Malta – An Ever-Shifting Cultural Kaleidoscope: Exploring Cultural Competence in Doctors Working in Primary Health Care

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Dedicated to the one who embarked on this journey,

persevered through every chapter,

and brought it to completion with quiet determination

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Abstract

The increasing cultural diversity within populations presents healthcare systems with the challenge of delivering culturally sensitive care. Although cultural competence is widely recognised as essential, its consistent integration into practice remains limited. This study assessed the cultural competence of family medicine specialists in Malta's Primary Health Care system, across both public and private sectors, by examining individual competencies and organisational strategies promoted by healthcare leaders.

Guided by a pragmatic philosophy and an abductive research strategy, the study employed a concurrent mixed-methods design. Quantitative data were collected using the validated Healthcare Provider Cultural Competence Instrument (HPCCI) via an online survey sent to all eligible family medicine specialists. A total of 41 responses were received from 240 invited MMCFD members, yielding a response rate of 17.1%. Qualitative insights were drawn from seven semi-structured interviews with healthcare leaders and policy-makers from various roles within Primary Health Care.

Findings revealed a gap between cultural awareness and its application. While most respondents acknowledged its importance, only 12.2% had received formal training. Younger and less experienced doctors scored higher in awareness and self-assessment, and willingness to engage in training was linked to more culturally responsive behaviours. Although the response rate was low, the findings align with existing literature, supporting their validity.

Thematic analysis identified four core themes – *Beyond the Textbook, Beyond Barriers, Beyond the White Coat,* and *Beyond the Present* – highlighting conceptual

inconsistencies, systemic barriers, emotional strain, and strong support for formal training.

The study emphasises the need for longitudinal training, integration of culturally responsive practices into clinical routines, and policy reform to strengthen cultural competence in Malta's evolving healthcare landscape.

Keywords: Cultural Competence; Primary Health Care; Malta, Barriers; Mixed-Methods Research

Contents

List of Tables

List of Figures

Abbreviations

ACT	Activate consciousness, Connect relations, Transform to true cultural care (ACT Cultural Competence Model)
ANOVA	Analysis of Variance
CPD	Continuing Professional Development
df	Degrees of Freedom
EU	European Union
GAP	Global Action Plan (WHO)
GP	General Practitioner
HPCCI	Healthcare Provider Cultural Competence Instrument
M	Mean
MIPEX	Migrant Integration Policy Index
MMCFD	Malta College of Family Doctors
PHC	Primary Health Care
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

Chapter 1: Introduction

1.1. Overview of Cultural Diversity

From the mists of time, humankind migrated from one place to another in pursuit of a better life. Migration within one's country of birth continues to be the prevailing norm. However, over the last fifty years, the estimated number of international migrants has risen significantly (McAuliffe & Oucho, 2024).

In light of these demographic shifts, cultural diversity within populations is on the rise. In 2001, the Universal Declaration on Cultural Diversity, regarded cultural diversity as being "a source of exchange, innovation and creativity" which "is as necessary for humankind as biodiversity is for nature" (Stenou, 2002, p. 2). The global valuing of diversity aligns with the call for a more culturally competent workforce, a concept which began gaining traction in the late twentieth century.

True cultural competence requires recognising the multidimensional nature of culture. Culture is not a fixed or uniform construct. It is a complex and dynamic interplay of attitudes, values, and behaviours that vary not just between groups but within them. Within a single ethnic group, factors like age, gender, political views, or personal experiences can create significant differences in how culture is expressed or understood. Hence cultural competence is not about applying a one-size-fits-all framework but about cultivating the ability to engage respectfully and effectively with the diversity that exists both between and within cultural groups (Taylan & Weber, 2023).

The need for a more culturally congruent care, traces its origin to pioneers like Madeleine Leininger, who emphasized the need for healthcare providers to adapt their practices to meet the cultural needs of the patients (Busher Betancourt, 2015).

The concept of cultural competence was then formally established by Cross et al. (1989), who provided a roadmap for professionals to enhance service delivery to a widening spectrum of diverse communities.

Over the past three decades, the concept of cultural competence has evolved. However, the definition formulated by Cross et al. (1989), remains relevant as it targets not only institutions and policymakers but also the patients. According to Cross et al. (1989), “Cultural and linguistic competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations”.

This definition emphasizes a multifaceted approach, acknowledging that cultural competence is not merely an individual trait, but a systemic characteristic achieved through the alignment of behaviours, attitudes, and policies. It underscores the need for healthcare systems to be actively engaged in fostering an environment that respects diversity and facilitates effective communication across cultures (Cross et al., 1989).

1.2. Problem Statement

The increasing cultural diversification of societies underscores the importance of cultural competence in different sectors, particularly in healthcare. Despite its recognition as a key element in addressing diverse populations, the extent of incorporation of cultural competence into healthcare practices remains inconsistent. This disparity between the growing cultural diversity and the preparedness of healthcare professionals in delivering such care highlights a pressing issue for health and healthcare systems. A key factor contributing to this

issue is the inadequate emphasis on cultural competence training in education and practice. Despite its increasing recognition, cultural competence training within both undergraduate and postgraduate curricula remains scant. Research consistently shows that there is a deficiency in cultural competence training in medical education programmes (Constantinou et al., 2022; Hudelson et al., 2016; Sorensen et al., 2019).

This deficiency in culturally competent care can have profound consequences. Firstly, it can lead to miscommunication and misunderstandings between patients and providers, potentially resulting in misdiagnosis, non-adherence to treatment plans, and suboptimal health outcomes. Furthermore, a lack of cultural understanding can contribute to implicit bias and stereotyping, which can influence clinical decision-making and create barriers to equitable care. This can manifest in the form of health disparities, where certain populations experience poorer health outcomes and reduced access to care due to their cultural background. Ultimately, inadequate cultural competence can erode patient trust and satisfaction, leading to disengagement from the healthcare system and further exacerbating existing inequalities (Shen et al., 2018; Taylan & Weber, 2023). Addressing this gap is crucial not only for improving individual patient care but also for promoting health equity and social justice within our increasingly diverse societies.

Globally, research and implementation of cultural competence in healthcare vary widely. Countries such as Canada and Australia have developed robust frameworks and integrated cultural competence extensively into healthcare education and policy. In contrast, smaller or less diverse nations like Cyprus and Luxembourg have produced relatively limited research and show minimal integration in practice. In

the Maltese context, research specifically examining the extent of cultural competence integration and its impact remains scarce. While Malta has experienced a significant increase in cultural diversity in recent years due to migration and globalisation, there is a lack of studies investigating the specific cultural needs of diverse patient populations in Malta and the preparedness of healthcare professionals to address these needs. This gap in research not only obstructs the development of targeted interventions and policies to enhance cultural competence within the Maltese healthcare system, but also impedes the accurate measurement and representation of the current state, both as a static overview and as a trajectory of change over time. This situation justifies the pursuit of the need to urgently investigate the current state of cultural competence training and practice in Malta, identify existing barriers and challenges, and develop evidence-based strategies to promote culturally sensitive and equitable healthcare for all residents.

1.3. Context

In 2020, 281 million migrants, equating to 3.6 percent of the global population, lived outside their native country (McAuliffe & Oucho, 2024). These diverse populations bring with them a rich tapestry of cultural beliefs, values, and practices related to health and wellbeing, requiring healthcare systems to adapt and provide culturally sensitive care. This need is echoed in international guidelines, such as the World Health Organization's (WHO) most recent initiative, the WHO *Global action plan: promoting the health or refugees and migrants* (GAP). The GAP, launched in 2019, underscores the critical need to address the health challenges faced by refugees

and migrants and aims to promote their inclusion within national health and healthcare systems. It underscores the necessity of culturally sensitive care as a cornerstone of inclusive and effective health systems, ultimately improving health outcomes for all individuals (WHO, 2024).

When examining matters within Europe in 2020, a similar upward trend in international migration is noted, with an increase of nearly 16 percent since 2015 (McAuliffe & Oucho, 2024). This surge in migration has heightened the need for culturally competent healthcare systems across the continent. The European Commission has acknowledged this imperative and actively encourages Member States to prioritise culturally sensitive healthcare services. For instance, the EU Action Plan on Integration and Inclusion promotes initiatives aimed at addressing health inequalities among migrant populations and ensuring equitable access to quality care for all residents, regardless of their cultural background (European Commission, 2020). Furthermore, the ongoing Migrant Integration Policy Index (MIPEX) provides a comprehensive framework for assessing and comparing integration policies across different countries, including those related to healthcare access and cultural sensitivity (Solano & Huddleston, 2020). The latest EU Global Health Strategy also emphasizes the importance of cultural competence in reducing health disparities and promoting social inclusion (European Commission, 2022).

This focus on cultural competence is particularly relevant in Malta, an island nation situated in the middle of the Mediterranean Sea. Historically, Malta's strategic location has made it a central point for migration and cultural exchange. In recent decades, the country has undergone a rapid transformation from a conservative, traditional society to a more liberal, multi-ethnic, and multicultural one, fuelled by

its booming economy and increasing global connectivity. In 2022, Malta recorded the highest rate of immigration relative to the resident population, among EU member states, with almost 66 immigrants per 1000 persons. Eurostat estimates that of the 35,000 immigrants who arrived in Malta in 2022, 76.8% were from countries that are not part of the European union (Eurostat, 2024). A significant challenge associated with multiculturalism in Malta is the rapid pace at which it has developed. This rapid transformation is reflected in the limited number of initiatives and policies designed to support multiculturalism in Malta. While some strategies have been introduced, they remain relatively scarce in comparison to the growing needs of a diverse population. One notable example is the National Mental Health Strategy, which recognises the importance of addressing the unique challenges faced by individuals from different cultural backgrounds (Ministry for Health, 2019). However, broader, more comprehensive policies that integrate multiculturalism into healthcare and social services are still needed to foster inclusivity and ensure equitable access for all residents.

1.4. Aims and Objectives

This research aims to examine the cultural competence of family medicine specialists operating in Malta's Primary Health Care (PHC) system, encompassing both public and private service provision. The research is structured to investigate cultural competence on two levels: the individual level, focusing on the cultural awareness, knowledge, attitudes, and practices of PHC doctors, and the organisational level, exploring the perspectives and strategies of healthcare leaders in fostering cultural competence within their institutions. By targeting these two

layers, the study seeks to provide a comprehensive understanding of how and to what extent cultural competence is integrated in the Maltese PHC sector.

Specifically, the objectives for this research are to:

1. Explore the cultural knowledge, beliefs, and behaviours of PHC doctors during their interactions with patients;
2. Identify the primary care doctors' strengths and shortcomings in cultural competence;
3. Establish the level of cultural competence at the healthcare organisation level;
4. Make recommendations for implementing multicultural training for PHC doctors.

Furthermore, this research will identify potential gaps and challenges in providing culturally sensitive care, ultimately contributing to the development of targeted interventions to enhance healthcare equity and inclusivity for all residents of Malta.

1.5. Research Question

Building on the objectives outlined in the previous section, this study seeks to answer the following central research question:

"How does the perceived cultural competence of individual PHC doctors in Malta intersect with the cultural competence of their healthcare organisations?"

This question aims to bridge the two levels of analysis − individual doctors and healthcare organisations − by investigating the relationship between the cultural competence of doctors and the organisational practices designed to address cultural competence.

1.6. Significance

The significance of this study lies in its potential to address a critical gap in understanding how cultural competence is understood and practiced within the Maltese PHC system. As immigration reshapes Malta's cultural landscape and demographic, it is essential for healthcare professionals to be ready to meet the unique needs of patients from diverse cultural backgrounds. This research is significant as it will help assess the current state of cultural competence among medical specialists in family medicine and explore how healthcare organisations in Malta support and encourage these competencies.

Additionally, the study will generate evidence-based recommendations for more effective training for doctors within PHC, which will help reduce health disparities and ensure everyone receives the best possible care.

Lastly, the research has broader implications beyond PHC in Malta. It offers a model for how cultural competence can be assessed and strengthened across different medical specialties within the Maltese healthcare system. These findings can also be adapted and applied in other countries facing similar challenges related to cultural diversity in healthcare. Ultimately, this study is poised to advance the goal of equitable healthcare access for all.

1.7. Overview of Chapters

This dissertation is structured to provide a comprehensive exploration of cultural competence within Malta's PHC sector. The chapters of this dissertation are designed to guide the reader seamlessly through the research journey. Chapter 2 provides an in-depth exploration of the existing literature on cultural competence in

healthcare examining its key concepts, theoretical frameworks, and practical applications. Furthermore, this chapter delves into the crucial role of cultural competence in achieving health equity. Chapter 3 details the study's methodology, including its mixed-methods design, research tools, and ethical considerations. In Chapter 4, the core findings drawn from both the quantitative and qualitative phases of the research are presented. Chapter 5 analyses the study's findings and connects them to existing research. Lastly, Chapter 6 concludes the dissertation by synthesising the key findings of the research and presenting evidence-based recommendations to improve healthcare practice, inform policy development, and guide future research in this area. This chapter serves as a roadmap for enhancing cultural competence and promoting health equity within the Maltese healthcare system.

Chapter 2: Literature Review

2.1. Introduction

The initial chapter introduced the central research question: "How does the perceived cultural competence of individual PHC doctors in Malta intersect with the cultural competence of their healthcare organisations?" This chapter aims to examine existing research relevant to this question.

This review synthesizes existing literature on cultural competence in PHC, highlighting current understanding, identifying research gaps, and informing both the study's methodology and future research.

2.2. Theoretical Frameworks and Models of Cultural Competence

While the term "cultural competence" has faced multiple definitional challenges owing to its inherent complexity, it is generally understood as the ability to effectively deliver healthcare that is respectful and appropriate for diverse populations. This understanding encompasses awareness, positive attitudes, relevant knowledge, and skills necessary to provide culturally sensitive healthcare services. The reason for these definitional ambiguities stems from the apparent opposition between the concepts of "competence" and "culture." "Competence" often implies a fixed and specific skillset, while "culture" is recognised as a constantly evolving concept. This inherent tension creates confusion regarding how these two distinct notions can be integrated into a single, cohesive concept like "cultural competence" (Li et al., 2023). Hence for the purpose of this study, we adopt “cultural competence” as an overarching framework, recognising its

importance in highlighting healthcare professionals' ability to deliver optimal care while promoting cultural changes.

The seminal framework established by Cross et al. (1989) has had a profound effect in the development of numerous cultural frameworks and models along the years. These models provide a theoretical foundation for the development of tools to evaluate and strengthen cultural competence in healthcare settings.

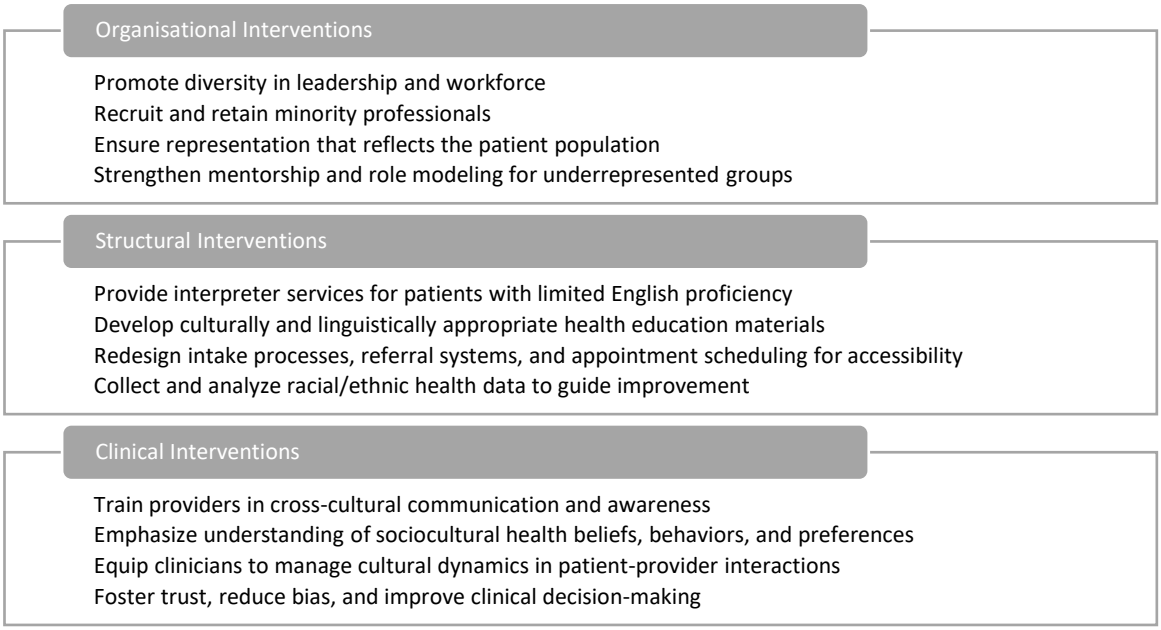
Three prominent models developed along the years are the Campinha-Bacote's Model of Cultural Competence (1998), Betancourt et al.'s (2002) Framework for Cultural Competence and the more recent ACT Cultural Competence Model (2016). Focusing on the Campinha-Bacote model, a key aspect is its emphasis on viewing cultural competence as a dynamic and evolving process for self-improvement. This process necessitates integrating the five core elements, namely cultural awareness, knowledge, skill, encounters, and desire. These constructs are intricately intertwined, and all constructs must be addressed and/or experienced, irrespective of when the healthcare provider embarks on the process. Emphasizing any of these constructs can positively influence the others, enhancing overall balance (Campinha-Bacote, 2002).

Betancourt et al. (2003) broadened our understanding of cultural competence by placing it within a larger view of how healthcare systems operate. This framework emphasizes that tackling ethnic inequalities, necessitates action not only in clinical settings but also within the broader organisational and structural aspects of the healthcare system. This framework groups interventions into organisational, structural, and clinical layers, underscoring the need for a systemic response

(Betancourt et al., 2003). Figure 2.1 illustrates these interventions targeting racial and ethnic health disparities.

Figure 2.1: *Multi-Level Framework for Cultural Competence in Healthcare*

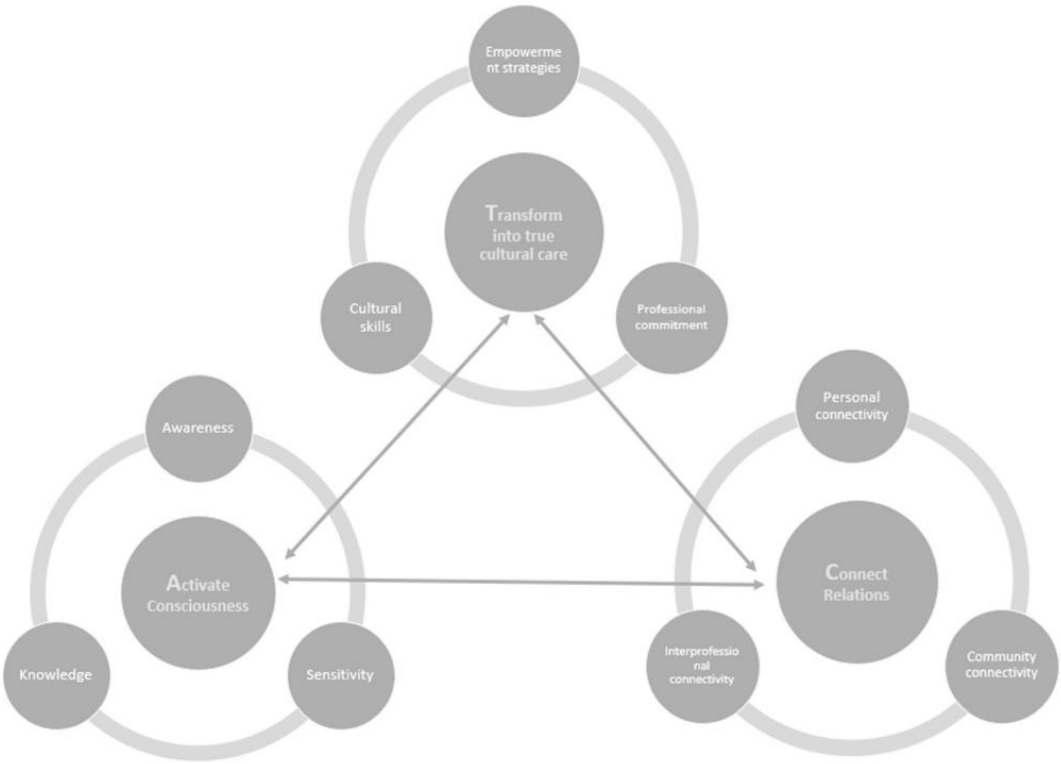
SOURCE: Adapted from Betancourt et al. (2003)



The third framework, the ACT Cultural Model, is distinguished by its action-oriented and transformative approach to cultural competence, as illustrated in Figure 2.2. ACT stands for activate consciousness, connect relations, and transform to true cultural care. This model bridges the gap between individual and organisational levels. It views cultural competence as dynamic, requiring the challenge of ingrained assumptions and classification systems used to label social groups. Furthermore, the ACT framework provides practical implications and recommendations for each of its three components (Li et al., 2023).

Figure 2.2: *The ACT Cultural Model*

SOURCE: Reprinted from Li et al. (2023)



Despite differing approaches, all three frameworks share core goals: delivering inclusive, culturally appropriate care through continuous learning, self-reflection, and adaptation. They reject a 'one-size-fits-all' model, emphasize action beyond knowledge, and promote a multilevel, dynamic approach to cultural competence (Betancourt et al., 2003; Campinha-Bacote, 2002; Li et al., 2023).

