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THE EVALUATION OF CULTURAL COMPETENCE IN HEALTHCARE: WHY IS THE INTRODUCTION OF QUALITATIVE APPROACHES SO NEEDED?

ABSTRACT

The article seeks to stimulate dialogue about the evaluation of cultural competence in healthcare. The first part of the paper presents the different attempts to measure cultural competence in the field of healthcare and critically analyses the problems that arise concerning the use of instruments that measure the cultural competence of health providers. The second part of the article focuses on the evaluation process of the first cultural competence educational programme for healthcare workers in Slovenia, serving as an example to demonstrate the importance of complementing quantitative methods with qualitative ones and to emphasize the need to shift the focus from measuring the cultural competence of individual healthcare workers to the evaluation of educator performances, patient perspectives, and the cultural competence of healthcare institutions as a whole.

Keywords: cultural competence, healthcare, education, evaluation, qualitative and quantitative methods

EVALVACIJA KULTURNIH KOMPETENC NA PODROČJU ZDRAVSTVA: ZAKAJ JE TREBA VPELJATI KVALITATIVNE PRISTOPE? – POVZETEK

Namen prispevka je spodbuditi dialog o evalvaciji kulturnih kompetenc v zdravstvu. V prvem delu članka bosta avtorici predstavili različne poskuse merjenja kulturnih kompetenc v zdravstvu, pri čemer bosta kritično analizirali probleme, ki se pojavljajo ob uporabi instrumentov, namenjenih merjenju kulturnih kompetenc zdravstvenih delavcev. V drugem delu članka pa se bosta osredotočili na evalvacijski postopek prvega izobraževalnega programa s področja kulturnih kompetenc zdravstvenih delavcev v Sloveniji. Evalvacijski postopek v Sloveniji bo služil kot primer, na podlagi katerega bosta avtorici pokazali na ponem dopolnjevanja kvantitativnih metod s kvalitativnimi ter potrebe po tem, da premaknemo pozornost

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od merjenja kulturnih kompetenc posameznih zdravstvenih delavcev k evalvaciji izvajalcev izobraževanja, k perspektivi pacientov ter k evalvaciji kulturnih kompetenc celotnih zdravstvenih ustanov.

Ključne besede: *kulturne kompetence, zdravstvo, izobraževanje, evalvacija, kvalitativne in kvantitativne metode*

INTRODUCTION

In recent decades, cultural competence has been one of the most popular concepts when it comes to the education of healthcare workers. Cultural competence efforts arose as a response to calls for new medical models that address the shifting demographics of ethnic migrants (Napier et al., 2014). Namely, many health care providers across Europe reported being in daily contact with heterogeneous groups of migrants who may speak only foreign languages, exhibit different health-seeking behaviours, and have different expectations of care, for which healthcare workers were not prepared. This resulted in many language-related and intercultural miscommunications and produced unfavourable health outcomes (Lipovec Čebron, 2017; Martínez, 2010). The growing health disparities that minority communities face (Barker & Beagan, 2014) clearly indicate that the “one-size-fits-all” healthcare model is incapable of adequately meeting the needs of an increasingly heterogeneous population (Barker & Beagan, 2014; Carpenter-Song et al., 2007).

The first steps in the field of cultural competence were taken in the USA as far back as the early 1970s (Muaygil, 2018, p. 15). At the time employees in the public sector began to feel increasingly unprepared to serve diverse and continuously changing populations (Muaygil, 2018, p. 15). Noticing these transformations, the healthcare sector also recognised that providing equitable medical care for different groups was a very challenging goal (Muaygil, 2018). Healthcare professionals initially “utilized an individualized model: clinicians were urged to recognize and understand the unique needs, preferences, and values of each patient individually in order to ensure effective delivery of a service” (Muaygil, 2018, p. 16). Over time, however, many different methods, approaches and models of cultural competence evolved in different countries and a variety of terms have been used in relation to cultural competence or similar concepts¹ (Cai, 2016; Diallo & McGrath, 2013; Jenks, 2011). These various efforts had a similar foundation: the acknowledgement that culture matters in healthcare and the commitment to respect cultural differences. Moreover, different cultural competence efforts had the common goal of ensuring equal healthcare access for and quality health care delivery to persons with diverse cultural and socio-economic backgrounds, i.e. people with a variety of values, norms, social practices,

¹ For example, culturally appropriate care, intercultural health, multicultural healthcare, cross-cultural healthcare, cultural sensitivity, cultural intelligence, cultural responsiveness, cultural safety or cultural humility (Cai, 2016, p. 268; Diallo & McGrath, 2013, p. 122; Jenks, 2011, p. 210). These concepts are sometimes used interchangeably with the term cultural competence, and sometimes as its hyponym or hypernym, indicating a significant terminological confusion in this field (Lipovec Čebron & Huber, 2020).

health beliefs, and health practices (Barker & Beagan, 2014; Cai, 2016; Carpenter-Song et al., 2007; Halbwachs, 2019; Muaygil, 2018). Thus, these efforts were not focused only on minority, marginalised or deprived groups of patients, but were instead trying to ensure access to healthcare institutions and quality health care delivery for all patients (Schouler-Ocak et al., 2015, p. 436).

Over the following decades, courses in cultural competence have increasingly become part of many health education programmes in North America and Europe. Not only targeting medical students, these courses are common in educational programmes for other health professionals and are a part of continuous medical education (Schouler-Ocak et al., 2015). Moreover, the last thirty years have seen a remarkable increase in theories, models, and approaches to teaching and conducting research in cultural competence, which is evident from the impressive quantity of scientific articles on this subject (Halbwachs, 2019; Perng & Watson, 2012; Purnell, 2016; Razlag Kolar et al., 2019). Many recent cultural competence efforts want to not only influence the clinical level in terms of patient-provider interaction, but also in terms of institutionalised healthcare policies and services (Barker & Beagan, 2014; Carpenter-Song et al., 2007; Schouler-Ocak et al., 2015). In this context, they were incorporated into the nationally as well as internationally recognised standards for healthcare quality assessment (Jenks, 2011)² and a range of instruments to measure the cultural competence of health care providers and institutions were created (Diallo & McGrath, 2013; Pulido-Fuentes et al., 2017).

