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Investigating the Educational Challenges Related to Cultural Competence Faced by Iraqi Nursing College Students

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Abstract

English for specific purpose is becoming increasingly considerable in various sectors, including medical sectors. Although numerous studies have investigated the effectiveness of such programs o n cultural competence behaviors and client outcomes, limited research has explored professionals' perceptions of cross-cultural educational representations (such as cultural consciousness and cultural competence) and the magnitude to which they and their administrations implement these values in preparation. In light of this gap, this study is directed to investigate the perceptions of healthcare professionals regarding customarily competent care, their involvements with multicultural patients, their own levels of cultural competence, and the degree to which they believe their cultural competencies discourse multicultural encounters. Data for this study are collected from a sample of 56 healthcare professionals affiliated with a Baghdad university in Iraq, representing various healthcare systems. A 19-item questionnaire, consisting of open-ended inquiries and multiple-choice items, is used to gather participants' perspectives and experiences. The majority of participants seem to perceive cross-cultural education primarily from a "cultural awareness" perspective. They emphasize on the importance of possessing practical cultural knowledge, such as understanding norms and customs, and facilitating communication

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through the use of interpreters. The study participants pay little attention to the principles of systemic cross-cultural approaches, such as cultural competence, cultural safety, and addressing issues like racism, power imbalances, and biases ingrained in the majority culture. Additionally, the need for self-reflection and awareness of personal prejudices was rarely acknowledged.

Key Words: **Educational Challenges, Cultural Competence.**

التحقيق في التحديات التربوية المرتبطة بالكفاءة الثقافية التي يواجها الطلبة العراقيين في كلية التمريض

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الـمستخلـص

ان اهمية اللغة الانكليزية للأغراض الخاصة تزداد بشكل متزايد في مختلف القطاعات ، بما في ذلك المجالات الطبية. على الرغم من أن العديد من الدراسات قد بحثت في فعالية مثل هذه البرامج في سلوكيات الكفاءة الثقافية ونتائج العملاء، فقد استكشفت الأبحاث المحدودة تصورات المهنيين للنماذج التعليمية عبر الثقافات (مثل الوعي الثقافي والكفاءة الثقافية) ومدى تطبيقهم ومنظماتهم في الممارسة العملية. في ضوء هذه الفجوة، هدفت هذه الدراسة إلى التحقيق في وجهات نظر المتخصصين في الرعاية الصحية فيما يتعلق بالرعاية المختصة ثقافيًا، وخبراتهم مع المرضى متعددي الثقافات، ومستويات الكفاءة الثقافية الخاصة بهم ، والدرجة التي يعتقدون أن كفاءاتهم الثقافية تعالج التحديات بين الثقافات. تم جمع بيانات هذه الدراسة من عينة من 56 أخصائي رعاية صحية تابعين لجامعة بغداد في العراق ، تمثل أنظمة صحية مختلفة. تم استخدام استبيان مكون من 19 عنصرًا ، يتكون من أسئلة مفتوحة وعناصر متعددة الخيارات ، لجمع وجهات نظر المشاركين وخبراتهم. تم حساب النسب المئوية لاستجابات الاختيار من متعدد لتحليل ملاحظات المشاركين.

أولى المشاركون في الدراسة القليل من الاهتمام لمبادئ النهج المنهجية بين الثقافات ، مثل الكفاءة الثقافية ، والسلامة الثقافية ، ومعالجة قضايا مثل العنصرية ، واختلالات القوة ، والتحيزات المتأصلة في ثقافة الأغلبية. بالإضافة إلى ذلك ، نادرًا ما تم الاعتراف بالحاجة إلى التأمل الذاتي والوعي بالتحيزات الشخصية. تشير هذه النتائج إلى الحاجة إلى تدخلات تعترف بقيمة المناهج القائمة على الوعي الثقافي مع استكشاف فعالية أكثر شمولاً للكفاءة الثقافية ونهج السلامة.

