then analysis, interpretation of the results and connection of everything into one whole, all with the aim of an appropriate assessment of the patient's health condition. Respecting and learning about the patient's culture ensures a greater ability to provide appropriate care. Adaptability, flexibility and empathy of the healthcare professional are necessary to provide everything the patient needs.

The ultimate goal of this model is effective and appropriate communication with the patient and an appropriate form of employee behavior to the specific intercultural situation. Consequently, the provision of interculturally competent care is certainly satisfactory. Deardorff's (2006) model is flexible in accordance with global and individual changes. The presented model is a continuous process, in constant interaction with both, employees and patients, because the development of skills and behavior has a continuum in the long term during the work process. Attitudes and emotional responses according to Deardorff' are crucial in the successful development of intercultural competence.

3. Health workforce cultural competency interventions

Cultural competence represents a series of interventions used to improve the functioning and work of employees in health care institutions. The goal of these interventions is to improve the competence of healthcare workers and improve their capacity to approach every patient who uses healthcare services in a culturally competent manner (Jongen et al., 2018). In order to achieve the desired cultural competence of the employees, different strategies were applied, such as cultural competency training interventions and professional development. Professional development includes various forms of training. When conducting trainings, supervisor should be careful not to have the opposite results, i.e. increasing cultural misunderstanding if attention is not paid to the diversity of cultural groups. In order to avoid cultural misunderstandings, it is necessary during training to use evidence-based knowledge regarding the provision of health care, as well as the advantages of direct contact with patients themselves and respect for their sociocultural perspective (Jongen et al., 2018). Supervision and reevaluation of knowledge for more effective cultural competence needs to be practiced and applied by health institutions, employees and medical students as well. Outcomes of the intervention that should be monitored are acquired knowledge, improved attitudes and beliefs, new communication skills,

adequate behavior and greater self-confidence in work. It is desirable to adopt a positive attitude about the importance of lifelong learning in this area.

Health care outcomes such as employee and patient satisfaction as well as their trust in the health system and employed health workers are proposed to be followed. The next outcome that can be monitored after cultural competency training is patient assessment, a significantly better option than practitioner self-assessment, which is also used. It is certainly best to use both types of evaluation in order to obtain as strong evidence as possible about the impact of interventions on employed health workers in the field of cultural competence (Hulland et al., 2021).

We should certainly not forget that, in addition to doctors and nurses, non-medical personnel are also employed in health institutions. Patients also come into contact and interact with them every day, so it is necessary to include them in the work on cultural awareness, issues of diversity and power (Gulati et al., 2022).

It is much easier to assess knowledge than attitudes. Also, it is not realistic to expect that a healthcare worker can be familiar with all cultural groups and their specificities in each society, also, "…simply having cultural knowledge and knowing about clients' culture is not sufficient to become a culturally competent healthcare practitioner" (Henderson et al., 2018).

In the field of cultural competence, most of the research has been done so far on trainings and educations and their impact on newly acquired knowledge, improved attitudes, developed skills and adapted behavior of employees.

4. Training of cultural competency

At the international level, cultural competence has emerged as a policy for resolving disparities in health care that may be the result of racial, ethnic and linguistic differences. To improve better health outcomes, the attention is on reducing intercultural misunderstandings by the development of competencies in the health system to address cultural issues during consultations. Acquiring new knowledge from cultural competences implies understanding the significant role of culture in the life of each person and the way in which it shapes the behavior of the individual, accepting cultural differences between people and adopting ways to effectively use culturally adapted practices (Jongen et al., 2018). Good example for health systems adapting in providing culturally competent healthcare is hiring bi-lingual healthcare professional or available interpreters for patients support (Chauhan et al., 2020).

Despite of trying to implement cultural competence in the health care system for a long time, there is no consensus on how to operationalize it. There is a need for current recommendations that comprehensively identify and assess the framework of cultural competences at the individual level. The development of academic frameworks alone is not enough for practical implementation with positive results in this crucial field (Alizadeh and Chavan 2016).

Various synonyms such as cultural intelligence, cultural, intercultural and communication competence are mentioned in the literature. Cultural awareness, knowledge and skills and behaviour are the most important constituents. Some authors combine awareness and knowledge into one cultural element known as cognitive one (Alizadeh and Chavan 2016).