2.3. Method for the Literature Search

2.3.1. Systematic Review Method:

2.3.1.1. Literature Search Strategy

A preliminary literature search was conducted using selected keywords and predefined inclusion and exclusion criteria, along with their rationale, as summarised in Table 2.1.

Table 2.1: *Eligibility Criteria and Rationale for Study Selection*

Criteria	**Inclusion Criteria**	**Exclusion Criteria**	**Rationale**
Population	Studies that explicitly include specialists in family medicine, healthcare administrators, or leaders, even if other specialties are also included	Studies that do not include family medicine specialists	Relevance to the research question and objectives of this study
Context	Studies conducted in Malta, Cyprus, Luxembourg, Singapore, Canada, or Australia	Studies from other countries	Countries were selected for their strategic location, size, and cultural context: Malta and Cyprus (small Mediterranean islands), Luxembourg and Singapore (small but strategic states), and Australia and Canada (larger, resource-rich for comparison)

(Table continues)

Criteria	Inclusion Criteria	Exclusion Criteria	Rationale
Study design	Peer reviewed scholarly articles	Non-peer-reviewed articles, editorials, commentaries, books, or conference reports	Peer-reviewed articles provide research grounded in evidence
Publication	Articles written in the English-language	Articles written in another language (non-English)	Ensures clarity, and accessibility for analysis
	Studies published between 2009 and December 2024	Studies published before January 2009	Reflects period of increased migration in Malta and ensures current, relevant literature
Accessibility	Full-text articles	Articles without accessibility to the full text	Ensures full evaluation of study quality and relevance

2.3.1.2. Databases and Information Sources

For this literature review, the selected databases were PubMed, Scopus, PsycINFO (EBSCO), and Cochrane. Access to the databases mentioned above was gained through HyDi. HyDi is the online library of the University of Malta.

2.3.1.3. Search Strategy and Key Concepts

A refined search strategy was developed using the specified databases. The strategy centred on four key concepts, with keywords for each subtheme combined using Boolean operators to identify relevant articles. Table 2.2 provides an overview of the subthemes and keywords used.

Table 2.2: *Search Terms by Subtheme*

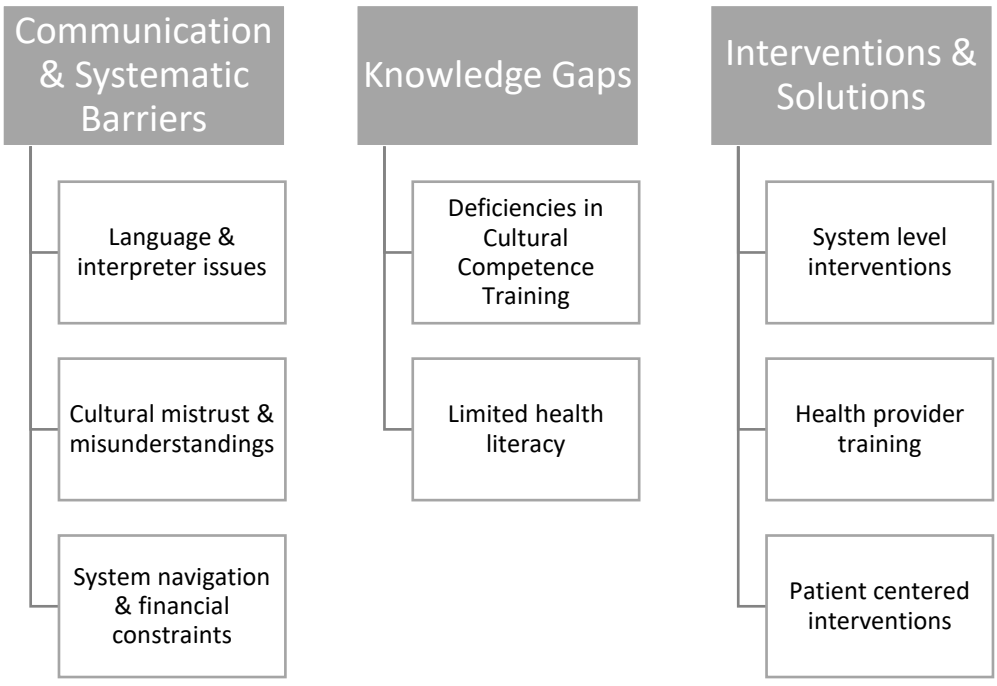
Subtheme	**Search Terms**
Migration & Diversity in Healthcare	("migrant health" OR "immigrant health" OR "refugee health") AND ("health disparities" OR "health equity" OR "healthy migrant effect") AND ("Malta" OR "Cyprus" OR "Luxembourg" OR "Singapore" OR "Canada" OR "Australia")
General Cultural Competence in Primary Health Care	("cultural competence" OR "cultural competency" OR "cultural sensitivity" OR "diversity responsiveness") AND ("primary health care" OR "family medicine" OR "general practice" OR "primary care doctors") AND ("Malta" OR "Cyprus" OR "Luxembourg" OR "Singapore" OR "Canada" OR "Australia")
Organisational Cultural Competence	("organisational cultural competence" OR "multicultural healthcare policies") AND ("healthcare organisations" OR "primary health care")
Training for Healthcare Professionals	("cultural competence training" OR "multicultural training" OR "cross-cultural training") AND ("primary health care" OR "general practice" OR "family medicine") AND ("Malta" OR "Cyprus" OR "Luxembourg" OR "Singapore" OR "Canada" OR "Australia")

The literature search was carried out throughout January 2025. This review adhered to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Moher et al., 2009).

2.3.1.4. Establishing Relationships Between Studies

To facilitate conceptualisation of the interrelations among extracted studies, Noblit and Hare (1988) suggested creating "a list of key metaphors, phrases, ideas and/or concepts used in each account, and to juxtapose them" (Noblit & Hare, 1998, p28). For this stage, an Excel sheet was tabulated and information was extracted from the articles. A structured coding framework was then developed to compare the findings. For a detailed breakdown of the coding system, please refer to Appendix A. This framework ensures a clear thematic organisation, facilitating a more comprehensive interpretation of the data. The distinct themes within this framework are visually represented in Figure 2.3.

Figure 2.3: *Visual Representation of Distinct Themes*



2.3.1.5. Expanding the Search Scope

The initial search yielded results that concentrated on studies from Australia and Canada, revealing a significant gap in research from other relevant regions. To

address this interlude, a targeted search was conducted to gather data from Malta, Cyprus, Luxembourg, and Singapore. The search was conducted using HyDi, governmental websites, international sources, and Google Scholar. Search terms such as healthcare, cultural competence, migrants, Malta, Cyprus, Luxembourg, and Singapore were used, and documents not written in the English language was the only exclusion criteria used.

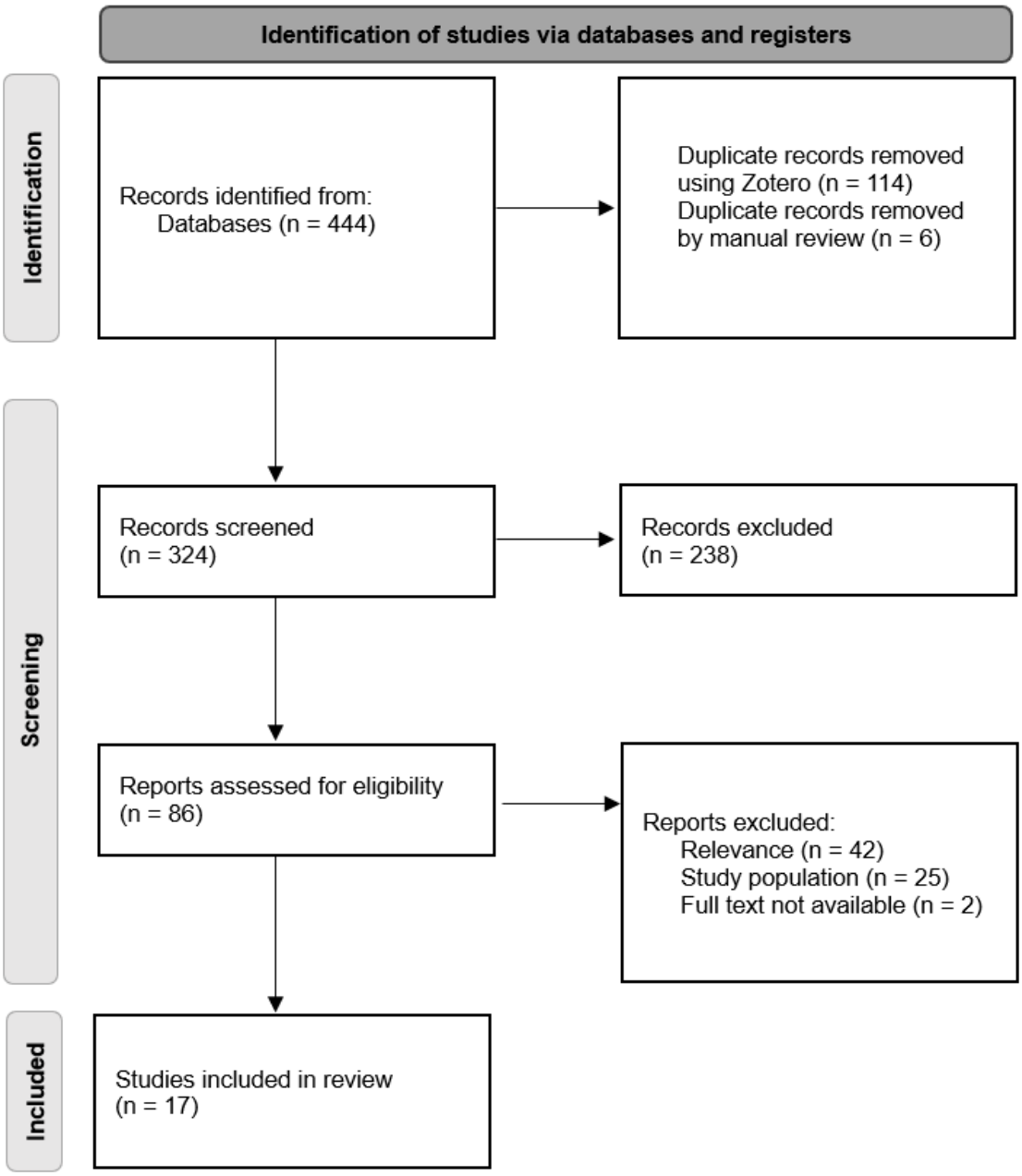
This expanded search strategy, incorporating diverse sources such as academic databases, government websites, and grey literature, facilitated a more comprehensive understanding of migrant healthcare and integration policies, particularly within the Maltese context.

2.4. Results

2.4.1. Systematic Review Results

As depicted in the PRISMA flowchart (Moher et al., 2009), in Figure 2.4, the systematic review of four databases resulted in the retrieval of 444 articles. The search results were exported to Zotero, an open-source reference management tool used for organising research sources. Duplicate records were then identified and removed. The automated process identified 114 duplicate articles. A further 6 duplicates were identified through manual review. The remaining articles underwent title and abstract review, with 86 articles being eligible to full-text review. Of these, 17 articles fulfilled all the inclusion criteria for the final review.

Figure 2.4: *PRISMA Flow Diagram: Systematic Review Process*



The 17 articles were published between 2013 and 2024. Of these, 13 studies were conducted in Australia and 4 in Canada. No studies originating from Malta, Cyprus, Luxembourg, or Singapore were identified. The methodological approaches of the 17 included studies varied: 10 employed qualitative research methods, 4 used a mixed methodology approach, and 3 adopted quantitative methods.

Appendix B presents a table of the included articles, detailing the author(s), publication date, journal, study type, and research aim.

2.4.2. Expanded Literature Search Results

The extended literature search resulted in 16 additional sources that included: 5 journal articles, 3 websites, 2 dissertations, 2 government and 1 non-governmental organisational report, and 1 official guideline. 11 of these sources originated from Malta and 3 in Cyprus, with additional 2 comparative reports covering multiple countries. No relevant studies were found from Luxembourg and Singapore that were written in the English language.

2.5. Discussion

The aim of this literature review is to examine how cultural competence is understood, implemented, and challenged within PHC settings. To support this aim, the discussion is structured into two distinct sections: the systematic literature review and the extended literature search.

This division reflects the different methodologies of each component. The systematic review integrates evidence derived from meticulously selected studies, underscoring key themes such as the importance of cultural competence in PHC, interpersonal and structural barriers, gaps in cultural competency training, and multi-level interventions. The extended literature search complements these findings by offering contextual insights from the selected countries, focusing on PHC structures, national strategies, barriers, and training practices.

2.5.1. Systematic Review Discussion

2.5.1.1. The Role of Cultural Competence in Primary Health Care

PHC often serves as the initial point of contact for patients and, hence, ensuring accessible, equitable, and high-quality service is of paramount importance within the healthcare domain.

2.5.1.1.1. Importance of Cultural Competence

The reviewed studies highlight the essential role of cultural competence, noting its influence on both providers and patients in improving care delivery and outcomes. For healthcare providers, cultural competence is key to delivering high-quality, culturally appropriate care. Its absence can create discomfort or perceived threats when interacting with diverse populations. A study by Smith et al. (2017) substantiates that those providers confident in cultural competence tend to acknowledge cultural diversity, which in turn fosters cultural safety. This ensures that patients feel respected and empowered during clinical encounters. Additionally, culturally competent providers are better equipped to address health and manage disparities (Watt et al., 2016).

Sundareswaran et al. (2024) caution against relying on knee-jerk reactions when tackling the multifaceted issues of healthcare access, advocating instead for more structured care models for both staff and especially newcomers. These structure models are particularly crucial for immigrants experiencing several barriers to healthcare such as communication barriers, and financial limitations along systematic and structural hurdles. Consequently, the adoption of such models is posited as contributing to the provision of quality healthcare, enhanced

effectiveness of care delivery, and the mitigation of health disparities (Alzaye et al., 2019; Farley et al., 2014; Ofosu et al., 2023; Sundareswaran et al., 2024).

Cultural competence plays a vital role in managing chronic conditions such as diabetes, obesity, and asthma, among minority groups. It is critical for addressing root causes of inequities when managing diabetic patients to ensure tailored interventions and effective care (Ofosu et al., 2023). Similarly, addressing disparities in asthma care, requires culturally sensitive approaches addressing the many barriers' immigrants face when accessing the healthcare system (Alzaye et al., 2019).

In conclusion, cultural competence is not merely a desirable attribute but a fundamental necessity.

2.5.1.2. Interpersonal Barriers to Cultural Competence in Primary Health Care

The pursuit of cultural competence in healthcare is an ongoing challenge due to a number of identified barriers. Two overarching themes found in this literature review are language and communication barriers along cultural misunderstanding and trust issues. These interpersonal barriers impact the provider-patient interaction and, as a result, healthcare outcomes.

2.5.1.2.1. Language and Communication Barriers

Effective communication between the healthcare provider and the patients is an essential pillar in PHC. However, communication is hindered not only by language incongruence but also by the influence of cultural factors (Farley et al., 2014).

Being unable to understand, speak, read, or write in English, can negatively impact healthcare on various levels, from the scheduling of appointments, to communication with the healthcare provider, to compliance and adherence to management plans (Alzaye et al., 2019; Cheng et al., 2015; Davidson et al., 2024; Dolan et al., 2020; Farley et al., 2014; Kay et al., 2016; Singh, R. et al., 2023; Sundareswaran et al., 2024). GPs face challenges educating patients with limited English proficiency on early medical abortion, with informed consent hindered by poor comprehension and a lack of multilingual resources (Singh et al., 2017). The lack of multilingual and culturally appropriate educational material, was also highlighted in a study on diabetes and obesity (Ofosu et al., 2023). Alzaye et al. (2019) reinforces the detrimental effect of language barriers in managing chronic conditions, specifically in asthmatic patients. As a result of language barriers, asthmatic patients tend to have a higher number of visits to the emergency department and an overall poorer asthmatic control (Alzaye et al., 2019).

Moreover, the literature presents divergent perspectives on interpreter use in PHC, noting reliance on both formal medical interpreters and informal support from family members (Alzaye et al., 2019; Duncan et al., 2013; Farley et al., 2014; Ofosu et al., 2023; Singh, B. et al., 2017; Watt et al., 2016).

The role of interpreters is often considered a double-edged sword. While formal interpreters are deemed essential by some GPs for an accurate medical translation, GPs recognise the limitations of these staff. GPs express concerns about interpreter bias and inconsistent translation quality (Alzaye et al., 2019). Informal interpreters, often family members, are used due to limited awareness of formal services and convenience. However, this can lead to inaccuracies, reduced patient autonomy,

and confidentiality issues (Alzaye et al., 2019; Duncan et al., 2013; Farley et al., 2014; Ofosu et al., 2023; Singh, B. et al., 2017; Watt et al., 2016).

2.5.1.2.2. Cultural Misunderstandings and Trust Issues

Western person-centred care models often clash with the cultural expectations of patients from different cultural backgrounds (Duncan et al., 2013; Kay et al., 2016; Sundareswaran et al., 2024; Watt et al., 2016). Sundareswaran et al. (2024) found that new migrants often assume that health systems operate similarly to those in their native country. Studies suggest that Aboriginal and Culturally and Linguistically Diverse (CALD) patients' preference for traditional medicine can conflict with providers' Western approaches, particularly when such practices are dismissed. This may lead to patient mistrust and misinterpretations of medical advice (Alzaye et al., 2019; Smith et al., 2017). This issue is further compounded by stigma surrounding certain conditions such as mental health, sexual health, and early medical abortion, erecting barriers to necessary care (Davidson et al., 2024; Singh, R. et al., 2023; Sundareswaran et al., 2024).

Patients who lack trust in the healthcare system often delay seeking medical assistance, changes GPs more frequently and in some cases disengage from formal healthcare services altogether. These patterns have been widely observed across multiple studies (Alzaye et al., 2019; Ofosu et al., 2023). The success of PHC services hinges on acquiring trust and building rapport between the provider and the patients (Alzaye et al., 2019; Ofosu et al., 2023; Singh, B. et al., 2017; Smith et al., 2017; Watt et al., 2016).

To bridge this gap, experts recommend integrating cultural competency training, prioritising community-based approaches and patient centred communication (Duncan et al., 2013; Kay et al., 2016; Liaw et al., 2015; Sundareswaran et al., 2024).

2.5.1.3. Systemic and Structural Barriers to Cultural Competence

Beyond language barriers and mistrust, broader systemic and structural factors further hinder cultural competence in PHC. This section examines these obstacles, grouped into two key categories: challenges related to system navigation and health literacy among foreign patients, and practical constraints such as limited consultation time, financial barriers, and policy-related issues affecting access and quality of care.

2.5.1.3.1. System Navigation and Health Literacy Barriers for Foreign Patients

Accessing and navigating healthcare systems can be a daunting experience, sometimes even for healthcare providers themselves (Farley et al., 2014; Ofosu et al., 2023). Both unfamiliarity with healthcare systems and the absence of culturally appropriate health education are critical challenges affecting not only patients but also healthcare providers.

A major challenge recognised by multiple studies is the struggle to understand how the healthcare system operates. The gatekeeping role of PHC is non-existing in certain countries, where patients can directly access secondary care. This structural disparity can pose difficulties for immigrants, leading to an over-reliance on emergency departments for non-urgent conditions and specialist care for issues manageable by GPs (Ofosu et al., 2023; Sundareswaran et al., 2024). Beyond the

referral process, immigrant patients are often unaware of existing programmes designed to assist them in navigating the healthcare system. Interestingly, these knowledge gaps extend to healthcare providers, who may be unfamiliar with available support programmes, further compounding access barriers (Farley et al., 2014; Ofosu et al., 2023; Sundareswaran et al., 2024).

Limited health literacy is a significant barrier, often leading immigrants to use healthcare reactively for acute issues rather than engaging in proactive health management. This is compounded by a lack of understanding of the system and familiarity with more paternalistic models in their countries of origin, which discourages active engagement in their own care (Ofosu et al., 2023; Sundareswaran et al., 2024). Limited health literacy not only affects access to healthcare, but also treatment adherence, incorrect medication dosages, and improper administration of prescribed treatments (Alzaye et al., 2019; Kay et al., 2016).

2.5.1.3.2. Time and Financial Barriers to Culturally Competent Care

Limited consultation times pose a substantial obstacle to effective care for immigrant patients. Research consistently demonstrates that the typical 15-minute appointment is frequently inadequate for addressing their multifaceted healthcare needs (Alzaye et al., 2019; Dolan et al., 2020; Duncan et al., 2013; Farley et al., 2014; Kay et al., 2016; Ofosu et al., 2023; Singh, B. et al., 2017; Sundareswaran et al., 2024). Crucially, caring for patients using cultural competence − a key component of effective care for this population − requires dedicated time. Existing reimbursement methods frequently fail to account for the additional time and

resources required to deliver culturally competent care, creating a disincentive for providers to offer the necessary level of service (Kay et al., 2016; Singh, B. et al., 2017; Sundareswaran et al., 2024).

Beyond provider compensation, financial and insurance-related barriers further hinder access to care for immigrants. Research examining barriers among immigrants in Canada reveals how newcomers face ambiguity about insurance policies, eligibility, and healthcare costs. Changes in both residency and academic status may have implications on healthcare coverage, a fact often unknown to patients seeking care (Sundareswaran et al., 2024). A similar disparity exists in Australia. Refugees generally receive full Medicare coverage, whereas asylum seekers face increased uncertainty as their healthcare coverage is dependent on their visa status (Duncan et al., 2013). These may contribute to delayed care, untreated chronic conditions, and increased reliance on emergency services.