الكلمات الدالة: التحديات التربوية، الكفاءة الثقافية

1. Introduction

A good teacher should have a model of competence and authority that includes professional knowledge (theoretical knowledge, commitment and practical competence), lifelong learning, teacher knowledge, moral characteristics, knowledge about students, their learning problems, knowledge of educational theories and strategies, and knowledge of educational resources.

Cultural competency in advanced education is a valuable preliminary point for schooling, learning, investigation, and management in higher education institutions(Clutton, 2017). Finding the origins of cultural proficiency is not easy. It seems to have appeared in the medical field in the United States in the 1970s. The American variety of cultural competency is born out of children's intellectual health and social services, but African Americans, Latinos, Pacific Islanders, and Native Americans are treated poorly and equity in care has become a problem.(Cross et al., 1989). Furthermore, we need to find models for working effectively with East Asian refugees, who have different patterns of cultural understanding, speak different languages, and have complex social and health needs.

Over the next several decades, practice and research on the concept of cultural competency spread across business, education, and the social sciences. There appears to be a general consensus in the literature that cultural competence is difficult to consistently define (Pecci et al., 11). One report states that there are over 300 interrelated concepts (Leung, Ang, & Tan, 2014) and many instruments that can measure them. However, the most widely cited definition in the scientific community is the one proposed by Cross et al. (1989, p. iv) who define cultural competency as “a set of consistent behaviors, attitudes, and policies that are integrated into and enable the achievement of a system, organization, or profession.”. Cross et al. (1989) emphasize that while efforts to improve cultural competency at the organizational level are an ``ambitious journey,'' the process should not be seen as an obstacle for organizations. The ability to possess institutionalized cultural knowledge to address cultural self-concept, understand the dynamics inherent in cultural interactions, and develop adaptation to diversity (p. v) .

Critically engaging with existing scholarship provides a valuable opportunity to understand the meaning of 'cultural competence' from both theoretical and practical perspectives. Frisbie and O'Donoghue (2018) recommend viewing cultural competency rationally and critically rather than dogmatically, thoughtlessly, or blindly. Similarly, Palmer and Carter (2014) argue that cultural competence is an ongoing endeavor, a process rather than an end state, and requires a lifelong commitment to self-criticism and reflection. . Clutton (2017) believes that the term “cultural competency” is unhelpful because it focuses on culture as a race.

1.1. Statement of the Problem

The research problem is embodied in the fact that Iraqi students face difficulty in coping with the new authentic EFL syllabuses . On the other hand, even teachers whose responsibility is to bridge between the student and the syllabus may face some obstacles in

simplifying the syllabus to be adequate in the eyes of their students. Brown (2007) confirms that it is a difficult duty for a non-native speaking learner to complete a mission of interpreting a curriculum specification into materials and of interpreting materials into operant teaching.

1.2. Aims

The current study aims at finding out to what extent the students of medical colleges face difficulties when studying English.

1.3. Limits

The study is limited to a sample of 56 EFL students in the College of Nursing during the academic year 2022-2023.

1.4. Hypothesis

It is hypothesized that students face a number of difficulties when they study English as non-departmental college students.

1.5. Value

The study is hoped to be significant to teachers of EFL as well as researchers who will conduct future studies concerning ESP and EFL.

2. Theoretical Background

2.1. Educational Challenges

In 2020, the share of foreign residents, including immigrant women, foreign workers, and international students married to local residents, was 4.1% of South Korea's total population (2,146,748 people), up from 1.1% in 2006. . Social culture is developing at a rapid pace. Under these circumstances, foreign residents face a number of difficulties, including migration, adaptation to an unfamiliar environment, childbirth and access to medical facilities. Due to poor working conditions, migrant workers also face health risks when seeking medical treatment. 2] Increasing cultural diversity in communities challenges health systems to provide quality care to patients with different cultural backgrounds and needs to implement health policies accordingly. 3] We pay special attention to the development of our services.