The following pages critically reflect on the dilemmas and problems that arise in connection to the instruments intended to measure the cultural competence of health providers. In the first part of the article, the different attempts to measure cultural competence in the field of healthcare will be presented and the problems that arise concerning the use of instruments that measure the cultural competence of health providers will be critically analysed. The second part of the article will focus on the evaluation process of the first cultural competence educational programme for healthcare workers in Slovenia. The 20-hour course took place in different locations across the country and 485 healthcare workers and other professionals working in primary-level health care attended the 13 cycles in 2018 and 2019. The evaluation process will demonstrate the importance of complementing quantitative methods with qualitative ones and establish the need to shift the focus from measuring the cultural competence of the individual healthcare worker to the evaluation of educator performances, patient perspectives, and the cultural competence of healthcare institutions as a whole.

2 In 2001, the Culturally and Linguistically Appropriate Service (CLAS) standards were established in the USA – a series of 14 requirements and recommendations for the development of CLAS (Office of Minority Health, 2001). On the basis of these standards, cultural competence efforts include a range of activities (from using interpreters to recruiting providers from underrepresented ethnic groups, creating ethnically specialised clinics as well as educating and training health providers) (Jenks, 2011, p. 210).

MEASURING CULTURAL COMPETENCE

As previously mentioned, courses in cultural competence have experienced a remarkable upswing in recent decades and have become an integral part of graduate and postgraduate study curricula at medical and health sciences faculties (e.g., Beach et al., 2005; Jenks, 2011; Napier et al., 2014) as well as continuing educational programmes for health care providers (Battle, 2010; Eche & Aronowitz, 2017; Razlag Kolar et al., 2019). However, it should be emphasized that these efforts to address the “softer” side of healthcare in education are neither new nor unique (Jenks, 2011, pp. 210–211). What is new and singular is the fact that legislative and regulatory efforts – particularly in North America and in some parts of Europe – have accelerated the introduction of cultural competence in the field of healthcare education. The consequences of this development are impressive: for example, a survey of medical schools in California found that between 1991 and 1992 only 13 of 98 schools offered a cultural sensitivity course, which was optional (Lum & Korenman, 1994, as cited in Jenks, 2011), while 10 years later 100% of the schools included issues of cultural diversity as a requirement (Wilson & Houghraling, 2001, as cited in Jenks, 2011, p. 211). These and other courses across different countries vary in length (from a one-day course to a continual year-long course), method (from lectures to different workshops), the number of participants (from a few participants to large groups), form (from online courses to immersion programmes designed to expose providers to various groups of patients) (Jenks, 2011, p. 211), approach (from the categorical approach, where information about specific groups is provided, to the cross-cultural approach, where methods for communicating with and caring for patients from diverse backgrounds are taught) (Jenks, 2011, pp. 216–217), and the professional background of the lecturers (varying from interdisciplinary groups that include renowned experts in the field of social sciences, humanities as well as healthcare, to a single novice lecturer). Therefore, two courses with an identical title featuring “cultural competence” could, on the one hand, indicate a short training session that lasts a few hours and only addresses a few basic concepts, and on the other hand, refer to a programme that spans several months and provides an in-depth understanding of this field through interactive lectures, role play, participant observation, and cultural consultation (Schouler-Ocak et al., 2015, p. 437; see also Kirmayer et al., 2008).

As the variety of courses in cultural competence increased it also became necessary to assess their impact. In general, many authors estimated that cultural competence is one of the key strategies with which healthcare institutions seek to overcome the problem of unequal care for increasingly heterogeneous populations and point to the need for educating health care providers in this field (Babnik & Šavle, 2014; Betancourt, 2006; Napier et al., 2014; Purnell, 2016). Numerous studies have also proved that cultural competence can significantly contribute to safer and more efficient care (Betancourt, 2006; Campinha-Bacote, 2002) as well as improve the accuracy of diagnosis and clinical outcomes (Cai, 2016; Napier et al., 2014) by addressing the needs of different groups – not only marginalised and deprived ones, but others as well. As a result, both healthcare

professionals and patients are more satisfied with the treatment process and quality of care. Furthermore, overall satisfaction with the work and employee relationships in healthcare facilities also increases (Barker & Beagan, 2014; Cai, 2016) and the frequency of medical errors declines.

While recognising the many achievements cultural competence efforts have made, there exist certain conceptual and methodological pitfalls connected to many such projects, especially those in the field of education (Lipovec Čebron & Huber, 2020). As we will see in the following pages, there is a terminological and conceptual confusion that arises in defining cultural competence in educational programmes. Besides problematic attempts to define cultural competence, anthropologists (e.g., Cai, 2016; Carpenter-Song et al., 2007; Kleinman & Benson, 2006; Pulido-Fuentes et al., 2017) have sharply criticised the conceptual background and implementation of various educational programmes on cultural competence that are based on an oversimplified and erroneous understanding of culture – one that is in stark opposition to the anthropological understanding of this concept. Multiple authors (Carpenter-Song et al., 2007; Kleinman & Benson, 2006; Kumaş-Tan et al., 2007; Pulido-Fuentes et al., 2017) have pointed out that the most troubling aspect of these educational programmes is the misguided equation of culture with race, nationality and ethnicity, and the use of the concept of culture to conceal social and economic inequalities, which in practice leads to negative or even harmful consequences (Lipovec Čebron & Huber, 2020).

Besides various studies and reviews that assessed cultural competence in healthcare on a general level, there has been an increasing emphasis on examining cultural competence on an individual level and therefore to measure the cultural competence of individual health care providers. This shift emerged as a response to criticism suggesting that satisfactory evidence has not yet been presented to support the commonly-held belief that cultural competence is sufficient to produce the desired patient and family outcomes (Bhui et al., 2007; Schim & Doorenbos, 2010). As a result, many proponents of cultural competence started pushing for more tangible, measurable, “objective” proof of the positive effects of culturally competent healthcare. Some of the authors even perceive the introduction of measuring cultural competences as a fundamental step towards assessing cultural competence learning strategies and towards achieving cultural competence among health care providers (Cai, 2016; Ličen et al., 2017; Smedley et al., 2003). Or, as Larry Purnell (2016) puts it: “While cultural competency is widely promoted, the lack of tools to measure cultural competency limits the ability to evaluate when culturally congruent care is truly delivered” (p. 126). This resulted in the creation of a range of instruments to measure the cultural competence of health care providers and healthcare institutions (Diallo & McGrath, 2013; Pulido-Fuentes et al., 2017).