2.5.1.4. Knowledge Gaps in Cultural Competency Training

Cultural Competency Training (CCT) is essential for equipping GPs to effectively engage with refugees, CALD communities, and indigenous patients (Alzaye et al., 2019; Davidson et al., 2024; Ofosu et al., 2023; Singh, R. et al., 2023; Smith et al., 2017; Sundareswaran et al., 2024). Nevertheless, a substantial body of research demonstrates notable shortcomings in the current CCT models implemented in Australia and Canada.

The complexities of caring for diverse patient populations often overwhelm GPs due to the inconsistent and inadequate nature of CCT they receive both at undergraduate and post-graduate levels (Liaw et al., 2015). PHC providers have

raised concerns regarding the effectiveness of cultural competency courses, questioning their ability to equip practitioners with the necessary skills to provide culturally appropriate care. The training is often criticised for being too general and superficial (Smith et al., 2017). Despite these shortcomings, feedback on the Educating for Equity (E4E) workshop (Crowshoe et al., 2018) and the Ways of Thinking and Ways of Doing (WoTWoD) programme (Liaw et al., 2015), has yielded tangible improvements. Participants showed a practical application of their learning through improved clinical communication, cultural awareness, and attention to social determinants of health in patient care.

2.5.1.4.1. Deficiency in Cultural Competency Training in Australia

A detailed analysis of two of Watt et al.'s (2015, 2016) articles, one exploring registrars' perspectives and the other examining supervisors' views on CCT in general practice, reveals a substantial lack of structured learning and consistent implementation. The registrar study indicates that learning primarily occurs through patient exposure, with CCT described as inconsistent and opportunistic. Supervisors corroborate the ad hoc nature of training, yet perspectives diverge regarding training preferences. While registrars favour structured workshops, many supervisors express concern that such formats can promote stereotyping. Furthermore, conflicting opinions exist among supervisors concerning the value of established Aboriginal and Torres Strait Islander cultural awareness workshops. Some advocate for their significance in cultivating a richer understanding of health, while others criticise them as "excessive and politically driven" (Watt et al., 2015 p. 7; Watt et al., 2016). Reath et al. (2018) affirm that cultural competence extends

beyond solely theoretical instructions, requiring direct engagement with indigenous communities, as a fundamental aspect of effective training.

2.5.1.4.2. Deficiency in Cultural Competency Training in Canada

Canadian studies have revealed a significant disconnect between theoretical CCT and its practical application in clinical settings. They highlight the lack of formal training opportunities, emphasizing their reliance on informal learning such as googling to better understand their patients (Farley et al., 2014; Ofosu et al., 2023; Singh, B. et al., 2017). This dependence highlights the lack of, structured, and evidence-based cultural competency resources in training programmes.

Ofosu et al. (2023) highlights that more experienced practitioners and providers who have migration backgrounds, possessed a greater understanding of the contextual challenges and were thus able to suggest appropriate avenues for assistance.

2.5.1.5. Interventions to Improve Cultural Competence in Primary Care

Findings from the studies indicate that cultural competence can be enhanced through interventions on three levels: systemic changes, provider-level capacity building, and initiatives focused on patient engagement and empowerment. This section delves into each of these layers, exploring how targeted actions at every level can contribute to more culturally competent and inclusive PHC.

2.5.1.5.1. System-Level Interventions in the Healthcare System

A key component of system-level interventions is the establishment of centralised points of access for culturally diverse populations. These can provide a comprehensive initial access and helps guide newcomers on how to navigate the healthcare system (Cheng et al., 2015; Farley et al., 2014; Sundareswaran et al., 2024). These centres can facilitate continuity of care by establishing connections between patients and PHC providers (Farley et al., 2014).

A recurring theme in the literature is the importance of improving language access services. This can be achieved by employing culturally sensitive medical interpreters as well as by the providing multilingual resources (Alzaye et al., 2019; Cheng et al., 2015; Dolan et al., 2020; Farley et al., 2014; Kay et al., 2016; Singh, R. et al., 2023). Logistical and financial challenges may be addressed by financial incentives such as higher remuneration for healthcare providers serving culturally diverse populations (Alzaye et al., 2019; Farley et al., 2014; Kay et al., 2016). Moreover, partnership between formal healthcare systems and cultural brokers can ensure effective support and trust building (Ofosu et al., 2023)

Systems-level interventions mentioned include formalising forums for resource exchange among providers (Farley et al., 2014) as well as policies promoting the hiring of staff from locally representative ethnic backgrounds (Singh, R. et al., 2023) These interventions may help create a more culturally safe environment.

2.5.1.5.2. Interventions for Health Professionals

Addressing shared gaps in CCT requires effective interventions for health professionals. GPs often seek experiential learning, a reliance that often leads to

inconsistency in cultural competency levels amongst providers. Despite the different healthcare models in Australia and Canada, the shared challenges in providing culturally competent care indicate that both countries require a more comprehensive approach to CCT. Studies suggest that CCT could be more effective by implementing mandatory, multi-session training frameworks that incorporate ongoing professional development, standardised registrar and supervisor training opportunities, continuous evaluation, and access to cross-cultural resources. Furthermore, sustained clinical encounters with a diverse patient population are essential to translate theoretical knowledge into practical competence (Alzaye et al., 2019; Crowshoe et al., 2018; Davidson et al., 2024; Farley et al., 2014; Kay et al., 2016; Ofosu et al., 2023; Reath et al., 2018; Singh, R. et al., 2023; Smith et al., 2017; Sundareswaran et al., 2024; Watt et al., 2015; Watt et al., 2016).

2.5.1.5.3. Patient-Centred Interventions

Patient empowerment strategies, achieved through education, community engagement, and support systems, are crucial for enhancing cultural competence in PHC. Health literacy initiatives are essential in assisting newcomers to navigate healthcare systems and make informed health choices (Farley et al., 2014). Structured educational programmes focusing on accessing local healthcare services, managing chronic conditions, and utilising preventive care can substantially reduce health disparities and improve patient outcomes (Farley et al., 2014; Kay et al., 2016).

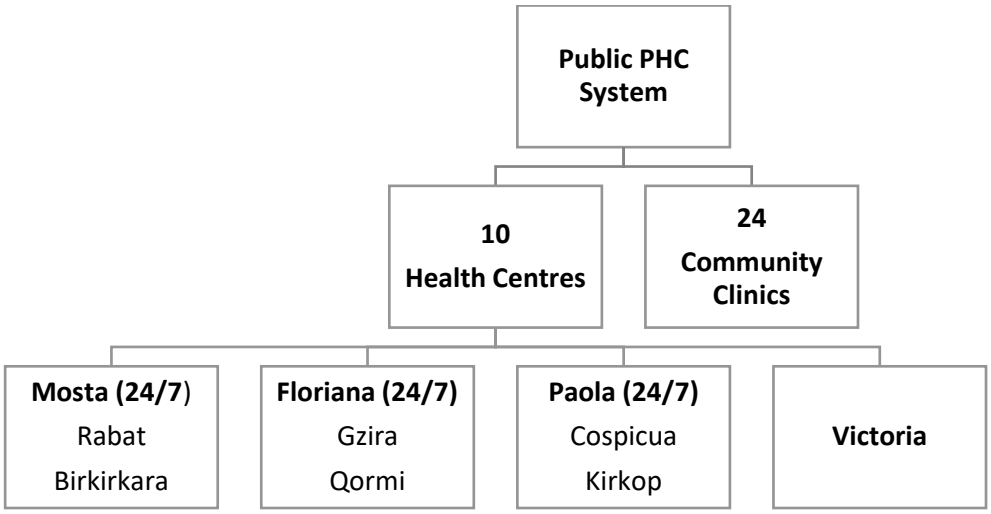
2.5.2. Expanded Literature Search Discussion

To address the initial research's focus on Australia and Canada, a more targeted search broadened the scope to include Malta, Cyprus, Luxembourg, and Singapore. This expanded data collection allowed for a richer and more relevant understanding of migrant healthcare access, cultural competence, and integration policies. This section provides an expanded review of the literature relevant to PHC provision for migrants and asylum seekers, with a focus on the Maltese context.

2.5.2.1. Primary Health Care in Malta

PHC in Malta is delivered through both public and private services. The public PHC system is supported by a network of 10 health centres (HCs), with these facilities primarily functioning as walk-in clinics. Mosta HC oversees satellite clinics in Rabat and Birkirkara, Floriana HC is linked to the Gżira and Qormi clinics, while Paola HC operates alongside the Cospicua and Kirkop clinics. Similarly, Victoria HC serves the island of Gozo. Among these, Paola, Floriana, and Mosta operate 24/7 (Primary Health Care, n.d.a). Additionally, a total of 24 community clinics (21 in Malta and 3 in Gozo) operate on a pre-established schedule (Primary Health Care, n.d.b). An overview of this structure is presented in Figure 2.5.

Figure 2.5: *Structure of Malta and Gozo's Public PHC System*



The private healthcare sector primarily consists of independently operating practitioners with a few group practices. Additionally, several groups of company doctors are employed by local companies for sick leave verification (Sammut, 2000).

2.5.2.2. National Strategies

A comparison of Migrant Integration Policy Index (MIPEX) scores for Australia, Canada, Cyprus, Malta, and Luxembourg reveals varying levels of inclusivity in their migrant healthcare policies. MIPEX assesses integration policies across eight areas − including health − using four main criteria: entitlements to health services, accessibility of services, responsiveness of healthcare systems to migrants' needs, and the existence of policies aimed at promoting systemic change. Each country is scored out of 100, with higher scores indicating more inclusive and supportive healthcare environments for migrants. Among the European countries, Malta ranks the highest with a score of 56, followed by Luxembourg at 46, and Cyprus at 36. However, when compared to Australia (79) and Canada (73), these European

nations' scores remain significantly lower, highlighting room for improvement (Solano & Huddleston, 2020).

In response to these challenges, Malta has implemented government-led initiatives aimed at improving healthcare accessibility for migrants. Key measures include the establishment of the Migrant Health Liaison Office within PHC in 2008, which promotes cultural competence, health education, and training. Additionally, a GP service within the Detention Unit ensures medical support for detained migrants (Primary Health Care, n.d.a).

Recognising the importance of long-term strategic planning, the ministry responsible for health has integrated migrant health into the National Health Systems Strategy for Malta (2023-2033) (Bezzina et al., 2024). Complementing these, the Integration Strategy and Action Plan (2025-2030) streamlines integration through legal and administrative reforms, including a dedicated support "one-stop-shop" and interpretation hotline (Government of Malta, 2023). These inclusions initiatives reflect a commitment to strengthening healthcare accessibility for migrant communities living in Malta.

2.5.2.3. Barriers in Healthcare

A comparative analysis of healthcare access and living conditions for asylum seekers in Cyprus, Malta, Poland, and Romania reveals marked disparities in reported experiences. Malta recorded the highest proportion of asylum seekers encountering difficulties in accessing healthcare (87%), followed by Poland (81%), Cyprus (72%), and Romania (70%). These figures indicate that, despite structural provisions, practical access to healthcare in Malta remains particularly constrained. Both Malta

and Cyprus share common barriers, including language barriers, long waiting times, and a lack of information about rights and available services (Collantes et al., 2011). Studies corroborate these findings in Cyprus, adding lack of translated resources, fear of repatriation, mistrust towards the health system, and financial constraints (Panagiotopoulos et al., 2020; Pithara et al., 2012). In Malta, research highlights the detrimental impact of bureaucratic and language barriers across sectors, particularly in speech and language pathology and sexual health. In sexual health confidentiality is a concern with ad hoc interpreters, and even trained mediators lacking specialised medical knowledge (Grech & Cheng, 2016; Pisani et al., 2016). The 2016 ethnographic study in PHC by Depares highlights significant linguistic and cultural barriers, including interpreter shortages, brief consultations, mistrust, and a lack of cultural competence, all exacerbated by unclear policies. Discrimination within the system is a key finding, a point further supported by two other studies (Collantes et al., 2011; Zingariello, 2020). Indeed, this is borne out by the fact that 57% of migrants in Malta identify discrimination as the primary barrier to healthcare access, underscoring its pervasive impact, especially when compared to the much lower value of 15% of respondents in Cyprus (Collantes et al., 2011). This emphasis on discrimination in Malta stands in stark contrast to the experiences reported in Australia and Canada, where it was not identified as a major barrier to healthcare access in the reviewed literature.

2.5.2.4. Training and Awareness of Cultural Competence

A Cypriot study analysing self-assessed cultural competence among healthcare professionals revealed a disconnect between perceived and actual abilities. While

participants valued cultural competence and rated their transcultural communication knowledge highly, they simultaneously acknowledged gaps in their cultural understanding. Furthermore, despite these high self-assessments, self-reported skills related to anti-racism, activism, and self-directed learning were low. Qualitative data from interviews exposed a mismatch, with participants demonstrating lower cultural competence than their self-assessments suggested, a reliance on external training rather than self-education, and the presence of stereotypical views. These findings underscore the need for ongoing, specialised cultural competence training (Argyriadis et al., 2022). Depares's research underscores a notable deficiency in cultural competence among PHC workers. The findings highlight several contributing factors, including linguistic and cultural barriers, power imbalances during clinical encounters, reliance on stereotypes, inadequate educational preparation, and a general sense of unpreparedness and frustration among healthcare professionals. This absence of structured CCT for Maltese healthcare workers often results in reliance on Western biomedical models, with limited consideration for migrants perspectives on health, illness, and treatment (Depares, 2016).

Although the Maltese Specialist Training Programme in Family Medicine incorporates cultural considerations, its treatment of the subject appears superficial rather than deeply embedded within the training structure. While acknowledging cultural factors as part of holistic patient care, the curriculum lacks depth and structured training components to effectively address these crucial aspects of healthcare delivery (Zammit & MCFD Education Committee 2023, 2023).

2.6. Concluding remarks

This review analysed existing research on cultural competence in PHC. While several theoretical frameworks offer structured approaches to assessment and improvement (e.g., Campinha-Bacote, Betancourt et al., ACT), their practical application is inconsistent and scarce. Despite widespread recognition of the importance of cultural competence, barriers remain, including language/communication difficulties, cultural misunderstandings, system navigation challenges, and insufficient provider training.

This review reveals a significant gap in CCT for PHC providers. Australian and Canadian studies indicate that existing programmes are often superficial, inconsistent, and poorly integrated into medical education, favouring opportunistic learning over structured, evidence-based approaches. Systemic barriers like time constraints, financial limitations, and lack of institutional support further compound these challenges, hindering effective care for diverse populations.

The review also uncovered a stark research gap regarding cultural competence in Malta, Cyprus, Luxembourg and Singapore, where empirical studies are very limited. While Australian and Canadian research provides valuable insights into cultural competence, their healthcare structures, resources, and demographic compositions differ significantly from Malta's small-state healthcare system. However, from the very limited number of studies available in Malta and Cyprus, it appears that these countries share many of the barriers identified in larger healthcare systems, such as language difficulties, mistrust, and gaps in cultural competency training. Notably, discrimination was identified as a distinct and considerable barrier in Malta, albeit to a lesser degree in Cyprus and much less than Australia and Canada.

Given this critical research gap, this study is particularly timely and essential. It seeks to provide an in-depth assessment of how cultural competence is perceived and practiced within Malta's PHC system, filling a void in the literature. Ultimately, without structured training, institutional commitment, and systemic reforms, cultural competence will remain a theoretical ideal rather than a practical reality in Maltese healthcare. By bridging this knowledge gap, this study aims to contribute to both academic understanding and translate into real world improvements, moving Malta toward a more inclusive and culturally competent PHC system.

This literature review provides the foundation for the research study by identifying key themes and gaps in existing knowledge. The following chapter will build on this groundwork by offering an in-depth discussion of the methodology adopted for this mixed-methods research.

Chapter 3: Research Methodology

3.1. Introduction

This chapter presents the methodology adopted for the study, explaining the rationale behind the chosen research approach and key methodological decisions. The study adopts a pragmatic philosophy and an abductive reasoning approach, employing a concurrent mixed-methods design within a cross-sectional time-frame. Data were collected through targeted sampling, using quantitative surveys and semi-structured interviews, and analysed through SPSS and thematic analysis. The chapter also addresses ethical considerations, including approvals and consent, and discusses the study's methodological limitations alongside strategies to mitigate them.

3.2. Aims, Research Question and Objectives

This study explores cultural competence among specialists in family medicine within Malta's PHC, encompassing both public and private services. It examines cultural competence on two levels: the individual level, assessing PHC doctors' cultural awareness, knowledge, attitudes, and practices, and the organisational level, analysing healthcare leaders' strategies for fostering cultural competence. By addressing both perspectives, the research aims to provide a comprehensive understanding of cultural competence integration in the Maltese PHC sector.

In line with this, the study seeks to explore the following research question, originally formulated and documented in Chapter 1:

"How does the perceived cultural competence of individual PHC doctors in Malta intersect with the cultural competence of their healthcare organisations?"

In order to address the research question, the study will pursue the following objectives:

1. How do PHC doctors perceive their cultural competence in patient interactions?
2. What are the strengths and gaps in cultural competence among PHC doctors?
3. To what extent is cultural competence integrated at the healthcare organisational level?
4. What recommendations can be made for implementing multicultural training for PHC doctors?

3.3. Operational Definitions

Cultural competence: Recognising the definitional challenges surrounding the concept, this study adopts a flexible and evolving perspective on cultural competence, as outlined in Chapter 2. For the purposes of this research, cultural competence is used as an overarching framework, emphasizing its role in supporting healthcare professionals' ability to deliver optimal care while fostering broader cultural change.

Cultural diversity: UNESCO defines cultural diversity as the various ways in which different cultural groups and societies express, share, and preserve their unique traditions and identities. These expressions are transmitted both within and across communities, shaping collective heritage (UNESCO).

Primary Health Care (PHC): The setting typically within the patient's local community, in which the initial point of contact between the patient and a healthcare professional occurs (WONCA Europe, 2023).

General practitioners (GPs)/family doctors: These are specialist physicians trained to provide comprehensive, continuous, and patient-centred care to individuals of all ages, gender, and health conditions. They deliver medical care within the context of family, community, and cultural background while respecting patient autonomy and promoting holistic well-being (WONCA Europe, 2023).

Immigrant: Any individual who has relocated to a different country, encompassing all migrants regardless of their legal status, the circumstances, or the reasons for their migration (United Nations).

3.4. Research Design

The research design of this study was informed by Saunders' Onion framework, which consists of a series of layers guiding research decisions: philosophical assumptions, research approach, methodological choices and strategy, time horizon, and data collection techniques (Saunders et al., 2023). The layered approach of this model allows for a clear and comprehensive logical approach. This strategy helped to strengthen the methodological foundation of this study.

3.4.1. Research Philosophy:

A pragmatic research philosophy is adopted for this study as it prioritizes methodological flexibility over rigid adherence to a single approach. Pragmatism allows researchers to "focus on the research problem in social science research and

then use pluralistic approaches to derive knowledge about the problem" (Creswell & Plano Clark, 2018, p. 11). This philosophy is suited for this study as it is not confined to either the positivist or interpretivist approaches, allowing the integration of both qualitative and quantitative methods to explore cultural competence among GPs within the Maltese PHC. The dual focus of this study, exploring cultural competence at both the individual and organisational levels, necessitates a pragmatic approach that allows for the adaptation of research strategies to best capture these dimensions. Furthermore pragmatism, values knowledge that links theoretical concepts with practical application (Morgan, 2014), enabling researchers to concentrate on practical solutions in real-world contexts (Creswell & Plano Clark, 2018). This emphasis on practical solutions is particularly relevant to this study, which aims to translate theoretical understandings of cultural competence into recommendations for tangible improvements in healthcare delivery within the Maltese PHC.

3.4.2. Research Approach

This study employs abductive research approach which, according to Morgan, serves as an intermediary between induction and deduction, enabling researchers to shift between empirical data and theoretical explanations to refine their understanding (Morgan, 2014). This study uses a deductive approach to assess individual cultural competence among GPs and an inductive approach to explore organisational cultural competence through healthcare leaders' perspectives. By systematically moving between data and theory, this research approach facilitates a

balanced interpretation of cultural competence within the Maltese PHC sector, aligning with the pragmatic goal of generating actionable knowledge.

3.4.3. Methodological Choice and Research Strategy

Aligning with the study's pragmatic philosophy, a concurrent mixed-methods methodological choice was adopted for this study. This combines both the quantitative and qualitative approaches, with data collection occurring simultaneously so as, to thoroughly address the research question.

For the quantitative component of this study, a validated survey was employed to assess the cultural competence at the individual level among GPs. Concurrently semi-structured interviews with leaders and policymakers were used for the qualitative aspect, aiming to explore systematic factors and policies influencing cultural competence within the Maltese PHC. By integrating the breadth of quantitative data with the depth of qualitative analysis, a holistic understanding was sought and achieved.

3.4.4. Time Horizons

A cross-sectional time horizon was chosen as the best fit for this study, due to the exploratory nature of the research. By adopting a single-timepoint data collection, an immediate snapshot of cultural competence within the Maltese PHC was achieved. This approach facilitated the concurrent collection of data from the quantitative survey and the qualitative interviews, providing a robust assessment while accommodating the time and practical realities of dissertation work.

However, it is important to recognise the intrinsic limitations of cross-sectional designs. While this approach, effectively captures a snapshot of the current states, one must interpret findings by keeping in mind the temporal and causal constraints.

3.4.5. Research Techniques & Procedures

3.4.5.1. Sampling Strategies

For the quantitative phase of this research, a targeted sampling approach was utilised, specifically targeting specialists in family medicine practicing in the Maltese PHC, across both private and public sectors. The choice of targeted sampling was driven by the study's specific focus on specialists in family medicine, rather than the wider healthcare workforce. This non-probabilistic strategy is consistent with pragmatic mixed-methods research, where the goal is analytical rather than statistical generalisation (Creswell & Plano Clark, 2018). By intentionally selecting participants who possess the professional qualifications and contextual experience relevant to the research question, the study ensured that data collected would be directly aligned with the exploration of cultural competence in Maltese PHC. The study's focus on family medicine specialists minimised training variability within the sample and thus enabling more specific recommendations.