Mannion et al (2018) presented review of efficient policies for changing cultural attitudes in the healthcare organizations. Health care organizations differ a lot, in relation to the different specializations of employees, level of education, levels of health care and the types of services they provide. Obstacles and introducing systematic innovations must be taken into account when creating policies and strategies for improving work, patients' satisfaction, positive trend, increasing success and maintain the positive trend of changes (Mannion et al., 2018). Differences in the manifestation of cultural attributes should be taken into account. Some attributes are widespread and stable, while the others rarely occur, sometimes only in some cultural subgroups. We should not forget the readiness and capacity of the management of healthcare organizations for an innovative approach. It is necessary to analyze in detail the capacities of the management staff before organizational interventions in the field of cultural competence (Truong et al., 2014).

Cultural competence is attractive to professionals and policy makers as an instrument for improving the quality of work and better health care (Jongen et al., 2018). Cultural competence of healthcare workers implies the existence of awareness, knowledge, skills, respect of diversity, understanding cultural differences, ability of individual and organizational self-evaluation, adequate provision of services and support of colleagues in this area. It is necessary to consider aspects of self-awareness, ability to cultural communicate and analysis of existing obstacles in the provision of health care.

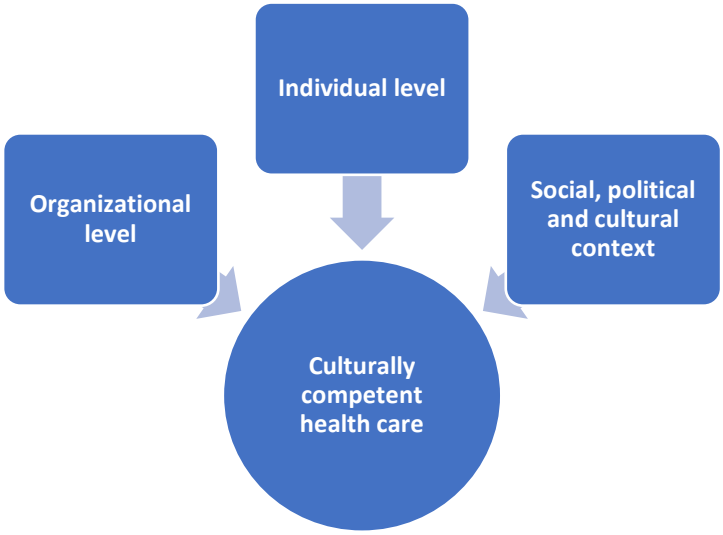

Figure 1. Contexts for implementing the cultural competence of health professionals
Source: Author's source based on literature review

The components of culturally competent health care according to Handtke et al (2019) are, at the organization level, training on cultural competencies for service providers, human resource development, integration of interpreter services, and adaptation of the social and physical environment of the organization. Strategies for providing culturally competent health care are the integration of health workers into the community, educating patients during home or clinic visits, using telemedicine, fieldwork methods, and forming a network of community health facilities. Strategies for the implementation of culturally competent health care creates and promotes intercultural management, which is responsible for monitoring changes within the organization (Handtke et al., 2019).

Incorporating training on cultural competences into didactic and clinical curricula is required to teach new generations of competent medical workers, trained with the facilities necessary to address disparities spread by prejudice. It is also crucial to ensure training on cultural competences to also exists in postgraduate medical education, taking care not to become too mechanical and to remain in line with the basic idea of patient-centered healthcare provision (Grewal et al., 2021). Despite the fact that interventions are needed to improve education related to cultural competence, there is still resistance to it and the attitude that an acceptable attitude, adopted knowledge and adopted values are sufficient for the cultural competence of healthcare workers (Gulati et al., 2022).

Providing health care in different languages, recruiting bicultural/bilingual health workers, training health staff on intercultural competencies, integrating health workers into the community, involving the families of individual patients in care, adapting the environment by offering ethnically adapted meals and written material in different languages, cooperating with minority communities and monitoring organizational development, telemedicine, field methods and creating community health networks are some of the proposals for successful implementation of strategies (Handtke et al., 2019). Betancourt et al (2003) believe that sociocultural factors are critical to clinical practice, when develop intercultural education for health workers. She argued that main goal of education should be to provide knowledge and skills with healthcare workers can better understand and manage socio-cultural areas in their workplace.