An overview of these instruments gives the impression that the field of cultural competence measuring is experiencing rapid growth. More than a decade ago, Zofia Kumaş-Tan et al. (2007) defined 54 different instruments used to measure cultural competence in training courses, acknowledging that “there is indeed little uniformity in the methods

used to evaluate cultural competence in the training of health professionals" (p. 548). Nowadays the variety of different instruments and tools used for measuring cultural competence in healthcare seems to be endless, so this section will focus only on those which seem to be referenced most frequently. The majority of the instruments were developed on the basis of models and theories of well-known authors in this field such as Madeleine Leininger, Josepha Campinha-Bacote, Larry D. Purnell, Marianne Jeffreys, etc. In some cases, theories or models have an accompanying tool to measure cultural competence (Purnell, 2016, p. 125),³ while in others researchers create only individual instruments. When designing these instruments, researchers usually draw on the work of Josepha Campinha-Bacote (1996, 1998, 2002) and identify three⁴ main components of cultural competence that are to be measured: *cultural sensitivity*, which refers to a health care provider's appreciation of, respect for, and comfort with patients' cultural diversity (Cai, 2016, p. 270); *cultural knowledge*, which deals with a knowledge and understanding of different cultural worldviews and practices (Gunaratnam, 2007, p. 471); and *cultural skill*, which refers to the ability to collect relevant cultural data concerning a patient's health problem, and also incorporates relevant data into care planning and provision in a culturally sensitive manner (Cai, 2016, p. 270; Gunaratnam, 2007, p. 471; Campinha-Bacote, 2002; see also Halbwachs, 2019).

Building on these three (or more) components, researchers usually develop a self-reported assessment tool to measure health care providers' knowledge, attitude and/or behaviours regarding the culture and health of a specific as well as general population. There have been many attempts to develop such a tool, for example, one by Shoa-Jen Perng and Roger Watson (2012) includes 4 domains (cultural awareness, cultural knowledge, cultural sensitivity, cultural skill) that are measured by 9–10 items each.⁵ In order to measure their level of cultural competence, the participants need to respond to 41 items using a five-point Likert-type scale (with the response categories strongly agree, agree, no comment, disagree, strongly disagree) (Perng & Watson, 2012, p. 1680). In this context, the participants show the level of their cultural skills by agreeing or disagreeing with statements such as: "I can teach and guide other nursing colleagues about the differences and similarities of diverse cultures" or "To me collecting information on each clients' belief/ behavior about health/illness is very easy." Correspondingly, their level of cultural knowledge is measured by responding to items such as "I can explain the possible relationships

3 Probably the most well-established model in this context is *The Process of Cultural Competence in the Delivery of Healthcare Services* (Campinha-Bacote, 2015), which includes four self-reported tools for measuring cultural competence, each addressing a particular profile of healthcare workers. For example, *Inventory For Assessing The Process Of Cultural Competence Among Healthcare Professionals In Mentoring* (IAPCC-M), *Inventory For Assessing The Process Of Cultural Competence Among Healthcare Professionals – Student Version* (IAPCC-SV), and others (Campinha-Bacote, 2015).

4 In her works Campinha-Bacote (2002, p. 181) defined five (not three) main constructs of the cultural competence model: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire.

5 The specificity of this tool is that the researchers used Mokken scaling to establish whether items on a scale conform to a cumulative, hierarchical structure (Perng & Watson, 2012, p. 1680).

between the health/illness beliefs and culture of the clients”, while the level of cultural sensitivity is established with items such as “I usually actively strive to understand the beliefs of different cultural groups” (Perng & Watson, 2012, p. 1682).

Similar self-report questionnaires with several items addressing cultural knowledge, cultural sensitivity and/or cultural skills can be found using many different scales (e.g., Baghadi & Ismaile, 2018; Chae & Lee, 2014). These may vary in the number of items that range from 25 (Schim et al., 2003) to 83 (Jeffreys, 2000) and in the Likert-type scales that vary from 4 points (Campinha-Bacote, 1999) to 10 (Jeffreys, 2000; see also Chae & Lee, 2014). Moreover, the scales differ according to the profile of healthcare workers they are intended for: some are aimed at all profiles of healthcare workers (Schim et al., 2003), others only at healthcare professionals (Campinha-Bacote, 1999) or students (Jeffreys, 2000). Certain instruments are developed not only for a specific group of healthcare workers but also for their specialised fields of expertise:

For example, one instrument developed for evaluating this construct was targeted toward assessing one aspect of cultural competence such as cultural awareness in students (Rew, Becker, Cookston, Khosropour, & Martinez, 2003), whereas another focused on a specialty group of mixed professionals in hospice care (Schim, Doorenbos, Miller, & Benkert, 2003). (Tulman & Watts, 2008, p. 162)

Why Are the Instruments that Measure Health Care Providers' Cultural Competence Inappropriate?