The Malta College of Family Doctors (MCFD) was intentionally chosen to aid in recruiting participants, as it has a wide membership of GPs, ensuring representative sampling. Furthermore, its established contacts and professional credibility aided in providing efficient and effective access to the intended population. At the time of dissemination of surveys, the college comprised 240 members, as per data provided by the Honorary Secretary (personal communication, January 2025).

Expert sampling was used for the qualitative interviews with PHC department leaders. This purposeful selection strategy aims to identify respondents who can provide the most relevant and informative insights (Kelly et al., 2010). To ensure comprehensive representation for the qualitative aspect of this study, invitations for participation in semi-structured interviews were extended to key stakeholders holding leadership positions within Malta's PHC. Senior clinical leaders, representatives from professional organisations, and postgraduate training co-ordinators were invited. Additionally, invitations were extended to decision-makers in PHC, including clinical leaders, personnel from major health centres, and migrant health service providers. This diverse group ensured a comprehensive understanding of perspectives within the PHC system while maintaining participant confidentiality. In total, fifteen invitations were sent for the qualitative interviews. 7 interviews were completed, with the remaining invitees either refusing participation or not responding. Table 3.1 provide an overview of the study interviewees.

Table 3.1: *Overview of the Study Interviewees*

Interviewee ID	Profession	Years of Experience
P1	Leadership role within a professional medical association Principal General Practitioner	6 1
P2	Principal General Practitioner	2
P3	Leadership role in healthcare services for migrants Principal General Practitioner	3 2
P4	Principal General Practitioner	2
P5	Principal General Practitioner Training co-ordinator	2 4
P6	Leadership role within a professional medical association Private Doctor	12 15
P7	Practice Nurse	17

3.4.5.2. Data Collection Methods

3.4.5.2.1. Quantitative Data Collection Method

Data collection for the quantitative phase occurred between August 2024 and January 2025. The survey, estimated to take 15 minutes to complete, was distributed electronically via an intermediary from the MCFD to facilitate access to the target population. Monthly reminder emails were sent to encourage participation.

The Healthcare Provider Cultural Competence Instrument (HPCCI) was employed to assess cultural competence among GPs. Permission to use the HPCCI was requested

and obtained (Appendix C). This validated instrument measures cultural competence across five key dimensions: Awareness/Sensitivity, Behaviour, Patient-Centred Communication, Practice Orientation, and Self-Assessment. Question 31 was removed from the 49-item questionnaire because, as confirmed by the tool's author, it did not load onto any of the validated dimensions, reducing the final questionnaire to 48 items. The HPCCI employs both 1-5 and 1-7 Likert scales, varying by construct. Reverse scoring was applied to some items, thereby ensuring that higher scores were always associated with a higher level of cultural competence. Cronbach's alpha confirmed strong internal consistency for the HPCCI's five dimensions (Schwarz et al., 2015). Additionally, a covering letter and a demographic questionnaire (Appendix D) were included to provide context and gather essential participant information.

Before the full distribution of the survey, a pilot study (n=6) assessed the HPCCI's clarity, feasibility, and applicability within the local context. Participants provided feedback on completion time, terminology, question difficulty, and potential discomfort. Most respondents of the pilot test completed the survey in 10-15 minutes, found the terminology clear, and reported no question difficulty. However, concerns arose regarding potential respondent identifiability within the demographic questionnaire. Consequently, the respondents' workplace location was removed from the demographic section to further reduce the risk of participant identification. The pilot confirmed the HPCCI's overall suitability with minor adjustments for the Maltese context.

3.4.5.2.2. Qualitative Data Collection Method

For the qualitative aspect of the study, a semi-structured interview guide was formulated with questions being grouped into three main categories: General Background & Personal Perspectives on Cultural Competence, Organisational Policies, and Practices on Cultural Competence, and Assessing Cultural Competence Training & Development. The semi-structured interview guide was informed by the key themes and gaps identified in the Literature Review and aligned with the study's research objectives. To ensure a comprehensive exploration of cultural competence within PHC, two complementary sets of questions were developed: one designed for physicians and another for non-physician healthcare professionals at the organisational level (Appendix E). The semi-structured interview format provided both flexibility and consistency in data collection, allowing participants to expand on their experiences and viewpoints.

Interviews were conducted between November 2024 and January 2025. To accommodate participants' preferences and logistical constraints, interviews were conducted either in person or via an online platform. The duration of interviews ranged between 15 to 45 minutes, depending on the depth of discussion and the availability of the interviewee. Audio recordings of the interviews were obtained with the individual participant's consent. Audio recordings were stored in a pseudonymised form in a password protected external hard disc. Then they were manually transcribed verbatim. This transcription method allowed for the preservation of all nuances and contextual meanings, enabling a rich and authentic qualitative analysis. During the transcription, interviewees were anonymised to protect participant confidentiality.

3.4.5.3. Data Analysis Methods

3.4.5.3.1. Quantitative Data Analysis Method

The quantitative data collected from the questionnaire via Google Forms was exported to Microsoft Excel. Data was collated and coded before being imported into IBM Statistical Package for the Social Sciences (SPSS) Statistics for further statistical analysis, including reliability testing, normality assessment, and comparative analysis.

This section will detail the descriptive and inferential statistical methods used to analyse the quantitative data. Firstly, the former was used to summarize data and evaluate internal consistency using standard deviations and reliability coefficients. Secondly, the latter helped determine whether domain scores differed significantly among demographic groups, which would permit inferences to a larger population.

3.4.5.3.1.1. Reliability Testing

Reliability testing is crucial because it verifies that observed differences in responses reflect genuine variations, and are not due to inconsistent measurement. A high reliability score, as highlighted by Tavakol and Dennick (2011) suggests that the instrument consistently assesses the intended constructs. The questionnaire's internal consistency was assessed using Cronbach's Alpha, and ranges from 0-1. Scores above 0.7 indicate acceptable internal consistency, scores between 0.5 and 0.7 indicate questionable internal consistency, and scores below 0.5 indicating unacceptable reliability. To enhance the accuracy of reliability, negatively worded items were reverse-scored.

For each construct, inter-item correlation matrices were evaluated to assess internal consistency. Correlations within the range of 0.3 to 0.7 were considered satisfactory, while correlations exceeding 0.8 indicated potential multicollinearity (items may be highly related and measuring the same aspect), while those below 0.3 suggested a weak inter-item relationship (Clark & Watson, 2016).

3.4.5.3.1.2. Normality Testing

Normality testing was initially conducted using the Shapiro-Wilk test to determine which statistical methods are suitable for comparing domain scores. This test was used to assess if the distribution of scores in each domain followed a normal distribution. The assumption of normality was retained when the p-value was > 0.05, whereas p values ≤ 0.05, necessitating the rejection of the null hypothesis, indicating non-normal distribution (Yap & Sim, 2011).

3.4.5.3.1.3. Comparative analysis

The selection of comparative analysis methods was guided by the results of the normality test, ensuring that the most suitable statistical approach was applied to each dataset. For domains that followed a normal distribution, a parametric test (one-way ANOVA) was employed, allowing for the comparison of mean differences across multiple independent groups while maintaining high statistical power. Conversely, for domains that violated the normality assumption, a non-parametric test (Kruskal-Wallis Test) was used. This test, which is more appropriate for skewed or non-normally distributed data, compares the medians of independent groups, providing a robust alternative to ANOVA when parametric assumptions are not met.

For both the parametric (ANOVA) and non-parametric (Kruskal-Wallis) statistical tests, the null hypothesis assumed no significant differences in domain scores between the groups defined by demographic factors. A p-value ≤0.05 led to the rejection of the hypothesis, indicating statistical significance variation within domain scores.

3.4.5.3.1.4. Comparative Analysis of Related Statements

In addition to domain-wise statistical comparisons, intra-domain statement comparison was conducted using the non-parametric Friedman Test. The Friedman test compares mean rating scores across a set of related statements to determine whether there are statistically significant differences in how participants rated them. The null hypothesis, which assumed homogeneity of mean ratings, was retained if the resulting p-value was greater than 0.05. A p-value below this threshold necessitated the rejection of the null hypothesis, supporting the alternative hypothesis that mean ratings differed significantly among statements.

3.4.5.3.2. Qualitative data analysis method

To ensure a systematic approach to qualitative data analysis, an inductive thematic analysis was conducted following Braun and Clarke's (2006) six interconnected phases. This approach involves: (1) familiarisation with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the final report (Braun & Clarke, 2006).
In the first phase, engagement in active familiarisation with the data was achieved by listening to audio recordings to ensure transcription accuracy, followed by

repeated readings of the interview transcripts. This process facilitated familiarisation in the data and the identification of initial patterns. In the second phase, key features of the data were systematically labelled using both semantic (explicit) and latent (implicit) coding to capture directly stated content as well as underlying meanings. These codes were then reviewed and grouped based on similarities, enabling the identification of broader patterns and themes in the third phase.

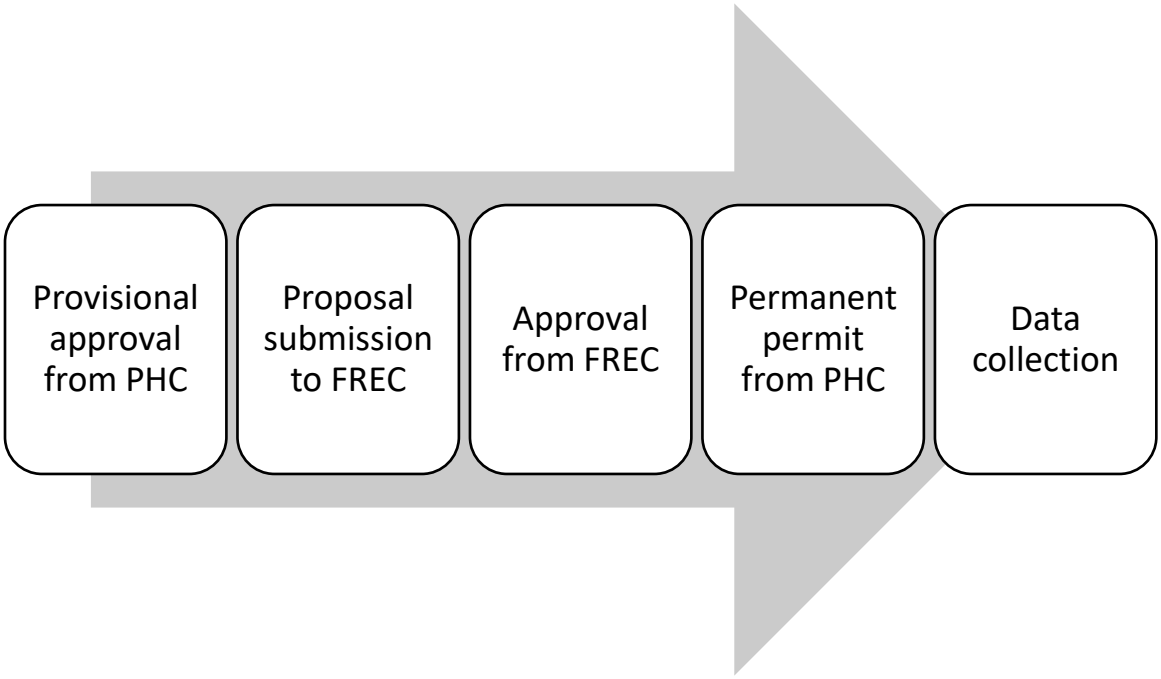
The subsequent phases focused on refining and distinguishing themes to ensure clarity while maintaining their interconnections. The initial themes were re-examined against the original coded data, leading to further refinements to enhance internal coherence and logical consistency. In the fifth phase, an infographic was developed and, finally, in the sixth phase, a comprehensive report was synthesized, integrating key themes and supporting evidence to provide a structured interpretation of the findings.

3.4.5.4. Ethical considerations

3.4.5.4.1. Ethical Approval

A multi-stage approval process was followed before initiating the study. Initially, provisional approval was obtained from the PHC Department (Appendix F), which supported the submission of the research proposal to the Faculty Research Ethics Committee (FREC) (Appendix G) for ethical clearance. Upon receiving approval from FREC, a Permanent Permit was granted by the PHC Department (Appendix H), allowing data collection within the public healthcare sector. The following figure (Figure 3.1) outlines the sequential stages of the data collection approval process.

Figure 3.1: *Sequential Stages of the Data Collection Approval Process*



3.4.5.4.2. Measures to Ensure Confidentiality

To ensure participants' anonymity, confidentiality, and voluntary participation, the Guidelines for Applicants Submitting Research Ethics Forms were carefully followed (Research Ethics Committee, 2021). All data were anonymized by omitting personal details from questionnaires and assigning coded identifiers to interview participants. Given Malta's small population, certain potentially identifiable data were purposely excluded from transcripts to further protect participants' identities. Prior to participation, informed consent was obtained. All data were securely stored on a password-protected external hard drive, accessible only to the researcher and supervisor. In exceptional cases, examiners may have accessed anonymized data for assessment purposes. Additionally, audio recordings of interviews were permanently deleted after transcription to prevent unauthorized access.

3.4.5.4.3. Informed Consent

Prior to commencing the data collection, participants were provided with an information letter, outlining the study's objectives, the nature of participation, and the estimated time for completion (APPENDIX I). For the survey, completion of the questionnaire constituted implicit consent, whereas interviews required signed informed consent (APPENDIX J). Participants were made aware that their involvement was completely voluntary and that they had the right to decline participation or withdraw at any time without repercussions. In accordance with General Data Protection Regulation (GDPR), participants maintained the ability to view, modify data throughout the study. However, deletion requests could be honoured up to the point of anonymisation and analysis after which it might not have been technically feasible.

3.4.5.5. Methodological Strengths

Several features of this study strengthen its methodological rigour and enhance the credibility of its findings. Firstly, the adoption of a pragmatic philosophical stance and mixed-methods design allowed for a comprehensive exploration of cultural competence by integrating numerical trends with rich contextual insights. This concurrent design enabled triangulation between quantitative and qualitative data, thereby increasing the validity and interpretive depth of the results.

Secondly, the use of a validated and reliable quantitative instrument (HPCCI) provided a standardised measure of cultural competence, ensuring congruence with established international research. The piloting of this tool within the Maltese

context further enhanced contextual relevance and ensured clarity and feasibility for participants.

Thirdly, the targeted sampling of specialists in family medicine within the Maltese PHC context ensured that data were gathered from those most knowledgeable and directly involved in culturally competent care delivery. This alignment between sampling and research objectives enhanced internal validity and the applicability of findings within this professional group.

Finally, robust ethical safeguards, including informed consent, anonymity, and multi-stage ethical approvals, supported the integrity of the research process and promoted participant trust. Collectively, these strengths contribute to the reliability, coherence, and practical relevance of the study's findings.

3.4.5.6. Methodological Limitations and Mitigation

Recognising inherent methodological limitations is essential to provide a comprehensive interpretation of the findings of research.

Firstly, limitations pertaining to sampling will be discussed. The generalisability of findings in this study are constrained by the study's focus on family medicine specialists within PHC, potentially failing to represent the broader spectrum of healthcare professionals in this sector. Furthermore, the 17.1% response rate for the quantitative component could introduce selection bias. The low response rate may limit the representativeness of the quantitative findings and introduce non-response bias, as participants more interested in cultural competence may have been more likely to respond. This restricts the extent to which results can be generalised to all Maltese family doctors. However, the study's exploratory aim was

to identify key trends rather than achieve statistical generalisation, and triangulation with qualitative data helped to strengthen interpretation and mitigate the impact of the limited response rate.

Also, a sample size of 7 for the interviews may not have adequately captured the breadth of healthcare leader perspectives. Recognising potential sampling limitations, the study prioritised internal validity by exclusively including specialist in family medicine in PHC. To mitigate the low survey response rate, an intermediary was used and periodic reminders were sent. Furthermore, anonymity was ensured to minimise concerns regarding repercussions. Purposeful sampling for the qualitative interviews, focusing on key decision-makers, ensured that the small sample provided rich, reasonably diverse, and policy-relevant insights.

Secondly, this study acknowledges the potential for response bias. In the quantitative survey, the self-reported nature of responses raises concerns about social desirability bias, where participants may have overestimated their cultural competence to align with perceived professional expectations. Additionally, recall bias may have influenced both the quantitative and qualitative aspects of the study, as participants' recollection of past experiences might have been inaccurate or selective. Finally, in the qualitative component, interviewer bias is a potential concern. The interviewer's own perspectives or questioning techniques could have inadvertently influenced participant responses, potentially skewing the data collected.

To address potential response biases, several methodological steps were implemented. All survey responses were anonymised, reducing the likelihood of social desirability bias by minimising concerns regarding identification. Furthermore,

the quantitative survey utilised the validated Health Professional Cultural Competence Instrument (HPCCI), ensuring standardised and reliable data collection. Triangulation was employed to facilitate cross-verification of themes and responses between the qualitative and quantitative data, enhancing the robustness of the findings. Finally, neutral, and open-ended phrasing was incorporated into the semi-structured interview protocols to minimise interviewer bias, allowing participants to express their perspectives freely.

Maintaining participant anonymity in the qualitative interviews posed a challenge due to Malta's small population. To protect confidentiality, potentially identifying data were excluded from transcripts, which may have limited the depth of analysis by removing contextual details. To mitigate these challenges, coded identifiers were used instead of names or professional titles, ensuring that responses remained anonymous while preserving the integrity of the data. Additionally, participant responses were aggregated when presenting findings, minimising the risk of indirect identification.

A final consideration pertains to the potential for subjectivity arising from the researcher's limited experience with content analysis and the non-utilisation of qualitative analysis programmes. To ensure methodological rigour, the analysis was conducted in adherence to the established guidelines, and emergent themes were systematically aligned with the existing body of literature to establish validity and consistency.

Chapter 4: Results

4.1. Introduction

Building upon the methodological foundation laid out in the preceding chapter, this chapter provides a comprehensive overview of the results and findings obtained through the study's quantitative and qualitative research methods. This chapter is structured into two main sections. The initial section delves into quantitative data analysis focusing specifically on internal consistency, normality testing, and a comparative analysis of the collected data. The second section focuses on the analysis of the qualitative data, exploring thematic patterns derived from the semi-structured interviews.

4.2. Quantitative Results

4.2.1. Response Rate and Respondent Demographics

This section presents the response rate of the study and an overview of the demographic characteristics of the respondents. A total of 41 responses were received from 240 MMCFD members that were invited to participate, resulting in a response rate of 17.1%. The respondents' demographic compared to the demographics of the total population that were invited to respond can be seen in Table 4.1. The data presented in Table 4.2 summarises findings on respondents' views and experiences with cultural competence training.

Table 4.1: *Demographic Data*

Demographic Data		**Number of Respondents**	**Percentage (%) of Respondents**
Age	25-34	17	41.5
	35-44	13	31.7
	45-64	11	26.8
Number of years working within PHC	0-9 years	22	53.7
	10-19 years	11	26.8
	20-29 years	8	19.5
Gender	Male	13	31.7
	Female	28	0.68
Job Grade	GP	18	43.9
	Senior GP	20	48.8
	Principal GP	3	7.3
Occupational Sector	Public	27	65.9
	Private	4	9.8
	Both	10	24.4

Table 4.2: *Respondents' Views on Cultural Competence and Training Preferences*

Respondents' Views		**Number of Respondents**	**Percentage (%) of Respondents**
Have you had any cultural competence training	Yes	5	12.2
	No	36	87.8
How important do you consider cultural competence is?	Very Important	13	31.7
	Important	27	65.9
	Not Important	1	2.4
Would you participate in non-compulsory training in cultural competence	Yes	18	43.9
	No	10	24.4
	Maybe	13	31.7
Do you think that compulsory training in cultural competence should be implemented?	Yes	16	39.0
	No	10	24.4
	Maybe	15	36.6

4.2.2. Internal Consistency

Cronbach's Alpha based on standardised items was used to assess internal consistency and reliability. A value of 0.70 or higher indicates satisfactory internal consistency. The five domains assessed were, Awareness/Sensitivity, Behaviours, Patient-Centred Communication, Practice Orientation, and Self-Assessment. Table 4.3 provides a summary of the Cronbach's Alpha and Cronbach's Alpha based on standardized items for each domain.

Table 4.3: *Cronbach's Alpha Scores for Cultural Competence Domains*

Domain	**Number of items**	**Chronbach's Alpha**	**Cronbach's Alpha Based on Standardised Items**
1. Awareness/Sensitivity	11	0.689	0.717
2. Behaviours	16	0.928	0.931
3. Patient-centred communication	3	0.923	0.924
4. Practice orientation	9	0.781	0.798
5. Self-assessment	9	0.844	0.863

After reverse scoring the negatively worded statements (a1, a2, a5, a8, d1, d2, d3, d4, d5, d7, d9), all the Cronbach's Alpha based on standardised items (0.717, 0.931, 0.924, 0.798, 0.863) exceeded the 0.7 threshold value. This confirms that the items within each domain exhibit satisfactory internal consistency, ensuring that they reliably measure their respective constructs.

To further examine internal consistency, Inter-Item Correlation Matrices were analysed. The full Inter-Item Correlation Matrices can be found in Appendix K. These analyses revealed generally strong internal consistency across the constructs, with most items exhibiting moderate to high correlations.