Public health nurses in public health settings such as health centers need to be culturally competent as they are on the front lines of providing culturally diverse public health services to meet the needs of culturally diverse clients. Cultural competency is the capacity to provide operative, safe, and quality care to people from different cultures and is a dynamic process that takes into account different aspects of culture (ibid)

2.2. Cultural competence:

Improving the cultural competency of nursing staff will reduce health care disparities in culturally sensitive care plans and related patient interventions and provide a foundation for comprehensive care. This will increase patient consummation and sureness in health services and quality of life, further improving public health (Palmer. 2014). In an progressively multicultural society, cultural competency of public health nurses is important to provide culturally compatible care, which is the area of cross-cultural nursing

2.3. Cultural Proficiency and Education

Australia's leading university organization, has developed the Aboriginal Cultural Competency Program as a key source of cultural competency leadership and direction in Australia's higher education sector. UA (2011) recommends that universities develop a full range of cultural competency, including research practices, teaching practices, and employment practices, and recognize their role as agents of change in addressing social justice issues. UA describes cultural aptitude as students' and staff's knowledge and considerate of Australian Aboriginal culture, history and existing realities, consciousness of Aboriginal customs and ability to work and function effectively in an Aboriginal environment are consistent with Australian Aboriginal expectations . Skills and ability to think critically, understand cultural constraints, and use unique cultural and professional paradigms.

Developing cultural competency in higher education requires leaders to encourage and guide an organization-wide approach. This includes considering and assessing cultural competency in relation to individual perspectives and practices, management, implementation, policy and strategic initiatives in teaching and learning. “Cultural Competence in Practice.” Decent places for teaching, learning, scholarship, research and occupation” (Taylor et al., 2014). A document that commits to more equitable opportunities and outcomes “Committed to building the capacity of Aboriginal communities” (Taylor et al., 2014).

2.4. Perspective

The notion of culture is a valuable preliminary point, but like cultural capability, it is an elusive concept. Given that the concept of culture is constantly changing and not easily understood, there are always challenges in measuring it along one dimension or using sensible terminology (Wang et al., vol.3). However, discovering the concept of nation can provide a framework for thinking about how culture is used in cultural competency. Additionally, consider how the terms “culture” and “cultivation” are used in conjunction with terms such as “workplace culture” and “organizational culture,” as well as terms related to institutional racism. Cross-cutting concepts of cultural competency include: IC, racism, and related concepts of leadership.

Indigenous knowledge in higher education must expand beyond Indigenous perspectives to all subjects and disciplines where “scholars can themselves compete” (Bradly et al., 2008). Parent (2014) says about his IC: Covers the technical, community, pecuniary, theoretical, transcendent, educational, legal, and administrative elements of specific local cultures around the world. Because tribal knowledge is context-specific and linked to the lived experiences of particular communities, it is dynamic, constantly changing, and reflects adaptation to the environment and society. Tribal knowledge is

therefore not a single body of knowledge, but multidimensional and pluralistic as it spans multiple levels of existence, consciousness and expression.

Indigenous knowledge in the academy requires transformative practices, not only in terms of teaching and learning, but also in the meaning it brings to students' experiences (Martin, 2016). It also demands that the co-creation of cultural spaces where cultures and knowledge can be shared and developed together, achieving a balance between Western awareness systems and local ways of perceptive, being and acting. However, caution must be exercised when incorporating IR into the academy. This process remains problematic, complex and controversial, and it is not sufficient to limit this knowledge to the realms of educational policy, curriculum and legal education (Yasuichi et al., 2016, 2018, 2023; Anisi and Butler, 2019).

3. Data Collection Procedure

The research has employed a combination of qualitative and quantitative methods. The qualitative part utilizes the phenomenological method, while the quantitative part employs a descriptive method using a survey. To gather information in the qualitative phase, a method called data triangulation is employed. Data triangulation involves utilizing various data collection methods, multiple sources of information, analysts' perspectives, and theories to ensure the validity of research findings, as described by(Gal et al. , 2013).