As in some other fields of cultural competence where authors seldom engage in critical examinations of the theoretical concepts underlying cultural competence and in the different aspects of the training process (Willen et al., 2010, p. 247), critical analyses of existing instruments for measuring cultural competence are few and far between. In this section, we will present a short overview of the main conceptual and methodological problems connected to the instruments that measure cultural competence in healthcare. Namely, we will address problems that concern the validity and reliability of these instruments, the problematic theoretical concepts and assumptions behind them, and the questionable need to measure and quantify cultural competence in healthcare.

a) Problems Related to the Validity of the Instruments

One of the most common criticisms concerning the instruments that measure cultural competence in healthcare is related to questions of their validity. Some researchers in this field acknowledge the need to examine the validity of the instruments (Perng & Watson, 2012; Razlag Kolar et al., 2019) and others openly pronounce the existing instruments to be inaccurate: “However, to date, a valid and reliable means to measure the extent to which content on cultural competence is taught and retained by our students does not exist” (Tulman & Watts, 2008, p. 161). Some authors attribute this shortcoming to the fact that the majority of these instruments relies on self-report measures (Betancourt et al.,

2003; Kumaş-Tan et al., 2007; Perng & Watson, 2012; Purnell, 2016) that cannot be rigorously examined and is susceptible to social desirability effects. The authors of one of the self-reported assessment tools for clinical nurses admit:

Given the nature of cultural competence, there is the possibility of a social desirability response set. Although anonymity was maintained during the data collection procedure, respondents may have chosen answers that they perceived to meet social norms as professional nurses. (Chae & Lee, 2014, p. 311)

b) Problematic Theoretical Concepts and Assumptions Behind the Instruments

Another, though less common criticism, concerns the theoretical concepts on which the instruments that measure the cultural competence of health care providers are based. Some authors see the main problem in the absence of a clear definition of cultural competence as well as in the lack of clarity about what it encompasses: “whereas many measures are based on the awareness–knowledge–skill model of cultural competence, there is ongoing dispute about the very meaning of and components of cultural competence” (Kumaş-Tan et al., 2007, p. 548). This lack of a unanimous definition of the concept of cultural competence is, according to some, one of the main obstacles preventing the creation of valid and reliable quantitative instruments (Chae & Lee, 2014; Perng & Watson, 2012; Suh, 2004).

Although such criticism is usually made only *en passant* in works that focus specifically on measuring cultural competence, it brings up the same conceptual problems that anthropologists have emphasized for a long time. Namely, they (e.g., Kleinman & Benson, 2006; Pulido-Fuentes et al., 2017) recognise cultural competence as an abstract and theoretical concept that seems difficult to define and is therefore difficult to teach and understand well (Diallo & McGrath, 2013, p. 122). Moreover, the anthropological criticism that addressed the conceptual background and the implementation of various cultural competence courses (Lipovec Čebron & Huber, 2020) could certainly be expanded to include the instruments measuring cultural competence in healthcare.

In examining the most widely used measuring instruments, Kumaş-Tan et al. (2007, p. 548) identified some underlying assumptions that clearly show how they oversimplify both culture and cultural competence. Based on their findings, the first assumption behind the majority of the instruments is that culture is more or less equivalent to race and ethnicity (Kumaş-Tan et al., 2007, p. 549). Correspondingly, the most common anthropological criticism of cultural competence educational programmes emphasizes that although cultural competence has been expanded beyond its initial definition to include gender, social class, and sexual orientation, in practice, it tends to still be equated with ethnicity and race (Barker & Beagan, 2014; Carpenter-Song et al., 2007; Kleinman & Benson, 2006). Anthropologists warned against such an understanding of culture as it is misleading and fails to effectively address diversity within cultural groups and only reinforces harmful ethnic stereotypes and biases (Lipovec Čebron & Huber, 2020). The second common assumption shaping the instruments that measure cultural competence, pointed out by

Kumaş-Tan et al. (2007, p. 551), is that they tend to equate the cultural with the ethnic and racialised Other while the dominant groups are seen as culture-free. The idea that culture is an attribute possessed only by the “other” race or an ethnic group different from “ours” has also frequently been criticised by anthropologists that evaluated the cultural competence courses. One of the main problems with this focus on the “exotic” cultures of “others” in cultural competence is that it gives health professionals an incentive not to face their own socio-cultural conditionality and reinforces the false assumption that biomedicine is culture-free (Carpenter-Song et al., 2007, p. 1364). Moreover, Kumaş-Tan et al. (2007) found other hidden assumptions in cultural competence instruments that are highly problematic, such as the idea that the main problem of cultural incompetence lies in the practitioners’ lack of familiarity with the Other or that the respondents to the questionnaires of these instruments are “white and that the recipients of care are patients from ethnic and racialized minority groups” (p. 554).

c) The Questionable Need to Measure and Quantify Cultural Competence

The last and also less frequent criticism found in the relevant literature is connected to a simple question: why should the cultural competence of health care providers even be measured and/or quantified?

It is clear that behind this enormous quantity of different instruments, tools and scales lies the need to assess the cultural competence of health care providers as well as the urge to evaluate the “effectiveness” of the cultural competence courses and related endeavours. Nevertheless, it seems interesting that researchers in the field focus only on quantitative methods and rarely consider more qualitative approaches – and even when they do, the qualitative approaches are utilised only to supplement quantitative methods (Purnell, 2016, p. 126). It should be noted that cultural competence was introduced into healthcare to address the “softer” side of medicine, specifically to sensibilize health care providers to cultural dimensions of clinical encounters that are difficult to quantify. Despite this being the initial purpose, it seems that different fields of cultural competence underwent drastic transformations once they became part of the healthcare system. As a result, the highly complex, multidimensional and elusive concept of culture was, in a clinical setting, often reduced to a technical skill (Kleinman & Benson, 2006, p. 1673) in order to be concrete and measurable, while at the same time “cultural competence tools became so categorized and rigid that they can be likened to diagnostic criteria one may use to diagnose and manage a disease condition such as pneumonia” (Muaygil, 2018, p. 17). These observations are in line with Tervalon and Murray-Garcia’s (1998) statement that:

in the laudable urgency to implement and evaluate programs that aim to produce cultural competence, one dimension to be avoided is the pitfall of narrowly defining cultural competence in medical training and practice in its traditional sense: an easily demonstrable mastery of a finite body of knowledge, an end point evidenced largely by comparative quantitative assessments (Tervalon & Murray-Garcia, 1998, p. 118).