4.2.3. Normality Analysis

To assess whether the score distribution follows a normal pattern or is skewed, the Shapiro-Wilk test was conducted for each domain. The null hypothesis for the Shapiro-Wilk test states that the data are normally distributed. A p-value greater than 0.05 indicates that the data is normally distributed, supporting the null hypothesis. Conversely, a p-value less than 0.05 suggests that the data deviates from normality, leading to the rejection of the null hypothesis. The results are presented in Table 4.4.

Table 4.4: *Normality Assessment of Cultural Competence Domain Scores*

Domain	Shapiro-Wilk		
	Statistic	**df**	**P-value**
1. Awareness/sensitivity	.980	41	.665
2. Behaviours	.901	41	.002
3. Patient-centred communication	.876	41	<.001
4. Practice orientation	.941	41	.034
5. Self-assessment	.949	41	.063

Domain 1 and 5 satisfy the normality assumption but domains 2, 3 and 4 violate the normality. A parametric test will be used to analyse domains 1 and 5, while a non-parametric test will be used to analyse domains 2, 3 and 4.

4.2.4. Comparative Analysis

The One-Way ANOVA test (parametric) and the Kruskal-Wallis test (non-parametric) were used to compare mean domain scores across respondent groups categorised by demographic factors. The One-Way ANOVA was applied to domains 1 and 5, whereas the Kruskal-Wallis test was used for domains 2, 3, and 4.

The mean scores for the first two domains range from 0 to 6, where 0 corresponds to strongly disagree/never and 6 corresponds to strongly agree/always. In contrast, the mean scores for the last three domains range from 0 to 4, where 0 corresponds to strongly disagree/never and 4 corresponds to strongly agree/very often.

No significant difference in mean domain scores between groups is assumed (null hypothesis) and accepted if $p > 0.05$. A significant difference is assumed (alternative hypothesis) and accepted if $p < 0.05$.

4.2.4.1. Analysis of Mean Domain Scores by Age

Table 4.5. presents the comparison of mean domain scores by age group. The results show a decreasing trend in mean scores across age groups for all five domains. A statistically significant difference was found in Awareness/Sensitivity ($p = 0.008$) and Self-Assessment ($p = 0.047$), with younger respondents scoring higher than older respondents. The Behaviours domain neared statistical significance ($p = 0.063$), suggesting a potential age-related difference. These trends may have been even more pronounced with a larger sample size.

Table 4.5: *Table comparing mean domain scores by age*

Domain	Age	Sample size	Mean	SD	P-value
1. Awareness/ sensitivity	25-34	17	4.66	.552	0.008
	35-44	13	4.43	.553	
	45-64	11	3.96	.516	
2. Behaviours	25-34	17	2.78	1.037	0.063
	35-44	13	2.75	1.343	
	45-64	11	1.95	.475	
3. Patient-centred communication	25-34	17	3.25	.750	0.296
	35-44	13	3.31	.645	
	45-64	11	2.91	.685	
4. Practice orientation	25-34	17	3.25	.462	0.749
	35-44	13	3.32	.281	
	45-64	11	3.11	.598	
5. Self-assessment	25-34	17	3.14	.439	0.047
	35-44	13	3.15	.431	
	45-64	11	2.77	.353	

4.2.4.2. Analysis of Mean Domain Scores by Work Duration

Table 4.6 shows a trend of decreasing mean scores across all five domains with longer work duration. Specifically, those with 0-9 years of experience scored significantly higher in Awareness/Sensitivity (p=0.007) and Self-Assessment (p=0.021) than those engaged for 20-29 years. Behaviours (p=0.058) and Practice Orientation (p=0.090) showed similar, near-significant trends. Patient-Centred Communication was not statistically significantly affected by work duration (p=0.267).

Table 4.6: *Table comparing mean domain scores by work duration*

Domain	Work duration	Sample size	Mean	SD	P-value
1. Awareness/ sensitivity	0-9 years	22	4.62	.545	0.007
	10-19 years	11	4.33	.564	
	20-29 years	8	3.88	.500	
2. Behaviours	0-9 years	22	2.83	1.071	0.058
	10-19 years	11	2.43	1.241	
	20-29 years	8	1.95	.566	
3. Patient-centred communication	0-9 years	22	3.24	.778	0.267
	10-19 years	11	3.30	.526	
	20-29 years	8	2.83	.667	
4. Practice orientation	0-9 years	22	3.27	.436	0.090
	10-19 years	11	3.41	.273	
	20-29 years	8	2.90	.565	
5. Self-assessment	0-9 years	22	3.13	.422	0.021
	10-19 years	11	3.15	.451	
	20-29 years	8	2.67	.272	

4.2.4.3. Analysis of Mean Domain Scores by Gender

Gender significantly impacted Awareness/Sensitivity scores (p=0.014), with females scoring higher. Although females had higher average scores in all other domains, these differences did not reach statistical significance.

Table 4.7: *Table comparing mean domain scores by gender*

Domain	Gender	Sample Size	Mean	SD	P-value
1. Awareness/ 2. sensitivity	Male	13	4.06	.566	0.014
	Female	28	4.55	.562	
3. Behaviours	Male	13	2.42	1.224	0.341
	Female	28	2.61	1.021	
4. Patient-centred communication	Male	13	2.95	.743	0.180
	Female	28	3.29	.671	
5. Practice orientation	Male	13	3.18	.528	0.672
	Female	28	3.26	.423	
6. Self-assessment	Male	13	2.91	.484	0.175
	Female	28	3.11	.410	

4.2.4.4. Analysis of Mean Domain Scores by Job Grade

Job grade showed no statistically significant differences across all five domains ($p > 0.05$) as shown in table 4.8.

Table 4.8: *Table comparing mean domain scores by job grade*

Domain	Job Grade	Sample size	Mean	SD	P-value
1. Awareness/ Sensitivity	GP	18	4.64	.537	0.070
	Senior GP	20	4.19	.619	
	Principal GP	3	4.33	.458	
2. Behaviours	GP	18	2.68	1.062	0.502
	Senior GP	20	2.44	1.176	
	Principal GP	3	2.46	.439	
3. Patient-centred communication	GP	18	3.19	.786	0.812
	Senior GP	20	3.20	.696	
	Principal GP	3	3.00	.000	
4. Practice orientation	GP	18	3.28	.453	0.552
	Senior GP	20	3.17	.473	
	Principal GP	3	3.44	.333	
5. Self-assessment	GP	18	3.08	.381	0.784
	Senior GP	20	3.03	.504	
	Principal GP	3	2.89	.401	

4.2.4.5. Analysis of Mean Domain Scores by Cultural Competence Training Factor

Table 4.9. presents an overview of the mean domain scores analysed across various factors related to cultural competence training. Cultural competence training was significantly linked to higher scores in Behaviours (p=0.003) and Self-Assessment (p=0.027). Similarly, perceiving training as "Very Important" (p=0.016) and willingness

to undertake non-compulsory training (p=0.013) were also associated with significantly higher Behaviours scores. No other domains showed significant differences based on training factors or opinions on mandatory training. The small size of some subgroups (e.g., those with prior training, n=5) limits further interpretation and generalisability of these training-related findings.

Table 4.9: *Mean domain scores by cultural competence training factors*

Domain	Factor		Sample Size	Mean	SD	P-value
Awareness/ Sensitivity	Training Status	Yes	5	4.33	0.625	0.786
		No	36	4.41	0.607	
	Importance of Training	Very Important	13	4.57	0.666	0.299
		Important	27	4.36	0.521	
	Non-compulsory Training	Yes	18	4.55	0.604	0.193
		No	10	4.12	0.591	
		Maybe	13	4.4	0.573	
	Compulsory Training	Yes	16	4.53	0.66	0.516
		No	10	4.3	0.683	
		Maybe	15	4.32	0.483	
Behaviours	Training Status	Yes	5	4.15	1.304	0.003
		No	36	2.33	0.846	
	Importance of Training	Very Important	13	3.18	1.285	0.016
		Important	27	2.28	0.843	
	Non-compulsory Training	Yes	18	2.99	1.062	0.013
		No	10	2.01	0.624	
		Maybe	13	2.36	1.186	
	Compulsory Training	Yes	16	2.8	1.364	0.280
		No	10	2.14	0.771	
		Maybe	15	2.55	0.866	

(Table continues)

Domain	Factor		Sample Size	Mean	SD	P-value
Patient-centred Com-munication	Training Status	Yes	5	3.73	0.435	0.057
		No	36	3.1	0.703	
	Importance of Training	Very Important	13	3.23	0.699	0.833
		Important	27	3.21	0.668	
	Non-compulsory Training	Yes	18	3.31	0.631	0.379
		No	10	2.9	0.754	
		Maybe	13	3.21	0.752	
	Compulsory Training	Yes	16	3.21	0.654	0.757
		No	10	3	0.889	
		Maybe	15	3.27	0.645	
Practice Orientation	Training Status	Yes	5	3.2	0.298	0.673
		No	36	3.24	0.474	
	Importance of Training	Very Important	13	3.32	0.32	0.738
		Important	27	3.24	0.466	
	Non-compulsory Training	Yes	18	3.29	0.389	0.856
		No	10	3.17	0.62	
		Maybe	13	3.21	0.417	
	Compulsory Training	Yes	16	3.26	0.421	0.244
		No	10	3.01	0.563	
		Maybe	15	3.36	0.376	
Self-Assessment	Training Status	Yes	5	3.44	0.527	0.027
		No	36	2.99	0.403	
	Importance of Training	Very Important	13	3.11	0.433	0.631
		Important	27	3.04	0.426	
	Non-compulsory Training	Yes	18	3.15	0.41	0.406
		No	10	2.98	0.518	
		Maybe	13	2.95	0.415	
	Compulsory Training	Yes	16	3.13	0.437	0.62
		No	10	3.02	0.564	
		Maybe	15	2.97	0.358	

4.2.5. Statistical Analysis Using the Friedman Test

The Friedman test was employed to compare mean rating scores across multiple related statements. The mean scores for the first two domains range from 0 to 6,

where 0 corresponds to "Strongly Disagree/Never" and 6 corresponds to "Strongly Agree/Always." The mean scores for the last three domains range from 0 to 4, with 0 representing "Strongly Disagree/Never" and 4 indicating "Strongly Agree/Very Often."

The null hypothesis (H_o) states that there is no significant difference in the mean rating scores across the statements, and it is retained if the p-value exceeds the 0.05 level of significance. Conversely, the alternative hypothesis (H_1) asserts that there is a significant difference in the mean rating scores among the statements, and it is accepted if the p-value falls below the 0.05 threshold.

4.2.5.1. Analysis of Statements Related to the Awareness/Sensitivity Domain

The analysis of the Awareness/Sensitivity domain statements, as demonstrated in Table 4.10, was conducted to compare mean rating scores across related statements. The high variability in values ($p < 0.001$) indicates that respondents had significant differing views about the statements.

Respondents showed strong agreement with statements reflecting cultural awareness and sensitivity, particularly regarding diverse understandings of healthcare, the influence of cultural factors and spirituality on health, and the value of cultural knowledge in practice. Conversely, they disagreed with simplistic notions about immigrants, race as the primary determinant of culture, the homogeneity of cultural groups, and the idea that cultural understanding replaces individual

preference assessment. Notably, despite acknowledging the importance of cultural awareness, respondents reported low enjoyment in working with diverse cultures.

Table 4.10: *Respondent responses to statements on awareness/sensitivity (mean scores and standard deviations)*

Statements related to Awareness/Sensitivity	Mean	SD
Race is the most important factor in determining a person's culture.	2.83	1.687
People with a common cultural background think and act alike.	2.93	1.679
Many aspects of culture influence health and health care.	5.07	1.191
Aspects of cultural diversity need to be assessed for each individual, group, and organisation.	4.73	1.025
If I know about a person's culture, I don't need to assess their personal preferences for health services.	1.22	1.151
Spiritually and religious beliefs are important aspects of many cultural groups.	5.02	0.961
Individual people may identify with more than one cultural group.	4.51	1.399
Language barriers are the only difficulties for recent immigrants to the Maltese Islands.	0.80	0.901
I understand that people from different cultures may define the concept of 'health care' in different ways.	5.22	0.791
I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organisations.	4.80	0.843
I enjoy working with people who are culturally different from me.	2.78	1.370

$X^2(10) = 253.063$, $p < 0.001$

4.2.5.2. Analysis of Statements Related to the Behaviour Domain

As displayed in Table 4.11, the mean scores analysed in relation to culturally competent behaviours exhibit significant variability ($p < 0.001$). The mean scores for this domain range from 0 to 6.

Respondents positively rated welcoming input on cross-cultural interactions from patients, families, and colleagues, as well as avoiding stereotypes and recognising cultural barriers. They reported acting slightly more often on identified barriers than those raised by patients/families. In contrast, the lowest ratings concerned the availability of cultural competence resources and proactive information gathering on new patients' cultural needs. Documentation of cultural competence behaviours, such as assessments and adaptations, was also low.

Table 4.11: *Respondent responses to statements on behaviour (mean scores and standard deviations)*

Statements related to behaviours	Mean	SD
I include cultural assessment when I do client or family evaluations.	2.10	1.428
I seek information on cultural needs when I identify new patients and families in my practice.	1.66	1.257
I have resource books and other materials available to help me learn about patients and families from different cultures.	0.59	1.161
I use a variety of sources to learn about the cultural heritage of other people.	1.22	1.314
I ask patients and families to give me their own explanations of health and illness.	2.54	1.925
I ask patients and families to tell me about their expectations for health services.	2.78	1.891
I avoid using generalisations to stereotype groups of people.	3.63	1.392
I recognise potential barriers to service that might be encountered by different people.	3.56	1.517
I act to remove obstacles for people of different cultures when I identify such obstacles.	3.46	1.614
I remove obstacles for people of different cultures when patients and families identify such obstacles to me.	3.29	1.585
I welcome feedback from patients and their families about how I relate to others with different cultures.	4.00	1.533
I welcome feedback from co-workers about how I relate to others with different cultures.	3.88	1.990
I find ways to adapt my services to my patients and their families' preferences.	3.07	1.439
I document cultural assessments.	1.27	1.550
I document the adaptations I make with patients and their families.	1.34	1.353
I learn from my co-workers about people with different cultural heritages.	2.39	1.595

$X^2(15) = 306.044$, $p < 0.001$

4.2.5.3. Analysis of Statements related to the Patient-Centred Communication Domain

The analysis of statements related to patient-centred communication reveals significant variability, as indicated by a p-value of 0.004. The high average mean scores (all above 3 on a 0-4 scale) suggest respondents' agreement with the principles of Patient-Centred Communication.

Table 4.12: *Respondent responses to statements on practice-centred communication (mean Scores and standard deviations)*

Statements related to patient-centred communication	Mean	SD
When there are a variety of treatment options, how often do you give the client and their family a choice when making a decision?	3.32	0.687
When there are a variety of treatment options, how often do you make an effort to give the client and their family control over their treatment?	3.17	0.771
When there are a variety of treatment options, how often do you ask the client and their family to take responsibility for their treatment?	3.05	0.805

$X^2(2) = 11.105$, $p = 0.004$

4.2.5.4. Analysis of Statements related to the Practice Orientation domain

When analysing the statements related to practice orientation on a 0–4 response scale, there is notable variability in the responses. As shown in Table 4.13, most of the mean scores are below 1.3, suggesting that respondents generally disagree with the majority of the statements. The statements with the lowest mean values are negatively worded, indicating that respondents align more with the positive aspects of practice orientation.

Table 4.13: *Respondent responses to statements on practice orientation (mean scores and standard deviations)*

Statements related to practice orientation	Mean	SD
The health care provider is the one who should decide what gets talked about during a visit.	0.68	0.567
It is often best for the client and their family that they do not have a full explanation of the client's medical condition.	0.61	0.586
The client and their family should rely on their health care providers' knowledge and not try to find out about their condition(s) on their own.	0.93	0.818
When health care providers ask a lot of questions about a client and their family's background, they are prying too much into personal matters.	0.76	0.830
If health care providers are truly good at diagnosis and treatment, the way they relate to client and their family is not that important.	0.39	0.542
The client and their family should be treated as if they are partners with the health care provider, equal in power and status.	3.10	0.917
When the client and their family disagree with their health care provider, this is a sign that the health care provider does not have the client and their family's respect and trust.	1.27	0.867
A treatment plan cannot succeed if it is in conflict with a client and their family's lifestyle or values.	3.41	0.706
It is not that important to know a client and their family's culture and background in order to treat the client's illness.	0.76	0.830

$X^2(8) = 196.710$, $p < 0.001$

4.2.5.5. Analysis of Statements Related to the Self-Assessment Domain

Analysis of respondent self-assessment responses on a 0-4 scale revealed a complex picture, with a general positive trend in mean scores. However, this was overshadowed by significant variability among respondents (Table 4.14).

Table 4.14: *Respondent responses to statements on self-assessment (mean scores and standard deviations)*

Statements related to self-assessment	Mean	SD
As a health care provider, I understand how to lower communication barriers with patients and their families.	2.68	0.687
I have a positive communication style with patients and their families.	2.98	0.612
As a health care provider, I am able to foster a friendly environment with my patients and their families.	3.05	0.545
I attempt to demonstrate a high level of respect for patients and their families.	3.34	0.575
As a health care provider, I consistently assess my skills as I work with diverse groups of patients and their families.	2.20	1.005
I attempt to establish a genuine sense of trust with my patients and their families.	3.22	0.525
I make every effort to understand the unique circumstances of each client and her/his family.	3.05	0.705
I value the life experience of each of my patients and their families.	3.34	0.575
The use of effective interpersonal skills is very important in working with my patients and their families.	3.54	0.552

$X^2(8) = 127.095$, $p < 0.001$

4.2.6. Conclusion of Quantitative Findings

The quantitative results showed significant variations in cultural competency by years of experience, training exposure, age, and gender. Significant variation was observed in domains like Self-Assessment and Awareness/Sensitivity, especially among younger and less experienced respondents. These findings demonstrate how professional and demographic characteristics affect cultural competency in the PHC context.

4.3. Qualitative Results

4.3.1. Profile of Interviewees

A total of seven interviews were conducted with participants from various PHC roles. The sample included five principal general practitioners (PGPs), one private general practitioner, and one practice nurse. All participants held leadership positions within PHC, professional medical associations, or migrant healthcare services, and their experience levels ranged from 1 to 17 years.

Fifteen invitations were sent for participation in the qualitative interviews. Seven interviews were completed, while the remaining individuals either declined the invitation or did not respond. In cases where the invitee declined, the interview was delegated to a colleague in a similarly informed position, ensuring that relevant insights from that role was still captured. Those who did not respond were nonetheless represented in the final sample, as participants with similar professional roles and backgrounds were included. As a result, even though there were fewer interviews than anticipated, the final cohort reflected the diversity and scope intended for the qualitative phase.

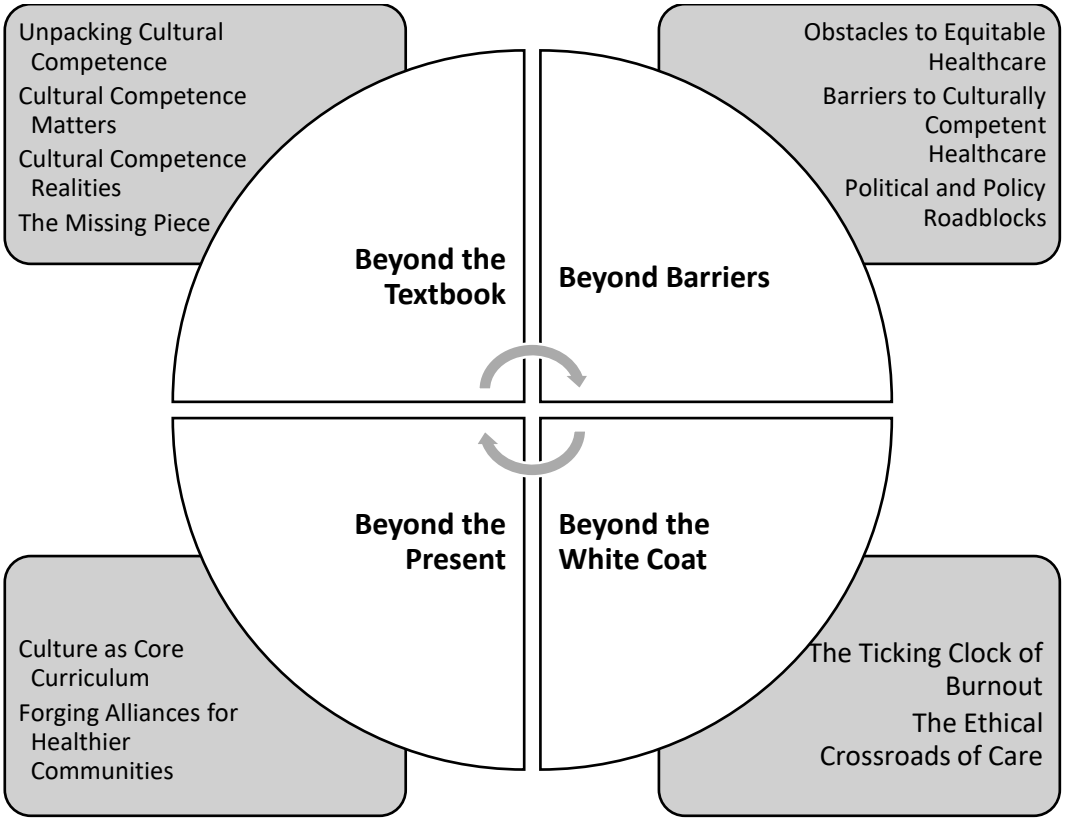
4.3.2. The Themes

This section presents the qualitative findings through four main themes derived from inductive thematic analysis. As outlined in the previous chapter, themes were developed using Braun and Clarke's (2006) six-phase approach. Through this process, four interconnected themes were identified: Beyond the Textbook, Beyond Barriers,

Beyond the White Coat, and Beyond the Present. Figure 4.1 provides an overview of these themes along with their corresponding subthemes.