3.1. Participants

The qualitative part of the research involved 56 nursing students from Baghdad University, who are selected using purposive sampling. The data collection method used in this qualitative phase is descriptive phenomenology. The research has continued until theoretical saturation is reached, which served as the criterion for its completion.

For data analysis in the qualitative part, the thematic analysis method is employed. This method can be implemented in various ways, and in this study, the topic network method is utilized. Through this approach, the network of themes extracts the most fundamental level of phenomena from the text, known as basic themes. These basic themes are then categorized and summarized to derive more abstract principles, referred to as organizing themes.

3.2. Procedures

The data collected from the interviews will undergo thematic analysis using a descriptive-interpretive approach. By revisiting and reviewing the interviews, the educational challenges concerning the cultural competencies of nursing students will be identified and formulated. To ensure the validity of the qualitative findings, the alignment method will be employed. This method involves utilizing various data collection methods, multiple sources of information, analysts' perspectives, and relevant theories to validate the research findings (Borg and Gal, 2014).

In this study, the alignment process will be employed to design the qualifications, consisting of three stages: 1) gathering theoretical foundations and fundamental principles related to students' cultural competencies, 2) examining previous research conducted in the field of cultural competencies, and 3) incorporating insights from key informants. To

enhance the qualitative reliability of the initial framework, a reliability test will be conducted.

In the quantitative phase, the research has focused on the statistical population consisting of all nursing students at the University of Baghdad in the second semester of the academic year2023. (according to official university statistics, totaling 854 individuals). Using the Cochran formula, a random sample of 56 students is selected. The sample size is determined based on the relative proportions of each class.

3.3. Instruments

For data collection in the quantitative part, a researcher has developed a questionnaire. The questionnaire's content is derived from the qualitative data and aimes to measure the educational challenges encountered by students on the path for developing cultural competence. It consistes of 26 questions covering four components, general competences, specialized competences, ethical competences, and research competencies. The questionnaire has employed a five-point Likert scale (ranging from "very low" to "very high") for respondents to indicate their agreement, and the corresponding scoring method is from 1 to 5, respectively.

3.4. Data Analysis

The analysis of the research data will be conducted in both qualitative and quantitative parts. In the quantitative section, the data will be analyzed at two levels: descriptive and inferential. At the descriptive level, measures such as, percentages, frequencies, means, and standard deviations will be employed. At the inferential level, statistical tests including Friedman's test, one-sample t-test, one-way analysis of variance (ANOVA), and Tukey's post hoc test will be utilized.

4. Results Analysis and Discussion

Data is obtained from a number of 56 health workers. However, after reviewing the information sheet and consent form, four individuals decide not to participate in the study. Because this study is anonymous, the dissemination of partakers across the intended health care institutions is unknown. The mean age of the included sample is 38.66 years (SD: 12.03, range: 20–65). The majority of participants are female (n = 52, 92.9%). Regarding self-identified race, over 85% of the sample identified as White/Caucasian (n=48), over 8.9% of the sample identified as Hispanic/Latino (n=5) , and over 3.6% of the sample identified as one. specific caste.

Participants identify their occupations as licensed aid /trainee nurse (n = 18, 32.1%), mental health professional (n = 9, 16.1%), and physician assistant (n = 7, 12.5). I have informed about this %) and hospital/clinic administrators (n = 7, 12.5%) , medical receptionist (n = 5, 8.9%) , doctor (n = 3, 5.4%), physical therapist (n = 2, 3.6%) , interpreter (n = 2, 3.6%) , Pharmacists (n = 1, 1.8%) , Community Workers (n = 1, 1.8%) , Clinical Laboratory Technicians (n = 1, 1.8%). .

Regarding years of acquaintance in the current business, 26.8% (n = 15) of the sample have more than 20 years of experience in their current business, and 23.2% (n = 13) have

more than 11 years in their current business. Have more experience. 21.4% (n = 12) reported 5 to 10 years of experience, and 28.6% (n = 16) reported less than 5 years of experience.