These authors and a few others suggest exploring different methods for evaluating cultural competence – qualitative and mixed methods such as participant observation, student essays, student or practitioner journals, qualitative interviews or/and open-ended questionnaires (KumAŞ-Tan et al., 2007, pp. 549–555). Similar appeals to introduce alternative approaches that will include observations during clinical practice are also present:

Can evidence of culturally competent practice be seen in the patient's medical record, including assessment data? What about direct observations of professionals while practicing? A literature search for this dialogue did not reveal any articles that addressed all three elements. (Purnell, 2016, p. 126)

The above quote indicates that these kinds of approaches are quite uncommon, since few researchers advocate for a non-quantitative approach in evaluating cultural competence. However, as we shall see in the next section, when evaluating a cultural competence course in Slovenia, we tended to follow this line of reasoning.

EVALUATION OF A CULTURAL COMPETENCE COURSE IN SLOVENIA

In the previous section we have seen that the most common focus of different instruments and tools in the field of cultural competence is to measure health care providers' cultural competence and that these instruments rely predominantly on quantitative methods. As we have tried to show, these evaluating instruments are connected with many methodological weaknesses as well as significant conceptual and epistemological problems. In this section we will briefly present our experiences with the evaluation of the first⁶ cultural competence course for healthcare workers in Slovenia, entitled *Developing the Cultural Competences of Healthcare Professionals*. The evaluation process of the course tried to avoid the limitations of previously adopted approaches abroad: instead of measuring the individual providers' cultural competence, the evaluation focused on the educator performances as well as the impact of the cultural competence course on the participants as a group and not as individuals. Moreover, instead of exclusively relying on quantitative methods, the evaluation process was based on a mixed methods approach and therefore combined quantitative and qualitative methods.

The cultural competence course in Slovenia was a 20-hour course carried out during 2018 and 2019⁷ by an interdisciplinary team of experts⁸ in 13 cycles that were held in different

6 Several other training courses were organised later, but they were shorter and non-continual. One such example was a training course entitled *A Patient Doesn't Speak Slovenian! A Challenge for Healthcare Professionals in Slovenia*, held in 2017, which also included themes from the field of cultural competence (more at: <http://multilingualhealth.ff.uni-lj.si/>). Another related educational training course was *Cultural Competence, Doctor–Patient Communication, and Minority Health*, which took place in 2018 as a summer school.

7 The course was piloted in 2016 for 41 healthcare professionals in three healthcare centres as part of the project *Towards Better Health and Reducing Inequalities in Health – Together for Health*, coordinated by the National Institute of Public Health.

8 The course was organised by the National Institute of Public Health within the framework of the project *Model Community Approach to Promote Health and Reduce Health Inequalities in Local Communities*

Slovenian cities and attended by 485 healthcare workers and other professionals working in primary-level health care. The course consisted of a three-day educational programme organised in the form of interactive lectures that alternated with workshops on a variety of topics⁹. The planning and implementation of this course was a six-year process¹⁰ that was accompanied by many dilemmas, difficulties and attempts to avoid the main pitfalls of previous educational programmes abroad. As these aspects of the cultural competence course have already been analysed elsewhere (Lipovec Čebron et al., 2019; Lipovec Čebron & Huber, 2020), we will here focus only on its evaluation process.

The evaluation of the course comprised of four different approaches: quantitative evaluation questionnaires for the participants, lecturer self-evaluation, participant observation, and open-ended questionnaires at the beginning and at the end of each course. Of the four chosen approaches, only one was quantitative. The decision to combine these approaches was based on experiences with mixed methods research that showed how the strengths of quantitative and qualitative approaches offset the different weaknesses of the two when used together (Brewer & Hunter, 1989). Moreover, we chose the mixed methods approach since we wanted to achieve a more in-depth understanding (Plano Clark et al., 2008, p. 365) of the course by capturing the perspectives of both lecturers and participants. In the following pages we will briefly present each evaluation approach (see Figure 1) without analysing the gathered evaluation results as they are not the focus of this article and have already been partially published elsewhere (Lipovec Čebron et al., 2019; Lipovec Čebron & Huber, 2020).

As already emphasized, the only part of the evaluation that was based on quantitative methods was the evaluation questionnaire for the participants filled in at the end of each day; they were asked to assess each lecture on a five-point Likert-type scale (1 – very poor; 2 – poor; 3 – good; 4 – very good; 5 – excellent) and also used the scale to express their satisfaction with the content, evaluate the perceived usefulness of the topics presented and the organisational aspect of each particular day of the course (for more, see Lipovec Čebron & Huber, 2020).

The other three approaches were qualitative. Lecturer self-evaluation took place at the beginning and end of each new cycle in the form of self-reflective notes, which were forwarded to the coordinators of the educational programme. These notes were of various lengths and quality, and they focused on several different issues: some considered the

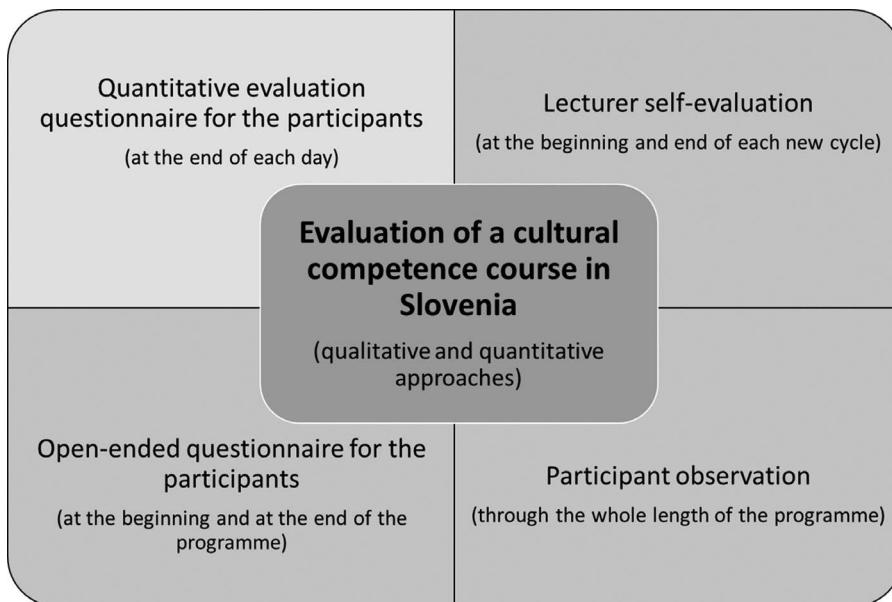
(MoST). More about the MoST project is available at <https://www.njjz.si/sl/most-model-skupnostnega-pristopa-za-krepitev-zdravja-in-zmanjsevanje-neenakosti-v-zdravju-v-lokalnih>.