The themes are presented in a clockwise sequence, beginning with Beyond the Textbook and ending with Beyond the Present. This structure was intentionally designed to reflect a progressive narrative evident in the data. It mirrors the evolution of participant reflections, starting with basic understandings of cultural competence, moving through systemic and structural barriers, addressing personal and emotional challenges, and culminating in future-focused insights and proposed solutions.

Figure 4.1: *Infographic showing the themes and subthemes*



4.3.2.1. Beyond the Textbook

'Beyond the Textbook' delves into the participants' definitions and perceived value of cultural competence. This theme uncovers a spectrum of understanding and

confidence levels among healthcare professionals, exposing both conceptual knowledge and areas where definitions remain vague or uncertain.

4.3.2.1.1. Unpacking Cultural Competence

This subtheme was derived from the participants' understanding of what cultural competence entails. P1 and P2 expressed uncertainty regarding its definition, while P4 paused for a significant period before attempting to respond. Additionally, two respondents (P5 and P6) employed tentative language, such as "I think" and "I understand," which may suggest a lack of confidence in their responses.

In contrast, P3 provided a nuanced and insightful definition of cultural competence, exceeding typical textbook explanations:

> Cultural competence [requires] realis[ing] that the way you were brought up ... does not mean [it] can be generalised to other people ... One of the big mistakes we make is assuming that because [migrants] are in Malta, they should follow our processes … It doesn't work. Every person has their own upbringing, past traumas, and beliefs … One has to sit, listen attentively, and be aware of cultural differences.

Most respondents described cultural competence in philosophical terms, emphasizing concepts such as mindfulness, awareness, and sensitivity. For instance, P1 stated: "Not so sure. I mean, I think the ability to deal, to understand, and adapt to the notion of culture in our practices." Similarly, P5 emphasized cultural sensitivity, "I think awareness, insights, mindfulness, that is seeing the world as a world. Not in silos, other countries. Being culturally sensitive". Only P6 provided an

operational definition: “I understand it to be that I can function as a family doctor in the culture of the place and the culture of the person with whom I'm doing the consultations”.

4.3.2.1.2. Cultural Competence Matters

Although several respondents were uncertain about how to define cultural competence, there was a clear consensus that it is an essential component of PHC. When asked whether cultural competence is essential in PHC, P2 responded affirmatively, stating: “Yes, definitely. You have to have at least a bit of a basic knowledge of certain things”. This confident affirmation was echoed across interviews.

Viewing cultural competence as crucial, respondents, highlighted the potential for significant barriers to marginalised groups when it is lacking in practice. P7 highlights the human cost of neglecting cultural competence:

> The patient might feel that there's no compassion, there's no humanity. There's just this piece of paper that I have to buy and I can't afford it. And that's it. There's no sort of satisfaction in the end.

Furthermore, P3 highlights the gravity of the absence of culturally competent care by linking it so severe mental health consequences: “Feeling that your health is being neglected means it's an additional stressor … that was leading to a lot of episodes of self-harm and mental health hardship.”

Moreover, respondents articulated the doctor's perspective by highlighting the necessity of cultural competence in adapting medical practice to meet the needs of

the everchanging population demographics. P1, articulated this point, stating, “When you're planning a service, you can't restrict yourself to one particular patient population because otherwise you run the risk of failing.”

P6 echoes the significance of this, asserting, “Culture is rooted in the consultation of PHC”.

In a reflective tone, P5 emphasized that cultural competence is not a supplementary skill but a core necessity in addressing inequalities, noting:

> Yes. I think it does [lead to inequalities]. I think there would be an intrinsic bias sometimes of preferring to treat your own people and your own culture ... it’s good to be conscious about it because then you make up an extra effort not to be biased.

4.3.2.1.3. Cultural Competence Realities

While the value of cultural competence was broadly affirmed as a cornerstone of PHC, notable inconsistencies emerged in its practical application. A palpable concern regarding its insufficient prioritisation was expressed, with four respondents stating that cultural competence is not adequately emphasized within current PHC systems in Malta.

P4 was very assertive stating: "It is not being prioritised. It’s a one-size-fits-all practice, basically", further stating that, “There are so many other issues which are more pressing at the moment that we leave cultural knowledge about cultural difference on the back burner”.

Similarly P5 refers to the shallow application of cultural competence in practice saying, “It's sort of like by default, it's there, it's happening, and we have to deal with it, but I don't think it's prioritized at all”. P7 highlighted a lack of engagement at the organisational level, “It's never mentioned in meetings. Unless we have a big issue, (and then) we make a story out of it”.

The lack of strategic priority for cultural competence within PHC, as revealed by these accounts, was implicitly corroborated by another respondent who recognises past initiatives but fails to mention sustained or ongoing efforts, “We used to have a few cultural mediators… but that seems to have died down a bit, to be honest”.

Meanwhile, P6 suggested that cultural competence receives only partial and limited priority in PHC. His remarks reflected a more individualised approach, likely shaped by his role in private practice: “I try as much as possible to reflect the changes in culture and in my community as I go along”.

4.3.2.1.4. The Missing Piece

These inconsistent practices in cultural competence reflect foundational issues stemming from the medical training system. While all respondents acknowledged the need for more training, there was a fragmented understanding of what current training opportunities exist. Only two respondents made direct reference to undergraduate education. P3 clearly stated, “Migrant health has never come neither nowhere undergraduate course training nor in our specialist of family medicine training”.

In contrast to P3's view, all five of the remaining respondents acknowledged the presence of cultural competence within the family medicine specialty training programme. However, their comments collectively implied that the coverage is superficial. P4 described it as, "a fraction of the curriculum", while P5 noted, "We have a lecture about migrant health… but I think we could do more."

When it comes to post-specialisation cultural competence training, P7, who is actively involved in delivering such courses, highlighted the lack of participation from doctors, explaining, "Very few attend training… unless it is clinical, they don't really come forward". This limited attendance is reflected in the fact that some doctors were unaware that such training exists. P1 expressed uncertainty, stating: "I don't think we offer any particular training… I'm not aware… possibly they exist, but the pick-up might be limited". Meanwhile, P6 was more direct, asserting: "I'm not aware that there are any training sessions for [qualified GPs]… An official training, I'm not aware that it is there".

4.3.2.2. Beyond Barriers

Building on the previous theme, the 'Beyond Barriers' theme identifies concrete obstacles that hinder culturally competent care. It highlights the systemic, institutional, and interpersonal challenges that prevent the equitable delivery of healthcare to culturally diverse populations.

4.3.2.2.1. Barriers to Equitable Healthcare Access

A central subtheme amongst all the respondents was communication barriers in PHC. All 7 respondents explicitly mentioned, language as an obstacle. Notably, P4 went a step further, highlighting how non-verbal communication can also complicate interpretation, stating, "Language, definitely… Even the way some people say yes… in itself is a language — verbal and nonverbal cues are different."

Furthermore, 5 respondents expressed concerns related to the availability and reliability of translators. The respondent that works in the private sector acknowledged the potential drawbacks of relying on patient-provided translators, admitting, “there is a question mark about the reliability of the translation.” This concern was echoed by P7: “Even when you do have cultural mediators, although they are trained, you will never know what they are telling them.” In contrast, P3 describes a reliable, structured online interpretation service used in detention settings, emphasizing that it is “tested specifically for refugees,” and that the translators' “are very knowledgeable about the issues we are discussing”.

Despite not being a dominant concern amongst all respondents, structural and bureaucratic barriers were brought up by three respondents. P3 accounts how prior to the setting up of the PHC structure in detention centres, whether individuals received medical access was decided by non-clinical gatekeepers, which led to delayed or missed interventions. He also highlighted the lack of logistical systems for prescriptions at the time, questioning, “Who buys the prescription? From what funds? Who gives it to them?” In addition, P3 described the undignified conditions in which detainees were transported for healthcare: “They would bring them in

handcuffs ... portrayed along the clinic corridor, everybody looking at them". While some of these issues have improved with the assignment of a dedicated doctor to the detention centre, P3 emphasized that the system remains fragile, describing it as a "one-man show".

P6 addressed these barriers by focusing on issues of access and system navigation. He acknowledged that, while "The service is almost the same for everybody, but then the access can be different". He attributed this disparity to economic hardships and lack of familiarity with the local health system. His view may reflect the realities of working within the private sector, where affordability barriers may be more visible. Similarly, P7 drew attention to the financial struggles faced by vulnerable populations, saying "it's useless telling him, eat vegetables and fruit because he can't afford them."

P7 critically noted increasing bureaucratic demands, like mandatory ID checks, potentially deterring undocumented migrants from seeking care. She also pointed out problems with the inconsistent patient registration system, explaining, "They are given multiple F numbers… so you're lost."

4.3.2.2.2. Barriers to Culturally Competent Healthcare

Findings from the interviews revealed that a principal impediment to the provision of culturally competent healthcare is a lack of formal training, as detailed in section 4.3.2.1.4. A significant proportion of respondents (n=5) indicated that cultural competence education is often treated as optional and left to the individual interest. For instance, P3 remarked, "Migrant health has never come in our…

training. I had to learn it on the go", highlighting the absence of formal instruction during medical education. Similarly, P5 stated that, "It's more on an individual basis if you're interested to read it".

This lack of formal training contributes to a healthcare system that remains rigid to address the needs of culturally diverse populations. As P5 reflected, "We're not equipped, and we're not that aware". P1 reiterated this concern, stating, "Our interventions are not specific or targeted enough for these individuals".

The lack of cultural training and inflexible systems contribute to reductive assumptions about culturally diverse populations. Only one respondent, P5, admits to how personal biases can influence treatment choices, pointing out that "There's an intrinsic bias sometimes of preferring to treat your own people."

If not addressed, these biases can promote stereotyping. A consultation with an Arab couple, as recounted by the same respondent, exemplified this:

> Sometimes with Arab countries, where the woman and the man consult together ... she won't speak, and when I addressed her, he got offended… it doesn't mean he does not respect her, but it comes across as that.

Some descriptions of cultural groups in the interviews reflected implicit generalizations, suggesting the presence of unconscious stereotyping. For instance, one participant remarked, "With nationalities from Arabic countries ... to be sick is something terrible", and made broad statements like, "The Asian people, they are quite friendly, they are quite nice, they are respectful", and "Some people with an Eastern European background are more mechanistic."

Finally, another barrier to delivering culturally competent care is the presence of xenophobic attitudes among some members of the Maltese patient population. Three respondents explicitly referred to this dynamic. P5 observed that,

> The ethnic Maltese population gets offended immediately because they feel threatened. They feel that their needs are not going to be met in a timely manner because of the influx of external people tapping into limited resources

Indeed P2 remarked that, “The Maltese have a tendency to be a bit pushy… sometimes it’s a clash of cultures”. Such attitudes may undermine efforts to deliver equitable and inclusive care.

4.3.2.2.3. Political Barriers

The xenophobic attitudes within some members of the Maltese patient population as expressed by the respondents may reflect a broader political climate in which societal resistance to migration impedes the advancement of migrant healthcare services. Policymakers, anticipating potential public backlash, may be hesitant to prioritise or promote such initiatives. P3 exemplified this caution, stating, “There has been expansion in PHC, but we have to wait for the right time to expand further. Arrivals have decreased, so it’s not the right time for this.” Similarly, P4 acknowledged how culturally competent care is often deprioritised: “Unfortunately, there are so many other issues which are more pressing at the moment that we leave knowledge about cultural difference on the back burner.” Most strikingly, P7 reflects on the politicisation of cultural competence itself, suggesting it is sometimes

viewed not as a clinical necessity but as an ideological agenda: “Maybe they think we are going to convert them into liking migrants”.

4.3.2.3. Beyond the White Coat

‘Beyond the White Coat’ highlights the internal impact of these challenges on healthcare workers' well-being and ethical considerations. This theme reveals the psychological stress, moral conflicts, and professional burnout experienced by providers as they navigate intricate cultural dynamics within demanding environments.

4.3.2.3.1. The Ticking Clock of Burnout

The interviews revealed a palpable sense of burnout among all respondents. While some spoke about it explicitly, others conveyed it more subtly.

Some referred to the time constraints, a common contributor to burnout, highlighting the demanding nature of their work. P1 remarked that “Our doctors are operating in a very busy, busy context, and therefore in order to adjust themselves between patients might be difficult.”. This sentiment was echoed by P7, who stated, “Some migrants … if you allow them, it would take hours. Very long hours”, illustrating how time constraints can exacerbate strain on the doctor. The pressure of time was also evident in the private sector. P6 stated that, “Primary Health Care is overrun, swamped at the moment”.

Furthermore, P4 and P5 both find culturally diverse consultations particularly taxing, with P4 stating, “There’s so much more we can do. It’s very difficult for us”,

and P5 noting, “You need much more mental energy to deal with people who are from another country”. Adding to this, P2 hinted at the emotional toll of intercultural tension, noting, “We try our best to avoid it ... but it can happen. Basically, it’s a clash of cultures.”

Together, these reflections underscore how time constraints and cultural complexity amalgamate to amplify stress and fatigue, contributing to burnout in doctors.

4.3.2.3.2. The Ethical Crossroads of Care

Another struggle doctors experience is the internal conflict that arises from administrative restrictions, systemic barriers, and policy limitations. A sense of powerlessness was commonly echoed across respondents, reflecting the emotional toll of working within a system that often contradicts their professional values and intentions.

P4 highlighted how compassion is often met with systemic inaction, stating,

> The Muslim society were actually helping her … we told her, ‘We're there for you’ ... but unfortunately, there wasn't much we could do.

Likewise, P3 described feelings of helplessness stemming from institutional exclusion: “Sometimes … maybe not being able to access the health service at all because they would have been ignored.” P5 expressed the ethical tension between care and paternalism, noting,

> Sometimes it's difficult not to feel sorry for them … and we might actually be doing them a disservice because … it’s not what they need.

This respondent also reflected on how system pressure undermines culturally sensitive care: “Sometimes you're too tired to do it [culturally sensitive care] because there's so much work to do”.

These insights reveal the internal struggle healthcare providers face, as structural constraints not only limit their actions but also create emotional strain.

4.3.2.4. Beyond the Present

This theme concludes the journey with a vision for the future, emphasizing the need for formal training and intersectoral collaboration. It captures participants' hopes for enhanced educational structures, the implementation of inclusive service design, and a healthcare system that is more effectively prepared to meet the demands of a diverse society.

4.3.2.4.1. Culture as Core Curriculum

Respondents expressed varied responses to training, with only one respondent reporting undertaking formal training, stating: "You do a lot of online training. Certifications. Here and there online, depending on what you find”. This response reflects a self-directed and informal approach to cultural competence development. The remaining respondents lacked experiencing structured training, leading to evident cultural competence insecurity.

Recognising this gap, there was widespread agreement among respondents that training should be a core element of family medicine specialisation with P1 stressing, "We need specific training, dedicated time towards this kind of training”.

P3 proposed that a dedicated rotation in detention centres should be “mandatory and completely within the package of the training”.

P4 advocated for more traditional, theory-based methods such as "online lectures, posters, getting patients to discuss their issues, and auditing their feedback", whereas P5 proposed a contrasting experiential and holistic pedagogical approach, incorporating volunteerism, reflective practice, and creative inquiry within the training curriculum:

> If, for example, they reflect and then produce something creatively, such as a poem, photography, painting, or music, inspired by their experiences with a diverse culture, and have an exhibition at the end of the three years ... It's a different way of looking at it.

This collective input highlights a strong consensus that cultural competence training must move beyond ad hoc learning to become more integrated and structured.

4.3.2.4.2. Forging Alliances for Healthier Communities

Several respondents moved beyond the notion of training alone, emphasizing the importance of co-designing health systems through collaborative alliances.

P1 highlighted the ongoing efforts to include service users in planning, stating,

> We're also working on involving, trying to involve representatives of the population more towards setting up services ... we're still not there yet, we're trying to get there.

P7 advocated for broader engagement beyond internal management structures, emphasizing,

> You ask an NGO, you ask someone who works in the centres ... You can't just limit your resource to the management where you're working.

Likewise, P3 underscored the need for inter-agency collaboration by explaining, “If we go to one of the centres, we have to also collaborate with AWAS, which is the Asylum Seeker and Welfare Agency.”

The respondent insights collectively illustrate that cultural competence development, with fully integrated training, should be embedded within a broader, collaborative framework encompassing interagency cooperation and diverse stakeholder participation.

4.3.3. Conclusion of Qualitative Findings

The qualitative findings revealed complex and multifaceted perceptions of cultural competence among healthcare professionals. Themes highlighted gaps in training, systemic barriers, emotional strain, and the need for greater institutional support. Despite these challenges, participants expressed a clear commitment to improving care for diverse populations through more integrated training and collaborative service design.

4.4. Concluding remarks

Together, the quantitative and qualitative findings provide a comprehensive understanding of the current state of cultural competence in PHC. They reveal both

structural and personal challenges, as well as areas of potential growth. The following chapter discusses these findings in relation to existing literature, drawing out key implications for practice, training, and policy.

Chapter 5: Discussion

This chapter presents a discussion of the combined quantitative and qualitative findings of the study. The discussion is guided by the research aims and objectives and is interpreted in light of the existing literature reviewed in Chapter 2.

5.1. Aims and Objectives

This study's objectives were to explore the cultural beliefs, knowledge, and behaviours of PHC doctors during patient interactions; to identify both strengths and deficits in their cultural competence; to establish the level of cultural competence at the organisational level; and to propose recommendations for implementing multicultural training for PHC doctors.

These objectives inform the pivotal research question: How does the perceived cultural competence of individual PHC doctors in Malta intersect with the cultural competence of their healthcare organisations?

5.2. Structure and Framing of the Discussion

The discussion is structured to mirror the study's four objectives, allowing for a coherent interpretation of findings. Section 5.2.1, The Value of Cultural Competence in Clinical Practice, explores PHC doctors' cultural knowledge, beliefs, and behaviours during patient interactions, addressing Objective 1. Section 5.2.2, Strengths and Shortcomings in GPs' Cultural Competence, addresses Objective 2, analysing both strengths and limitations. Section 5.2.3, The Organisational Landscape of Cultural Competence, focuses on Objective 3, assessing how cultural competence is embedded at the organisational level. Section 5.2.4, Gaps and

Opportunities in Cultural Competence Training, reviews current training practices and professional readiness. The final objective, to make specific recommendations for implementing multicultural training, is discussed in Chapter 6.

5.3. Discussion

5.3.1. The Value of Cultural Competence in Clinical Practice

This section responds to the first objective by examining the cultural understanding, attitudes, and practices of PHC doctors in the context of their interactions with patients.

5.3.1.1. Beliefs

Cultural competence is not simply a desirable trait in clinical practice; it is an essential requirement for delivering equitable, effective, and patient-centred care. In this study, 97.6% of respondents of the survey rated cultural competence as either “important” or “very important”, reflecting a broad consensus on its significance within the clinical setting. Qualitative findings further substantiated this perspective. Several participants articulated a deep philosophical appreciation for the role of cultural competence in healthcare. For example, P3 stated, “Not understanding culture means not understanding the patient,” while P5 observed, “It’s not just about language, it’s about how people see illness, the system, and even us as doctors” These reflections suggest that many practitioners view cultural competence as a foundational component of clinical understanding rather than a peripheral skill. These qualitative reflections complement the quantitative results, which showed near-unanimous agreement on the importance of cultural

competence, confirming that both the attitudinal and philosophical dimensions of competence are widely recognised among Maltese PHC doctors. Together, they demonstrate that the value of cultural competence is conceptually well-established, even if practical implementation remains rather sparse and uneven.

Participants emphasized that when cultural competence was present, it helped foster trust, improve communication, and reduce patient withdrawal. P7 remarked that “if you show a patient that you know a bit about his background ... that makes a difference”, highlighting how even simple acknowledgments of cultural context can strengthen the therapeutic relationship. Conversely, when competence was lacking, patients “might present a bit late... with florid symptoms”, (P5) noting how cultural misunderstandings can delay help-seeking and complicate clinical management. Comparable findings have been documented in the literature, where culturally competent providers have been shown to mitigate health inequalities, improve quality of care and foster cultural safety (Alzaye et al., 2019; Farley et al., 2014; Ofosu et al., 2023; Smith et al., 2017; Sundareswaran et al., 2024).

5.3.1.2. Cultural Knowledge

This alignment in attitudes is further substantiated by the respondents of the survey exhibiting high levels of cultural awareness and sensitivity. Quantitative findings showed strong agreement with statements emphasising cultural diversity and non-linguistic barriers, aligning with the “Awareness” and “Knowledge” domains of Campinha-Bacote’s Model.

However, this model also highlights the need of progression through the development of skill, ongoing cultural encounters, and a genuine desire to engage

meaningfully with cultural differences (Campinha-Bacote, 2002). This is echoed in Smith et al. (2017), who argue that awareness alone is insufficient to ensure culturally safe care.

However, the qualitative interviews revealed inconsistent understandings of cultural competence, with only one participant defining cultural competence in detail. This contrast suggests that while respondents are familiar with the concept of cultural competence, their understanding may be largely theoretical and lacking in practical application within clinical settings. This contrast between measured awareness and expressed uncertainty in the interviews illustrates the central finding of this study: cultural competence among GPs is conceptually endorsed but inconsistently enacted in practice. This interpretation is further supported by the significantly higher scores reported by younger doctors in both the Awareness/Sensitivity domain ($p = 0.008$) and the Self-Assessment domain ($p = 0.047$). These results may reflect a trend where less experienced GPs perceive themselves as more culturally competent, because, as younger individuals, they may have grown up in a more culturally diverse society compared to their older counterparts, whose exposure to such diversity often came later in their careers or lives.