Overall, most participants fully understand the importance of cultural factors in providing optimal health care, and emphasize the need for professionals to gain knowledge of different cultural groups. This has been proven. However, our view is whether organizations should increase efforts to meet the needs of diverse clients and adopt culturally sensitive approaches to health (such as traditional healers and spiritual healers

Participants are asked how they would rate the cultural competency of employees from different cultural backgrounds. As a result, 39.3% (n = 22) of the sample believe that employee diversity is "very important" and 28.6% (n = 16) think that it is "important" . Additionally, 12.5% (n = 7) of respondents believe that workforce diversity is somewhat important, 17.9% (n = 10) consider it somewhat important, and 1.8% (n = 1) not at all I think it's not important. It is only 3 (5.4%) of the participants who did not answer this question.

Table 2 shows the participants' perceptions of their experience and competence in the field of intercultural awareness. Healthcare providers acknowledged that they often treat patients of different nationalities and expressed a willingness to accommodate their needs. However, many also recognize that treating and interacting with patients from cultures different from their own can be difficult and come in varying degrees of complexity.

Approximately 40% (n = 23) of participants believe that their cultural background often causes discomfort in patients from other cultures, and one-fifth (n = 12), they believed it could cause anxiety and tension in patients of color. Participants are also asked to rate their satisfaction with their level of intercultural knowledge. Less than 15% (n = 8) say they are "very satisfied," 64.3% (n = 36) say they are "satisfied," and 16.1% (n = 9) say they are neither satisfied nor satisfied. Some participants 3.6% (n=2) express dissatisfaction. Remarkably, none of the participants expresses ``extreme dissatisfaction" with their level of intercultural knowledge.

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Table 2 ***Cross-Cultural Discernments of Health Professionals (Always – Never)***

Health care provider questions	Always % (*n*)	Often	Sometimes	Rarely	Never
Do you feel that you attend to the cultural n of patients from different cultural .backgrou	39.3 (22)	55.4 (3	5.4 (3)	–	–
How often do you treat patients of color?	80.04 (45	16.1 (9	3.6 (2)	–	–
Is it more difficult to engage with/treat pe from a different culture to your own?	–	21.4 (1	62.5 (35)	14.3 (8)	1.8 (1)
Do you think your cultural background m some patients from different cul backgrounds uncomfortable?	1.8 (1)	39.3 (2	–	41.1 (23	17.9 (1
Do you think that some patients of color anxious/nervous around you during treatme	–	1.8 (1)	19.6 (11)	42.9 (24	35.7 (2

1. *n = 56*

As a result of this study, the research leader has completed an investigation of the impact of cultural competence adjustment during the academic period and the relation among intercultural self-efficacy in addition to cultural competence.

The results are expressed as a need for high levels of cultural self-efficacy and higher levels of education and a strong cultural competence for public health nurses. Furthermore, there is also a relationship between demand, cultural competence, education, regulation, intercultural self-efficacy and the cultural competence.

According to the standard of cultural competency, this research compares the average cultural competence gains and the highest gains in use. For example, during a study by Sook et al.2010) they use the Korean modified version of the Cultural Awareness Table to measure the cultural competence of Korean barristers by 61.8% (3.09 per 5 points).

In addition, the cultural competence of medical personnel in the Korean medical treatment table was 53.8% (2.69 minutes out of 5 minutes), and the results of our research (59.4%) are similar. However, the cultural competence of Korean public health nurses is lower than that in other countries.

5. Conclusions

To improve intercultural competence, intercultural self-efficacy needs to be improved, and intercultural competence can surely be strengthened through intercultural education . Depending on the gained results of this survey, it is necessary not only to implement cultural competency training, but also to actively understand the cultural competency training needs of public health nurses, etc., and try to improve the cultural competency of the entire population. Increased self-efficacy is considered desirable. This will help in improving your cultural competency. Finally, although this study does not directly address this issue, future research could examine the impact of motivations related to intercultural competence development on intercultural self-efficacy and intercultural competence.

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