9 The title of the first day of the programme was *Why are cultural competences important?* The second day held the title *Different culture and health dimensions in the context of the preventive and promotion in healthcare*, and the third day was entitled *Socio-economic impact on health and culture, with a special focus on vulnerabilities and violence*.

10 The authors of this article were members of the interdisciplinary work group that was responsible for the planning, content design and implementation of this educational programme, *Developing the Cultural Competences of Healthcare Professionals*.

Figure 1

Evaluation of the Educational Programme in Slovenia



advantages and disadvantages at the organisational level, others discussed the reactions of the participants to particular topics or provided positive and negative criticism of various parts of the course. Similar information was provided at the self-evaluation meeting of all the lecturers held at the end of the last educational cycle.

The third method used was participant observation, which was conducted throughout the entire duration of the programme. An individual who was not a participant or lecturer¹¹ was present every day, participated in all of the educational activities and made notes about the educational process.¹² At the end of the course, he or she summarised the notes into a report and forwarded it to the coordinators. These reports were longer and more systematic than the lecturers' self-evaluations, and were of various depths: some of them illustrate mostly external facts, while the majority of the reports provided in-depth descriptions of many aspects of the educational process.

The last form of evaluation was the anonymous open-ended questionnaire presented to the participants at the beginning and at the end of the programme. The participants had 15 minutes to answer three questions: *What do you understand under the term cultural competence? How do you imagine intercultural mediation in your work? How do you at your work adapt to the needs of vulnerable individuals in your environment?* The same

¹¹ This was usually a master's student of ethnology and cultural anthropology or a National Institute of Public Health employee.

¹² All the participants' names and personal information were anonymised on the spot.

questions were asked at the end of the programme in order to understand to what extent the group comprehended and internalised the three key topics of the educational programme.

Based on the experiences with combining these four different approaches, we can deduce that their complementarity was essential for the evaluation process. Similarly to other researchers in this field (Košmerl, 2021; Plano Clark et al., 2008), we can assume that the value of the mixed methods approach arises from the different perspectives that can be included by combining quantitative and qualitative methods, while “researchers may obtain stronger, more corroborated conclusions when the results are derived from two different types of data instead of only a single type” (Plano Clark et al., 2008, p. 366). Namely, the results derived from the quantitative questionnaire offered the coordinators and lecturers immediate and clear information which was convenient as a start, but acquired meaning and usefulness only when compared and interpreted together with the results of other evaluation methods. For example, when a lecturer would receive a low rating for a particular workshop, the quantitative questionnaire could not provide the reason for the rating and, therefore, the workshop could not be successfully improved in the future. Only reading the participant observation report usually enabled the lecturers to fully understand the ratings of their performance. Similar advantages were observed in other aspects of the educational process measured using the quantitative questionnaire: from general satisfaction with the contents of the educational programme to the evaluation of the perceived usefulness of the presented curricula and the organisational aspect of each particular day of the course. The results of the quantitative questionnaire provided useful but one-dimensional and superficial information that needed to be further contextualised to understand the outcome. This necessary information was provided with the help of the three qualitative methods used. Furthermore, they offered new insights and brought up questions that were not covered or even considered in the quantitative questionnaire.

However, it is important to emphasize that we do not want to claim that the evaluation process was without its flaws. Like other mixed methods research (Plano Clark et al., 2008) our evaluation process also required considerable time, since the analysis of the qualitative approaches results was lengthy and therefore available only several weeks after the end of the course. Nonetheless, the key weakness of the evaluation process was that it excluded the evaluation of the impact of the educational programme on health care in practice. Like most evaluation instruments used abroad (see Purnell, 2016, p. 126), it never stepped outside the lecture room into the field of everyday practice in healthcare facilities, where the concrete influence of the programme could be observed. Therefore, it excluded the very subject that cultural competence in healthcare was meant for – the user.

CONCLUSION

Despite decades of remarkable growth in the importance of cultural competence in healthcare and an immense number of various quantitative instruments, tools or scales that measure the cultural competence of health care providers, it is surprising that few

researchers engage in the critical examination of these instruments. As Kumaş-Tan et al. (2007) concluded:

As we educators in the health professions develop and implement cultural competence training, we face the question of how to evaluate these initiatives. This is largely because of present difficulties in measuring cultural competence. Unfortunately, the literature provides little guidance. (p. 548)

Precisely because of the obvious lack of critical reflection into evaluating cultural competence in healthcare, we found it crucial to present the most commonly used evaluation approaches – all of which are almost exclusively based on quantitative methods and associated measuring instruments. As we tried to show in the previous sections, these measuring instruments are connected with methodological weaknesses as well as significant conceptual and epistemological problems, including ones that concern the validity and reliability of these instruments, problematic theoretical concepts and assumptions behind these instruments, as well as the questionable need to measure and quantify cultural competence in healthcare.

Considering these shortcomings of the majority of measuring instruments, we tried to forgo them in evaluating the first cultural competence educational programme for healthcare workers in Slovenia. Instead of exclusively relying on quantitative methods, the evaluation process was based on the mixed methods approach, using quantitative as well as qualitative methods. The evaluation comprised of four different approaches: quantitative evaluation questionnaires for the participants, lecturer self-evaluation, participant observation, and open-ended questionnaires for the participants at the beginning and at the end of each course. Of the four chosen approaches, only one was quantitative. Based on the weaknesses of the evaluations of such educational programmes abroad and instead of measuring the individual providers' cultural competence, as is the usual approach in the majority of the currently existing quantitative measuring instruments, we chose to focus on the evaluation of the lecturers' performances as well as the "effect" the cultural competence course had on the participants as a group and not as a single individual.