Interestingly, this generational trend in cultural competence aligns with findings from broader international literature. For example, Singh et al. (2017) noted that younger Canadian medical residents rated their preparedness for cross-cultural care more highly than their older counterparts, attributing this to their more recent exposure to evolving multicultural curricula. Similarly, the current study found statistically significant differences in both awareness and self-assessment domains among younger PHC doctors, indicating a potential generational shift in how cultural

competence is internalised. While this may initially appear encouraging, it also raises concerns about the sustainability of cultural competence over time. As Reath et al. (2018) and Watt et al. (2015) highlight, without structured and ongoing cultural competence training, early gains during residency or postgraduate education risk fading due to clinical pressures, burnout, and lack of reinforcement. This underscores the need for longitudinal professional development models that not only introduce cultural competence early but also maintain and deepen it across a clinician's career trajectory. A dynamic view of cultural competence, as articulated in the Campinha-Bacote model, emphasizes the importance of continuous self-assessment and skill refinement throughout practice (Campinha-Bacote, 2002), further supporting the necessity for institutionalised refresher training and reflective learning spaces. Taken together, the quantitative results establish a baseline of positive attitudes and self-awareness, while the qualitative data contextualise why these do not always translate into daily practice, particularly in the absence of structured reinforcement and institutional guidance.

5.3.1.3. Behaviours

Although GPs exhibited strong cultural awareness and sensitivity, the study highlights a notable gap between this awareness and its practical application in behaviour. Survey scores within the Behaviour domain were low overall, indicating infrequent documentation and active inquiry into cultural needs. These quantitative results were mirrored in the interview narratives, where participants described awareness as understood but not always applied, reflecting a disconnection between intention and habitual clinical behaviour. These findings further reinforce

the assertation that awareness of cultural competence is not consistently put into practice.

This gap becomes even more critical when considered in the light of Malta's walk-in PHC model, where patients are often seen by different doctors at each visit. In such settings, continuity of culturally competent care depends heavily on what is documented in the medical file. When cultural considerations are not recorded, they risk being lost between consultations, leading to fragmented or impersonal care. The consistently low documentation scores in this study suggest a form of practice inertia, where awareness remains theoretical and is not embedded in daily routines. Depares (2016) further confirms that Maltese healthcare workers often regard cultural factors as clinically relevant but too informal to be recorded, reinforcing the gap between awareness and action. These findings echo wider international concerns. For instance, studies in Australia and Canada have shown that without structured documentation systems, cultural insights are often lost between providers (Duncan et al., 2013; Ofosu et al., 2023).

Notably, GPs who expressed a willingness to participate in non-compulsory cultural competence training scored significantly higher in the Behaviour domain. This implies that GPs who are willing to learn are more likely to integrate culturally responsive behaviours into their practice. This aligns with existing evidence that proactive engagement in structured training, alongside meaningful cultural mentorship, plays a vital role in supporting GPs to translate knowledge of cultural competence into practical, behaviour-based application (Reath et al., 2018; Smith et al., 2017; Watt et al., 2015).

These findings suggest that culturally responsive behaviours do not occur in a vacuum but are influenced by many factors. One cannot examine these behavioural gaps without also considering the underlying barriers that shape them. The most prominent are language and communication challenges. In a study conducted locally, language was frequently cited by Maltese PHC providers as a barrier that led to limited interaction and overreliance on cultural assumptions (Depares, 2016). The literature frequently identifies challenges in cross-linguistic communication, unease with culturally sensitive dialogues, and variable communication approaches as prevalent issues. These factors impede healthcare providers' capacity to establish rapport, obtain precise patient information, and deliver genuinely patient-centred care, thereby ultimately constraining the behavioural manifestation of cultural competence (Argyriadis et al., 2022; Dolan et al., 2020; Smith et al., 2017; Watt et al., 2015).

All interview participants identified language and communication as a central obstacle, with P2 remarking, “Well, the biggest problem is the same one. It's the language barrier most often,” and P1 emphasizing the limitation of non-verbals saying “non-verbals might not be enough”. Several participants also described relying on ad hoc translation methods, such as Google Translate or untrained companions, which further limited effective communication. These qualitative insights align with the quantitative findings from the Self-Assessment domain, where participants rated themselves moderately on their ability to lower communication barriers.

This alignment between numerical and narrative data reinforces the conclusion that communication difficulties are both a measurable and personally felt barrier to

cultural competence. The convergence of these findings across methods strengthens the validity of this interpretation.

5.3.2. Strengths and Shortcomings in GPs' Cultural Competence

This section responds to the second objective examining the dual nature of cultural competence among GPs, highlighting key strengths that support effective cross-cultural care, while also identifying persistent shortcomings that hinder its consistent application.

5.3.2.1. Strengths in GPs' Cultural Competence

5.3.2.1.1. Commitment to Respect and Rapport

Analysis of both datasets revealed a substantial degree of intrinsic motivation among participants when it comes to interpersonal skills. From the quantitative perspective, the Self-Assessment domain yielded elevated scores in items indicative of interpersonal respect and empathic understanding. This includes valuing the patient's life experiences (M = 3.34), fostering trust (M = 3.22), and using effective interpersonal skills (M = 3.54). These findings were echoed in the interview narratives, where participants consistently framed cultural competence in terms of awareness, respect, and mindfulness. For instance, P7 reflected that "showing a patient you know a bit about his background … makes a difference", while P5 emphasized the importance of "awareness, insights, mindfulness … seeing the world as a world".

These findings align with Liaw et al. (2015), who argue that interpersonal connection, built through trust and mutual respect, is foundational to enhancing

cultural respect and achieving improved health outcomes. Furthermore, both Campinha-Bacote's model and the ACT Cultural Competence Model explicitly underscore the central role of interpersonal connection in the development of cultural competence. Campinha-Bacote (2002) argues that true cultural competence cannot be taught without an internal willingness to build meaningful, respectful relationships with patients from diverse backgrounds. Similarly, the ACT model places emotional responsiveness and relational engagement at the heart of culturally competent care, with its "Connect Relations" component emphasizing the importance of genuine, empathetic relationships that validate patient experiences and promote trust (Li et al., 2023). Quantitative and qualitative data converge on this point. The consistently high scores in patient-centred communication mirror interview narratives that foreground empathy, listening, and relational engagement as core strengths among GPs.

Additionally, participants rated themselves highly in Patient-Centred Communication, indicating positive perceptions of their ability to collaborate with patients and encourage their involvement (average scores between 3.05 and 3.32 out of 4), further supporting these findings. This suggests that many GPs already possess strong interpersonal skills, which are crucial for building more advanced cultural competence. Although their knowledge of specific cultures may differ, this basic tendency towards respectful and inclusive communication indicates a willingness to connect more effectively with patients from diverse backgrounds.

5.3.2.1.2. Commitment to Continuous Learning

The datasets collectively suggest a strong foundational sense of self-awareness and openness to growth among participants. Although only 12.2% had received cultural competence training, there was notable latent willingness to improve, with 43.9% of respondents indicating they would participate in non-compulsory training, and an additional 36.6% responding “maybe”. This openness was further substantiated by positive scores reflecting a welcoming attitude towards feedback on cross-cultural interactions from both patients (M = 4.00) and colleagues (M = 3.88).

Qualitative findings echoed this potential for development. Several participants expressed a reflective stance toward their cultural competence and acknowledged the need for further growth. This pattern reinforces the survey findings, where respondents expressed willingness to attend training despite limited prior exposure. Together, both strands suggest that although structural training opportunities are scarce, there exists a strong motivational foundation for professional growth. Even participants who struggled to define cultural competence affirmed its importance and expressed a willingness to learn more. These perspectives underscore a readiness for deeper engagement, suggesting that while practical application may be uneven, the mindset required for training and growth in cultural competence is already present.

The observed willingness to engage, reflect, and improve, evident in both quantitative and qualitative findings, indicates a promising context for effective training initiatives. Research suggests that this inherent motivation constitutes a significant advantage. If appropriately cultivated, it has the potential to foster substantial and lasting enhancements in culturally competent care. Nevertheless,

while this underlying disposition is positive, sole dependence on informal learning and individual motivation may result in inconsistent progress. Practitioners exhibit varying degrees of self-reflection and self-direction, and without structured training, standardisation, and continuous support, the advancement of cultural competence may remain inconsistent (Singh et al., 2017; Watt et al., 2016).

5.3.2.2. Shortcomings in GPs' Cultural Competence

5.3.2.2.1. Implicit Bias and Stereotyping

Argyriadis et al. (2022) found that while healthcare professionals often rate their cultural knowledge and attitudes highly, closer examination revealed the persistence of underlying stereotypes and generalisations. This disconnect between perceived competence and actual practice was also reflected in the findings of the current study. Although most GPs rejected explicit stereotyping, evidenced by strong disagreement with statements like "If I know about a person's culture, I don't need to assess their personal preferences" (M = 1.22), implicit bias remained a subtle but substantial challenge. Interview data illustrated how implicit bias can manifest through generalisations. For example, P6 characterised Eastern Europeans as "more mechanistic" and Asians as "quite respectful". P5, while attempting to explain a potential miscommunication, framed cultural behaviour through an assumed lens, stating: "It doesn't mean he does not respect her, but it comes across as that". Although not overtly prejudiced, such statements suggest the presence of deep-seated generalisations that shape clinical perceptions and may influence decision-making.

Notably, the statement “I enjoy working with people who are culturally different from me” yielded a relatively low mean score of 2.78, indicating potential emotional distancing or discomfort when engaging with diverse patient populations. While this does not suggest overt bias, it may reflect an underlying lack of confidence, or internal hesitation when navigating intercultural interactions. This lack of emotional connection is especially important because feeling enjoyment and ease in cross-cultural interactions often drives individuals to engage more deeply and use culturally sensitive behaviours. Low levels of enjoyment might reduce practitioners' motivation to build relationships or seek out training that promotes a richer understanding of different cultures. This suggests that even if practitioners are intellectually aware of cultural differences, the emotional comfort needed for truly culturally safe practice might be lacking.

This gap between knowledge and emotional engagement has been widely recognised in the literature. Watt et al. (2016) argue that cultural competence requires not only theoretical understanding but also affective components, such as empathy and sincere curiosity about others’ lived experiences, to drive meaningful behavioural change. However, many existing training models underemphasise these emotional dimensions, often favouring abstract frameworks over reflective or experiential learning (Kay et al., 2016; Smith et al., 2017). Consequently, the discomfort reflected in this study may point to a deeper systemic shortcoming: the lack of structured, safe opportunities for clinicians to explore and process their emotional responses to cultural encounters. Embedding emotionally immersive and reflective methods, such as patient narratives, facilitated case discussions, or arts-

based exercises into training curricula could bridge this gap and support the development of more authentic, emotionally attuned cultural competence.

5.3.2.2.2. Burnout and Emotional Fatigue

Burnout and emotional fatigue emerged as significant contextual barriers to the consistent application of cultural competence. Interview data revealed that culturally diverse consultations often carried a heavy emotional toll, with all seven interviewees expressing some degree of strain or fatigue.

This was frequently tied to time pressure, as P1 noted, “Our doctors are operating in a very busy, busy context… adjusting between patients is difficult”. Others described intercultural consultations as more mentally demanding, with P5 explaining, “You need much more mental energy to deal with people who are not from your own country”. These findings align with previous research showing that standard consultation times are often insufficient for complex cross-cultural interactions (Alzaye et al., 2019; Dolan et al., 2020) and that healthcare professionals often experience increased emotional and cognitive demands when caring for culturally and linguistically diverse populations (Farley et al., 2014; Ofosu et al., 2023).

The emotional burden described by participants in this study must be understood not merely as individual fatigue. When P3 recounts that migrants were "brought in handcuffs" or express helplessness (P4), “there wasn’t much we could do”, they articulate more than stress; they reflect ethically challenging scenarios in which doctors' core principles of fairness and compassion are compromised by institutional constraints. Literature from comparable settings reinforces this dynamic. Ofosu et al. (2023) and Farley et al. (2014) emphasize that cross-cultural

consultations are inherently more emotionally and cognitively taxing, especially when compounded by communication barriers, unmet social needs, or legal uncertainty. As Liaw et al. (2015) demonstrate through the "Ways of Thinking and Doing" framework, recognising and addressing emotional labour is essential for sustaining clinicians' capacity to provide culturally safe care. Embedding emotional support structures, such as peer debriefing, case discussions focused on ethical tension, and institutional recognition of emotional workload, could reduce compassion fatigue and enhance practitioners' resilience. Without such systemic interventions, cultural competence risks becoming aspirational rather than operational, as the emotional cost of caring may erode even the most committed clinician's capacity to deliver equitable care.

Without adequate emotional support or structural recognition of these demands, cultural competence risks becoming a principle acknowledged in theory but inconsistently applied in practice. These findings highlight the importance of addressing the emotional labour of intercultural care and embedding this recognition into both training and organisational structures.

These emotionally charged accounts help explain the relatively modest behavioural scores observed in the quantitative analysis, suggesting that systemic and emotional pressures may suppress even well-intentioned efforts to act on cultural awareness. Integrating both datasets underscores that competence gaps are not solely knowledge deficits but also reflections of contextual strain.

5.3.3. The Organisational Landscape of Cultural Competence

This section addresses the third objective of assessing the current state of cultural competence at the organisational level within Malta's PHC system.

5.3.3.1. Organisational Attitudes and Recognition

Despite the overwhelming personal value GPs placed on cultural competence (97.6% considering it "important" or "very important"), this commitment is not similarly reflected at the organisational level. Interview participants consistently described cultural competence as largely invisible within formal clinical discourse, with P7 noting that the issue is "never mentioned in meetings" unless triggered by a crisis. This suggests a reactive, rather than proactive, approach to cultural inclusion, where issues are addressed on an ad hoc basis rather than through strategic planning or policy. P4 similarly observed: "It is not being prioritised. It's a one-size-fits-all practice, basically."

Participants also described cultural competence as something that happens "by default" (P5), often dependent on individual motivation rather than system-wide support. This reliance on personal initiative contributes to inconsistency and variability in the quality of care provided to culturally diverse populations and between different encounters. These findings reflect broader concerns in the literature, where cultural competence is frequently acknowledged as important but remains poorly integrated into healthcare systems (Betancourt et al., 2003; Reath et al., 2018). Studies have highlighted the lack of institutional commitment and formal mechanisms, such as policies, audits, or performance indicators to embed cultural competence into routine practice (Ofosu et al., 2023; Sundareswaran et al., 2024).

As in the current study, cultural competence is often treated as an individual responsibility, rather than a collective organisational value, leading to fragmented and uneven implementation across PHC.

However, some studies offer a more optimistic picture. Liaw et al. (2015), shows that when cultural competence is integrated into organisational quality frameworks and supported by leadership, it can become a sustained priority rather than an individual effort. For example, structured initiatives within Aboriginal health services in Australia have demonstrated that cultural respect can be embedded into routine practice through staff training, policy development, and regular audits.

5.3.3.2. Structural Influences on Organisational Cultural Competence

It is widely acknowledged that systemic issues in PHC create significant barriers to equitable treatment, particularly for individuals from diverse cultural and socio-economic backgrounds. Although healthcare services may appear universally accessible, underlying challenges such as limited health literacy, financial hardship, and bureaucratic complexity often result in unequal access and outcomes (Cheng et al., 2015; Farley et al., 2014; Ofosu et al., 2023; Sundareswaran et al., 2024).

This was echoed by several interview participants who reflected on structural inequities within the local PHC system. For instance, P6 noted that while services are theoretically the same for everyone, “the access can be different”, citing economic limitations and low system literacy as key barriers. Similarly, P7 highlighted the disconnect between clinical advice and lived reality, stating, “It’s useless telling him, eat vegetables and fruit because he can’t afford them”. This is supported by Ofosu et al. (2023) who similarly observed that standardised clinical

guidance often overlooks patients' socioeconomic contexts, particularly in the management of obesity and diabetes. P3 echoed these concerns, asking: "Who buys the prescription? From what funds? Who gives it to them?", highlighting the operational ambiguity that can delay or block care.

Patients unfamiliar with navigating healthcare systems frequently experience delays, miscommunication, and fragmented care, as they struggle to interpret processes or access appropriate services. These challenges are compounded by administrative inefficiencies, including inconsistent patient registration and unclear referral pathways, which further erode continuity of care and perpetuate systemic disparities (Cheng et al., 2015; Ofosu et al., 2023). Reflecting this locally, P7 described flaws in the registration system, stating: "They are given multiple F numbers … so you're lost." This respondent further highlighted system-level barriers, such as ID requirements and registration pressures, noting that "it can prevent undocumented migrants from accessing care." These insights underscore how bureaucratic processes, rather than promoting equity, can reinforce exclusion.

5.3.3.3. Political Influences on Organisational Cultural Competence

Despite growing awareness of the importance of cultural competence in healthcare, the findings of this study reveal that political dynamics significantly hinder its development and implementation at the organisational level. Interview data exposed how "we have to wait for the right time to expand further. Arrivals have decreased, so it's not the right time for this" (P3). This quote highlights that the prioritisation of cultural competence in healthcare services is not driven by persistent healthcare inequalities but rather by the fluctuating visibility of

migration. Sundareswaran et al. (2024), criticizes the tendency to delay systemic interventions unless prompted by acute increases in migration or public pressure. Compounding this challenge is the presence of competing political pressures. P4 observed: “Unfortunately, there are so many other issues which are more pressing at the moment that we leave knowledge about cultural difference on the back burner”. This highlights how political and institutional attention and resources tend to be directed towards more politically acceptable and visible matters, thereby neglecting comprehensive inclusion-focused interventions. Reath et al. (2018), support this observation, stating that the underfunding of cultural mentoring and education within institutional plans were particularly evident when they had to compete for resources with other system-level priorities.

5.3.4. Gaps and Opportunities in Cultural Competence Training

This section explores the current state of cultural competence training in Maltese PHC, assessing both its gaps and the readiness of practitioners to engage in more structured and transformative professional development.

Despite increasing recognition of cultural competence as a cornerstone of equitable healthcare, its integration into formal medical education and ongoing professional development remains limited and inconsistent (Singh et al., 2017; Watt et al., 2016). The continued reliance on informal learning methods, such as workplace experience and personal reflection, contributes to variability in cultural competence and a lack of consistent confidence among healthcare professionals when engaging with culturally diverse populations (Singh et al., 2017). This inconsistency is further exacerbated by the tendency within medical education to marginalise cultural

competence, often treating it as a peripheral topic or reducing it to a “tick-box” exercise rather than embedding it as a core clinical competency (Reath et al., 2018). Dolan et al. (2020), also critique existing training programmes as fragmented and superficial, noting that they frequently lack opportunities for emotional engagement, critical self-reflection, and the development of sustained behavioural change.

Against this backdrop, the present study explores how these dynamics manifest in the context of Maltese PHC, highlighting both the gaps in current training provision and the opportunities for meaningful reform. Quantitatively, only 12.2% of respondents reported having received any cultural competence training, underscoring its marginal role in both undergraduate and postgraduate education. This was echoed in the qualitative data, where several participants expressed either uncertainty or unawareness about the existence of such training opportunities. For example, P1 admitted, “I don’t think we offer any particular training”, while P6 stated, “An official training, I’m not aware that it is there”.

This lack of structured training has significant implications. Statistical analysis underscores the significant benefits of structured cultural competence training, with trained participants scoring significantly higher in the Behaviours ($p = 0.003$) and Self-Assessment ($p = 0.027$) domains. This positive correlation extended to those willing to engage in non-compulsory training or who recognized its importance. These findings suggest that training not only enhances culturally competent behaviours but also improves self-awareness and reflective capacity, two pillars of effective patient-centred care. Consequently, the current lack of widespread training likely leads to inconsistencies in culturally responsive practice. This interpretation is

supported by the mixed-methods integration: quantitatively, those who had undergone any training scored significantly higher in behavioural domains, while qualitatively, leaders acknowledged the absence of systematic programmes. The combination of these findings highlights a shared awareness of the problem but limited structural mechanisms for resolution. Reinforcing this interpretation, Li et al. (2023), demonstrates through the ACT model how structured cultural competence frameworks can cultivate crucial clinician attributes such as self-awareness and emotional responsiveness. Similarly, Ofosu et al. (2023), found that focused cultural competence interventions led to improved provider confidence and a greater ability to adapt their behaviour, particularly in the context of managing chronic conditions. The qualitative findings underscored the perception that existing education lacks depth. While a few participants recalled fleeting mentions of migrant health in specialty training, the majority found it to be very limited. P4 characterised it as “a fraction of the curriculum”, while P5 noted, “We have a lecture … but I think we could do more”. Furthermore, the lack of engagement with the existing postgraduate training is evident, with P7, observing that "Very few attend training… unless it is clinical"*;* further highlighting the need to reposition cultural competence as a core clinical skill rather than an optional add-on.

The interviews also demonstrated strong support for more structured and innovative training approaches, with P3 suggesting a mandatory rotation in migrant health settings and P5 advocating for experiential and reflective methods, including creative outputs such as art or poetry. These proposals reinforce the growing support for transformative models of cultural competence training, which emphasise experiential, reflective, and emotionally engaged learning as key to

fostering deeper understanding and cultural humility (Kay et al., 2016; Li et al., 2023).