Training programs in the field of intercultural medicine are usually dedicated to getting the knowledge about the values, lifestyles by members of different cultures. Now, the current approach is focusing on learning appropriate communication and raising the awareness of healthcare workers about respecting cultural issues and habits in relation to health that exist in all cultures. The aim of the training for

healthcare workers is to experience the patient as a person who can help them develop new skills and necessary changes in attitudes (Matthews et al., 2018). Some of the desirable topics of education are improving knowledge about different styles of communication, motives for making certain decisions, relationships in the family, gender issues in a certain culture, prejudices or attitudes about sexuality. It is necessary to emphasize the need to establish a balance between the achieved level of knowledge and skills in communication when planning training in this area (Betancourt et al., 2003).

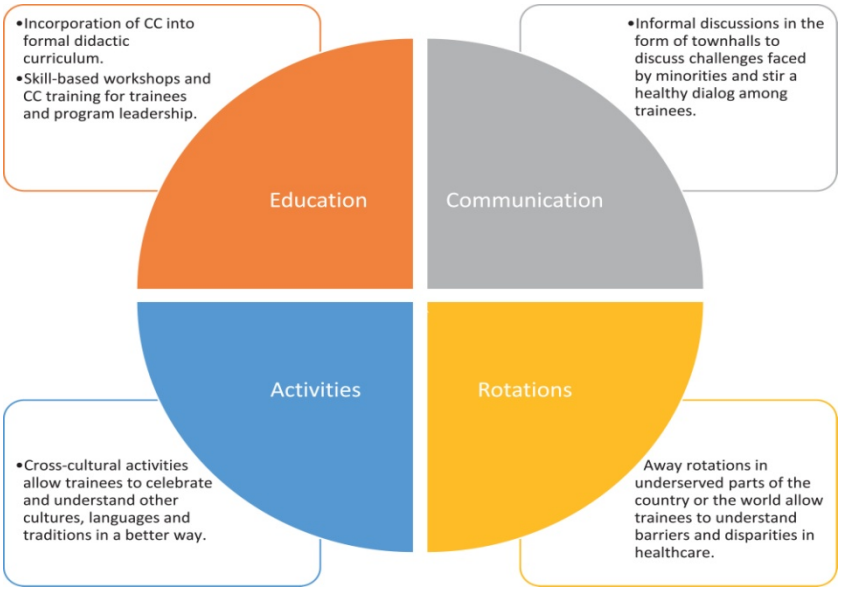

Figure 2. Forms of training of health workers on cultural competence
Source: Grewal et al., 2021

Some types of diversity among people can be influenced through education. It is necessary to carefully consider the ambition that cultural competence can be taught in seminars and training. Also, it is necessary to be aware that all interventions should be implemented in strategies and programs for the development of the health system, so a long-term positive effect can be expected (Gulati et al., 2022).

4. Conclusion

A culturally competent organization is actively created and reviews policies and practices that make services as accessible as possible to diverse populations and provides appropriate and effective services in cross-cultural situations. Such an organization effectively advocates the development of new theories, practices, policies and organizational structures that are more responsive to different groups (Tegarac et al., 2016). They apply the principles of cultural competence at different levels, management of an institution, publicly support cultural diversity and represent all communities that use the services, diversity and human resource management that enables the employment with skills for culturally competent service delivery. If necessary, qualified translators or cultural mediators should be engaged in their daily work (Chauhan et al., 2020).

The goal of health institutions should be promoting the reduction of health inequalities and the development of sustainable and cost-effective policies. It is necessary to ensure continuous training of employees, especially in the field of raising awareness of the impact of discrimination, free access to health care and developing a culturally competent approach to vulnerable groups. The potential of mentoring and supervision approaches to improve health practitioner cultural competence is a a research area worth further exploration and testing for its efficacy and impact. Physical access to health services must be ensured for the most vulnerable groups. Communication with users' needs to be improved, including the elimination of the consequences of the imbalance of power in communication between the user and the healthcare professional. The development of trust, respect, openness and empathy in dealing with customers is significant.

Service providers should take into account the experiences and opinions of the individual when

planning the health care process and learn to bridge differences and build relationships. Community participation is widely believed to be beneficial to the development, implementation and evaluation of health services. Promoting the active participation of service users and the local community in the planning, implementation and evaluation of health care, through partnerships to provide better services to vulnerable groups and inter department initiatives for more comprehensive addressing of health determinants. Cultural competence enables health care professionals to revolutionize the delivery of care, providing their patients with knowledge, the absence of language barriers, and a new space to explore the most critical dimensions of cultural differences.

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