Although we successfully avoided some previously detected weaknesses, we instead faced other issues, among them the lengthiness of the evaluation process and the fact that the process did not include the evaluation of the impact the educational programme had on health care in practice or the perspective of healthcare users.

Finally, considering that some propositions to create quantitative instruments to measure the cultural competence of healthcare workers have recently emerged in Slovenia (Ličen et al., 2017; Razlag Kolar et al., 2019; Sotler, 2016), we want to emphasize that – taking into account our multi-year process of planning, organising, and evaluating a cultural competence programme – we strongly advise against it. Instead, we propose the use of qualitative or mixed methods. We also suggest avoiding the evaluation of the cultural competence of an individual health care provider and instead focusing on the evaluation

of educator performances, patient and client perspectives, service outcomes and organisational competence (Kumaş-Tan et al., 2007, p. 549); in fact, focusing on healthcare institutions as a whole seems to be the most promising direction of all.

REFERENCES

Babnik, K., & Šavle, M. (2014). Kulturna raznolikost: Komunikacija s pacienti iz različnih etničnih, kulturnih in jezikovnih okolij. In T. Štemberger Kolnik, D. Ravnik, K. Babnik, & M. Bulič (Eds.), *Zdravstvena nega v javnem zdravju: Druga znanstvena konferenca z mednarodno udeležbo: Zbornik prispevkov* (str. 153–159). Založba Univerze na Primorskem.

Baghadi, A. N., & Ismaile, S. (2018). Cultural competency of nursing faculty teaching in baccalaureate nursing programs in the United States. *Australasian Medical Journal*, 11(2), 126–134. <https://doi.org/10.21767/AMJ.2018.3335>

Barker, K., & Beagan, B. (2014). Making assumptions, making space: An anthropological critique of cultural competency and its relevance for queer patients. *Medical Anthropology Quarterly*, 28(4), 578–598. <https://doi.org/10.1111/maq.12129>

Battle, A. (2012). Can cultural competence have an impact on health disparities? In S. R. Notaro (Ed.), *Advances in Education in Diverse Communities: Research policy and Praxis: Vol. 9. Health Disparities Among Under-Served Populations: Implications for Research, policy and praxis* (pp. 263–276). [https://doi.org/10.1108/S1479-358X\(2012\)0000009016](https://doi.org/10.1108/S1479-358X(2012)0000009016)

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M. W., Feuerstein, C., Bass, E. B., Powe, N. R., & Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, 43(4), 356–373. <https://doi.org/10.1097/01.mlr.0000156861.58905.96>

Betancourt, J. R. (2006). *Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care*. Commonwealth Fund.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports* 118(4), 293–302. <https://doi.org/10.1093/phr/118.4.293>

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, 7, 15. <https://doi.org/10.1186/1472-6963-7-15>

Brewer, J., & Hunter, A. (1989). *Multimethod research: A synthesis of styles*. Sage.

Cai, D. Y. (2016). A concept analysis of cultural competence. *International Journal of Nursing Sciences*, 3(3), 268–273. <https://doi.org/10.1016/j.ijnss.2016.08.002>

Campinha-Bacote, J. (1996). A culturally competent model of nursing management. *Surgical Service Management*, 2(5), 22–25.

Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of health-care services*. Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *The Journal of Nursing Education*, 38(5), 203–207.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of health-care services: A model of care. *Journal of Transcultural Nursing*, 13(3), 181–184. <https://doi.org/10.1177/10459602013003003>

Carpenter-Song, E. A., Nordquest Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, 58(10), 1362–1365. <https://doi.org/10.1176/ps.2007.58.10.1362>

Chae, D. H., & Lee, C. Y. (2014). Development and psychometric evaluation of the Korean version of the cultural competence scale for clinical nurses. *Asian Nursing Research*, 8(4), 305–312. <https://doi.org/10.1016/j.anr.2014.06.004>

Diallo, A. F., & McGrath, J. M. (2013). A glance at the future of cultural competency in healthcare. *Newborn & Infant Nursing Reviews*, 13(3), 121–123. <https://doi.org/10.1053/j.nainr.2013.07.003>

Eche, I. J., & Aronowitz, T. (2017). Evaluating cultural competence of pediatric oncology nurses at a teaching hospital: A pilot study. *Journal of Pediatric Oncology Nursing*, 34(6), 1–5. <https://doi.org/10.1177/1043454217713452>

Gunaratnam, Y. (2007). Intercultural palliative care: Do we need cultural competence? *International Journal of Palliative Nursing*, 13(10), 470–477. <https://doi.org/10.12968/ijpn.2007.13.10.27477>

Halbwachs, K. (2019). Samozavedanje in kritična refleksija v modelih kulturne kompetentnosti v zdravstvu. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 51–64). Visoka zdravstvena šola v Celju.

Jeffreys, M. R. (2000). Development and psychometric evaluation of the trans-cultural self-efficacy tool: A synthesis of findings. *Journal of Transcultural nursing*, 11(2), 127–136. <https://doi.org/10.1177/104365960001100207>

Jenks, A. C. (2011). From ‘lists of traits’ to ‘open-mindedness’: Emerging issues in cultural competence education. *Culture, Medicine, and Psychiatry*, 35(2), 209–235. <https://doi.org/10.1007/s11013-011-9212-4>

Kirmayer, J. L., Rousseau, C., Jarvis, G. C., & Guzder, J. (2008). The cultural context of clinical assessment. In A. Tasman, J. Kay, J. A. Lieberman, M. B. First, & M. Majeds (Eds.), *Psychiatry* (3rd ed., Vol. 1, pp. 55–65). Wiley. <https://doi.org/10.1002/9780470515167.ch4>

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS Medicine*, 3(10), 1673–1676. <https://doi.org/10.1371/journal.pmed.0030294>

Košmerl, T. (2021). Kombinirani raziskovalni pristopi kot način združevanja kvalitativnih in kvantitativnih metod. *Sodobna pedagogika*, 72(1), 88–107.

Kumaş-Tan, Z, Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine*, 82(6), 548–557. <https://doi.org/10.1097/ACM.0b013e3180555a2d>

Ličen, S., Karnjuš, I., & Prosen, M. (2017). Ensuring equality through the acquisition of cultural competence in nursing education: A systematic literature review. In A. Petelin, N. Šarabon, & B. Žvanut (Eds.), *Health of the working-age population* (pp. 113–121). University of Primorska Press.

Lipovec Čebron, U. (2017). Ko nujno postane nenujno: Raziskovanje zdravstvenih vidikov migracij v Sloveniji. *Glasnik Slovenskega etnološkega društva*, 57(1–2), 54–64.

Lipovec Čebron, U. (2020). Jezikovne in kulturne ovire v zdravstvenih ustanovah. In I. Huber, U. Lipovec Čebron, & S. Pistotnik (Eds.), *Neenakosti in ranljivosti v zdravju v Sloveniji: Kvalitativna raziskava v 25 okoljih* (pp. 120–140). Nacionalni inštitut za javno zdravje.

Lipovec Čebron, U., & Huber, I. (2020). Cultural competence and healthcare: Experiences from Slovenia. *Etnološka tribina*, 50(43), 68–88. <https://doi.org/10.15378/1848-9540.2020.43.02>

Lipovec Čebron, U., Pistotnik, S., Farkaš-Lainščak, J., & Huber, I. (2019). Medkulturne kompetence in zdravstvena oskrba v Sloveniji. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 35–49). Visoka zdravstvena šola v Celju.

Martínez, G. (2010). Language and power in healthcare: Towards a theory of language barriers among linguistic minorities in the United States. In J. L. Watzke, P. C. Miller, & M. Mantero (Eds.), *Readings in Language Studies: Language and Power 2* (pp. 59–74). International Society for Language Studies.

Muaygil, R. A. (2018). From paternalistic to patronizing: How cultural competence can be ethically problematic. *HEC Forum*, 30(1), 13–29. <https://doi.org/10.1007/s10730-017-9336-1>

Napier, D., Anca, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., Jadhav, S., Macdonald, A., Neuendorf, U., Parkhurst, A., Reynolds, R., Scambler, G., Shamdasani, S., Zafer Smith, S., Stougaard-Nielsen, J., Thomson, L., ... Woolf, K. (2014). Culture and Health. *The Lancet*, 384(9954), 1607–1639. [https://doi.org/10.1016/S0140-6736\(14\)61603-2](https://doi.org/10.1016/S0140-6736(14)61603-2)

Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. US Department of Health and Human Services.

Perng, S. J., & Watson, R. (2012). Construct validation of the nurse cultural competence scale: A hierarchy of abilities. *Journal of clinical nursing*, 21(11–12), 1678–1684. <https://doi.org/10.1111/j.1365-2702.2011.03933.x>

Plano Clark, V. L., Creswell, J. W., O’Neil Green, D., & Shope, R. J. (2008). Mixing quantitative and qualitative approaches: An introduction to emergent mixed methods research. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of Emergent Methods* (pp. 363–387). The Guilford Press.

Pulido-Fuentes, M., González, L. A., Vieira Martins, M. F., & Flores Martos, J. A. (2017). Health competence from a transcultural perspective: Knowing how to approach transcultural care. *Procedia – Social and Behavioral Sciences*, 237(21), 365–372. <https://doi.org/10.1016/j.sbspro.2017.02.022>

Purnell, L. (2016). Are we really measuring cultural competence? *Nursing Science Quarterly*, 29(2), 124–127. <https://doi.org/10.1177/0894318416630100>

Razlag Kolar, T., Filej, B., & Kaučič, B. M. (2019). Pomen kulturne kompetentnosti medicinskih sester za kakovostno in k pacientu usmerjeno zdravstveno nego in oskrbo. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 75–95). Visoka zdravstvena šola v Celju.

Schim, S. M., & Doorenbos, A. Z. (2010). A three-dimensional model of cultural congruence: Framework for intervention. *Journal of Social Work in End-of-Life & Palliative Care*, 6(3–4), 256–270. <https://doi.org/10.1080/15524256.2010.529023>

Schim, S. M., Doorenbos, A., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instruments. *Journal of Nursing Measurement*, 11(1), 29–40. <https://doi.org/10.1891/jnum.11.1.29.52062>

Schouler-Ocak, M., Graef-Calliess, I., Tarricone, I., Qureshi, A., Kastrup, M. C., & Bhugra, D. (2015). EPA guidance on cultural competence training. *European Psychiatry*, 30(3), 431–440. <https://doi.org/10.1016/j.eurpsy.2015.01.012>

Shoa-Jen, P., & Watson, R. (2012). Construct validation of the Nurse cultural competence scale: A hierarchy of abilities. *Journal of Clinical Nursing*, 21(11–12), 1678–1684. <https://doi.org/10.1111/j.1365-2702.2011.03933.x>

Smedley, A., Stith, J., & Nelson, A. R. (Eds.). (2003). *Unequal treatment confronting racial and ethnic disparities in health care*. The National Academies Press. <https://doi.org/10.17226/12875>

Sotler, R. (2016). Merjenje kulturnih kompetenc v zdravstvu - uporabnost in zanesljivost. In D. Velikonja Kregar (Ed.), *Celostna obravnava pacienta: Zbornik prispevkov: Mednarodna znanstvena konferenca* (pp. 74–75). Fakulteta za zdravstvene vede Novo mesto.

Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing*, 15(2), 93–102. <https://doi.org/10.1177/1043659603262488>

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117–125. <https://doi.org/10.1353/hpu.2010.0233>

Tulman, L., & Watts, R. J. (2008). Development and testing of the blueprint for integration of cultural competence in the curriculum questionnaire. *Journal of Professional Nursing*, 24(3), 161–166. <https://doi.org/10.1016/j.profnurs.2008.01.006>

Willen, S. S., Bullon, A., & Good, M.-J. D. (2010). Opening up a huge can of worms: Reflections on a “cultural sensitivity” course for psychiatry residents. *Harvard Review of Psychiatry*, 18(4), 247–253. <https://doi.org/10.3109/10673229.2010.493748>

Wilson, L., & Houghtaling, S. (2001). *Report on a study of cultural competence teaching in California medical and dental schools*. University of California San Francisco.