5.3.5. Strengths and Limitations

This dissertation demonstrates several strengths through the application of rigorous methods and timely relevance. It tackles the crucial issue of cultural competence among PHC doctors in Malta, an important topic given the country's growing cultural diversity. As one of the few studies on this subject in Malta, it fills a significant gap in existing research and offers valuable insights for policymakers, educators, and healthcare providers. The literature review was conducted systematically, following PRISMA guidelines and clear inclusion criteria, adding transparency and trustworthiness to the background evidence. The study's design is a major asset, employing a practical research approach and a concurrent mixed-methods strategy. This combination allows for both broad quantitative data and in-depth qualitative understanding. The use of a reliable and validated tool, the HPCCI, strengthens the quantitative findings, while Braun and Clarke’s method for thematic analysis ensures a structured examination of the qualitative data. Furthermore, by considering both individual healthcare worker and organisational viewpoints, the research provides a comprehensive analysis of cultural competence within the healthcare system. Throughout the research process, the researcher sought to maintain a high standard of rigour and complied with all ethical requirements, particularly regarding the confidentiality, secure handling, and responsible reporting of participant information.

Despite its strengths, this study has notable limitations that need to be acknowledged and considered. The low response rate (17.1%) for the quantitative survey restricts how widely the results can be inferred and weakens the statistical analysis for specific groups. This low response rate may introduce a potential for response bias, as those who chose to participate may differ systematically from those who did not. Furthermore, the limited number of participants with formal cultural competence training makes comparisons related to training less reliable. As a cross-sectional study, it captures only a single point in time, limiting its ability to track changes or establish causal relationships. Additionally, relying on what people report themselves might lead to socially desirable answers, especially on sensitive topics like unconscious biases or stereotypes. While the qualitative interviews offered detailed information, the small number of participants (seven), though varied, does not fully represent all perspectives, particularly those of non-doctors or patients. Lastly, the findings are specific to the Maltese context and might not directly apply to different healthcare systems or countries with different populations and organisational structures. However, even with these limitations, the researcher believes that the study offers a useful starting point for future research, training programmes, and policy changes focused on improving cultural competence in healthcare.

5.3.6. Concluding Remarks

In conclusion, this discussion highlights the complexity of cultural competence within Malta's PHC system, revealing strengths in awareness and openness to learning, but also significant gaps in practical application, organisational support,

and provision of structured training. Building on these findings, the concluding chapter synthesises the study's key insights and offers a series of recommendations aimed at strengthening cultural competence within Malta's PHC.

Chapter 6: Conclusion

6.1. Summary of the Study

This research directly addresses a salient lacuna in the literature on cultural competence within Malta's PHC sector. While international studies have explored cultural competence in various contexts, empirical studies within the Maltese context have remained very scarce. This research provides an early and thorough investigation into cultural competence within Malta's PHC system. By employing a mixed-methods approach it analyses and interprets quantitative data from self-assessment surveys alongside qualitative insights gathered through semi-structured interviews. At its core, the research explored how cultural competence operates on two levels: the individual, focusing on the knowledge, attitudes, and behaviours of PHC doctors, and the organisational, examining how healthcare institutions foster or hinder culturally competent care.

The key findings reveal several noteworthy patterns. First, the quantitative results show that PHC doctors generally perceive themselves as culturally aware and sensitive, particularly in understanding that cultural factors shape healthcare beliefs and experiences. Younger and less experienced doctors generally scored higher on cultural competence self-assessments, possibly due to their more recent exposure to diverse populations both during their medical education and in their everyday lives. However, the qualitative interviews uncovered a striking mismatch. While participants expressed confidence in their cultural competence, their in-depth reflections revealed significant shortcomings in knowledge and practical execution. These recommendations are based on the findings of this study, acknowledging that the quantitative component was limited by a small number of respondents.

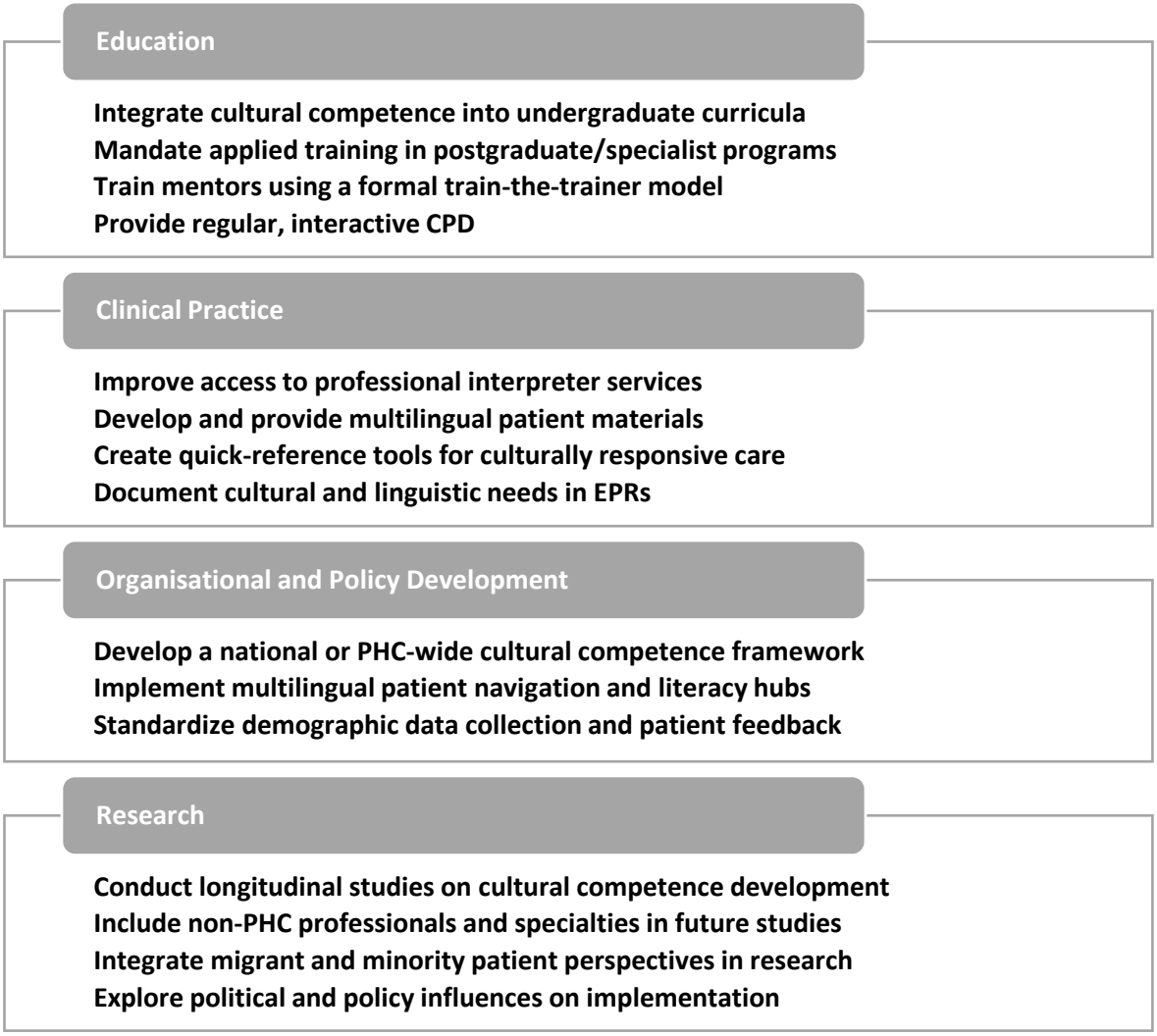
Notwithstanding this limitation, the findings were consistent with those identified in the literature review, suggesting that they can still support meaningful interpretation. As such, they provide a substantiated basis for recommendations aimed at strengthening cultural competence within the local health system and guiding future research efforts.

6.2. Recommendations

As John Dewey wisely noted, “There is no such thing as genuine knowledge and fruitful understanding except as the offspring of doing” (Dewey, 1916, p. 321). This research not only offers important insights into cultural competence in the Maltese PHC system but also underscores the urgent need to move from understanding to action. In line with Dewey’s philosophy, the following recommendations aim to transform theoretical knowledge into meaningful, practical interventions.

A number of recommendations were derived upon reflection on the research experience and its findings. These are organised into four key categories: Education, Clinical Practice, Organisational and Policy Development, and Further Research. Each category addresses a critical aspect of embedding cultural competence in PHC, whether by strengthening individual capabilities, enhancing daily clinical interactions, reforming institutional structures, or guiding future inquiry. The recommendations are summarised and presented in Figure 6.1 and elaborated upon in the sections that follow.

Figure 6.1: *Summary of Recommendations for Enhancing Cultural Competence in PHC*



6.2.1. Educational Strategies

Strengthening individual knowledge, skills, and attitudes is the foundation of meaningful cultural competence (Campinha-Bacote, 2002; Li et al., 2023; Reath et al., 2018; Smith et al., 2017). While many practitioners in this study expressed confidence in their cultural awareness, the findings revealed gaps in applied understanding and practical skills. Educational strategies, therefore, must go beyond raising awareness, they should provide structured, continuous opportunities for

healthcare professionals to develop, practice, and refine their cultural competence throughout their professional careers.

6.2.1.1. Integrate Cultural Competence into Undergraduate Medical Curricula

Findings revealed that many participants had minimal or no formal CCT. This aligns with broader international concerns that cultural content is often only "a fraction of the curriculum" (P4) and treated superficially (Cross et al., 1989; Liaw et al., 2015; Watt et al., 2015; Watt et al., 2016). The literature review also emphasized that without deep integration, cultural competence remains theoretical, not practical (Farley et al., 2014; Ofosu et al., 2023; Singh et al., 2017). Therefore, integrating structured modules on amongst others cultural determinants of health, religious practices, and nonverbal communication is essential to prepare medical students before they enter clinical practice.

6.2.1.2. Mandate Cultural Competence Training in Specialist Programmes

Quantitative findings showed that younger doctors, likely due to exposure to multicultural populations in their life more than their predecessors, scored higher in awareness and self-assessment ($p = 0.008$, $p = 0.047$). Yet qualitative data revealed many still lacked expertise when facing real cultural challenges. To effectively continue to bridge the gap, postgraduate medical education should emphasize the integration of applied cultural competence training. This should include a variety of teaching methods, such as case discussions, reflective practice, and supervised cross-cultural experiences. Introducing a dedicated clinical rotation in specialised services like the Migrant Health Unit is highly recommended, as it would give

trainees meaningful exposure to diverse patient groups and help them develop the practical skills needed to navigate cultural and communication challenges.

6.2.1.3. Equip Mentors and Trainers with Cultural Competence Skills

Since specialty training often pairs GP trainees with experienced mentors, it is crucial that these senior clinicians themselves possess strong cultural competence. Establishing a formal train-the-trainer approach will ensure that mentors are equipped to model culturally responsive care, and support trainees in applying cultural competence principles in practice (Watt. et al., 2015). Importantly, mentorship should not be limited to physicians alone. A multi-disciplinary mentorship model, engaging nurses, social workers, and other allied health professionals can provide trainees with a broader, more holistic perspective on delivering culturally competent care across different healthcare roles and contexts.

6.2.1.4. Offer Regular and Structured Continuing Professional Development (CPD)

Among more experienced doctors, the data showed declining scores in cultural competence domains, reinforcing the concern that, without continuous reinforcement, early training gains can fade over time. CPD programmes should therefore offer regular, accessible workshops or similar events focussing on real-world cultural challenges, using interactive methods such as simulations, patient stories, and peer discussions to ensure content is engaging and directly applicable to clinical practice (Argyriadis et al., 2022; Watt et al., 2016). These sessions should actively involve migrant patients, cultural mediators, community representatives,

and professionals from multiple disciplines, all of whom can share lived experiences that bring abstract concepts to life. Additionally, offering flexible digital learning options, can make cultural competence education more accessible and convenient for busy practitioners (Watt et al., 2015).

To ensure that this training is prioritized and not seen as optional, future frameworks could link cultural competence CPD to professional obligations. For example, cultural competence training could be formally integrated into CPD requirements for the revalidation or renewal of specialist registration status. Accrediting bodies might assign a minimum number of CPD points specifically tied to cultural competence, making it a measurable and mandatory component of lifelong learning.

6.2.2. Recommendations for Clinical Practice and Communication

The findings of this study reveal that while PHC doctors in Malta show cultural awareness and positive attitudes, there remains a clear gap between knowledge and practical application in clinical settings. Many participants reported struggling to engage effectively with patients from different cultural and linguistic backgrounds, often relying on ad hoc and improvised solutions that compromise the quality of care. These findings show that cultural competence is not yet systematically embedded into routine clinical workflows, underscoring the need for targeted improvements in both practice and communication.

6.2.2.1. Improve Access to Professional Interpreters

This study found that limited access to professional interpreter services in Maltese PHC leads to frequent reliance on informal interpreters, such as family members. This raises significant concerns about accuracy, confidentiality, and patient autonomy. It is therefore recommended that PHC settings implement a range of technology-based interpretation solutions.

In the short term, on-demand human interpretation, via telephone or video services accessible through tablets or dedicated consultation room terminals, can offer timely and reliable access to trained interpreters with the necessary medical knowledge to support safe, high-quality care. These services should not be restricted to clinical consultations alone, but extended to patient education, informed consent, and administrative interactions, where effective communication is equally critical (Depares, 2016).

Looking ahead, PHC systems should also explore the integration of AI-driven translation technologies, such as real-time speech-to-speech translation tools or multilingual chatbot interfaces for administrative communication. While these tools are not yet replacements for human interpreters in complex and sensitive consultations, they can significantly enhance communication efficiency, both in high-demand settings and settings where human resources are very limited (Argyriadis et al., 2022).

6.2.2.2. Provide Multilingual Resources

While professional interpreter services are important for real-time clinical interactions, they must be supported by multilingual resources that patients can

access to reinforce understanding (Kay et al., 2016; Reath et al., 2018). Without such resources, language barriers will continue to impair effective communication, limit patients' understanding, and increase the risk of medical errors (Alzaye et al., 2019; Kay et al., 2016). A comprehensive approach should include the creation and distribution of multilingual health education materials in various formats, ensuring they are both culturally appropriate and easy to understand and access through diverse means. Equally important, critical clinical documents like consent forms, and procedure refusal forms must be professionally translated, as misunderstandings in these areas carry significant ethical and legal risks. Additionally, multilingual websites and mobile applications should be developed to provide accessible health information, appointment scheduling, and other key services.

6.2.2.3. Develop Quick-Reference Tools for Clinicians

The findings of this study reveal that while PHC doctors in Malta demonstrate awareness of cultural issues, they often lack practical tools to apply and consistently supplement this knowledge in daily practice. To address this gap, we recommend developing easily accessible quick-reference tools that provide clinicians with key information on culturally relevant aspects of patient care. These tools should cover areas such as communication tips, common health beliefs, dietary considerations, family and social roles in decision-making, and important religious practices that may affect care (Farley et al., 2014; Kay et al., 2016; Ofosu et al., 2023). It is essential that these resources are readily available at the point of care, whether integrated into electronic patient records (EPRs) systems or provided through

mobile applications. To remain effective, the tools should be regularly reviewed and updated to reflect Malta's evolving community demographics.

In implementing these tools, it is essential to consider legal and regulatory aspects, including clinical governance and professional liability (Cheng et al., 2015; Ofosu et al., 2023). While quick-reference tools are designed to support, not replace, clinical judgment, healthcare providers may still rely on them when making decisions that affect patient care. Therefore, the content must be evidence-informed, peer-reviewed, and aligned with national clinical standards.

In the Maltese context, oversight could be guided by national authorities such as the Medical Council of Malta and the Superintendence of Public Health, which can provide accreditation, quality assurance, and guidance on the ethical use of such tools.

6.2.2.4. Encourage Documentation of Cultural Preferences in Health Records

To reinforce cultural competence among PHC doctors, it is essential to establish dedicated sections within EPRs to facilitate the systematic documentation of patients' cultural preferences, linguistic needs, and social context (Kay et al., 2016; Watt et al., 2015). This documentation plays a critical role in shaping healthcare experiences and decisions, ensuring that care plans are respectful, person-centered, and consistent across clinical encounters (Cheng et al., 2015; Ofosu et al., 2023; Reath et al., 2018). This is particularly relevant in the Maltese PHC system, where walk-in services mean that patients are often seen by different doctors on separate occasions. Developing standardised EPR fields or templates will make this process straightforward and uniform. This recommendation is especially urgent, as the

quantitative findings of this research revealed notably low rates of cultural documentation.

6.2.3. Systemic and Policy Measures

The findings of this study reveal a consistent perception among PHC doctors that there is a lack of clear systemic guidelines and organisational support for delivering culturally competent care. This gap points to the urgent need for PHC organisations to develop and implement a comprehensive organisational policy framework that explicitly integrates cultural competence across all levels and functions.

6.2.3.1. Develop a Comprehensive Cultural Competence Policy Framework

To address the systemic gaps identified in this study, it is essential for PHC organisations to adopt a structured, organisation-wide approach to embedding cultural competence into their policies and operations (Cheng et al., 2015; Reath et al., 2018). A phased approach is recommended, beginning with an assessment of the organisation's current cultural competence, followed by the development of a strategic plan that outlines prioritised policy changes, clear implementation timelines, and measurable outcomes (Watt et al., 2015). Additionally, policies should address the systematic collection and analysis of demographic data to identify health disparities, the use of culturally sensitive patient feedback mechanisms, and the formalisation of partnerships with community organisations to inform service design and delivery. Continuous review, adaptation, and improvement of these policies will be paramount to embedding cultural competence as an integral part of organisational practice (Kay et al., 2016). To

support these efforts, PHC may benefit from drawing on international best practices. Resources and models developed through EU-funded projects such as Mig-HealthCare offer valuable guidance and tested tools that can be adapted to the local context for effective policy development and capacity-building.

6.2.3.2. Strengthen Patient Navigation and Health Literacy Support

Findings from this study indicated the need to strengthen patient navigation and health literacy in Maltese PHC. A two-pronged approach would be recommended: establishing a comprehensive one-stop-shop and implementing proactive community outreach. The one-stop-shop would offer accessible, multilingual information on PHC services, referrals, and processes, with trained staff providing guidance on initial assessments, cultural context, language interpretation, and administrative matters (Cheng et al., 2015; Farley et al., 2014). A key function would be to enhance health literacy by supporting patients' understanding of healthcare information and linking them to essential social and community resources. For optimal accessibility, the one-stop-shop should be established with a physical presence in a central location with convenient public transportation links, complemented by a virtual platform. To further improve accessibility, the study recommends proactive community outreach, forging partnerships with migrant and community organisations to share information, and addressing barriers that impact access to care. Tangible measures could include organising regular community-based health outreach sessions in locations that are easily accessible to migrant populations, such as local councils, religious institutions, or NGOs. These sessions could be delivered in multiple languages and focus on raising awareness about

available health care services, patients' rights, and preventive care. Outreach efforts could also include targeted health education workshops, information booths at community events, and collaborations with migrant leaders to ensure that messaging is trusted, relevant, and culturally appropriate.

6.3. Unique Contribution to Knowledge

This study makes several distinctive contributions to the existing body of knowledge on cultural competence in primary health care. Firstly, it represents one of the first empirical mixed-methods investigations of cultural competence among family medicine specialists within the Maltese PHC system, addressing a previously unexamined context in the literature. By combining quantitative self-assessment data with qualitative insights from organisational leaders, the study provides a multi-level understanding of how cultural competence is perceived, practiced, and operationalised both individually and systemically.

Secondly, the research contributes context-specific evidence highlighting the gap between self-perceived competence and applied practice, a discrepancy rarely documented within small island healthcare systems. This insight extends international debates on cultural competence by showing how national size, close-knit professional networks, and limited training infrastructure influence the development and expression of culturally competent care.

Thirdly, the study advances methodological knowledge by adapting and validating the Health Provider Cultural Competence Instrument (HPCCI) within a Maltese context. This application offers an empirical foundation for future comparative studies in other small or culturally evolving nations.

Finally, the findings contribute to practice and policy by generating evidence-based recommendations for integrating cultural competence into education, organisational policy, and clinical practice. These outputs provide a tangible framework for health authorities and educators seeking to embed cultural competence as a sustainable, system-wide standard of care in Malta and similar settings.

6.4. Recommendations for Future Research Direction

This study provided a valuable foundation for understanding cultural competence among family medicine specialists in Malta's PHC system in 2025, but it identified glaring lacunae and raises important questions for future research.

Firstly, addressing the limitations of the current cross-sectional design, future research should employ longitudinal approaches to explore how cultural competence evolves over time. This is essential for assessing the lasting effects of targeted interventions, such as formal training programmes. Such studies could reveal whether the initial improvements in awareness and self-perceived competence, especially among younger doctors, are maintained over the long term or diminish without ongoing reinforcement. In designing such studies, particular attention should be given to strategies that maximise physician participation. Evidence from Brtnikova et al. (2018) demonstrates that allowing participants to choose their preferred mode of survey delivery, sending multiple reminders, and using personalized mailings can substantially improve response rates, even in the absence of monetary incentives. Their six-year study achieved response rates as high as 83%. These findings underscore the value of flexible, personalised, and

multi-modal contact methods in sustaining engagement across the duration of longitudinal research.

Secondly, future research could extend the scope in two important ways: by including other healthcare professionals within PHC and/or by focusing on doctors working in other medical specialties outside PHC. Both approaches would offer valuable perspectives on how cultural competence is developed and applied across different roles, clinical environments, and training pathways.

A third key area for future research involves the more direct integration of patient perspectives. The experiences and satisfaction of migrant and minority patients regarding culturally responsive care require further investigation. Subsequent research should aim to capture the voices of these patients to ascertain whether the cultural competence reported by providers translates into meaningful improvements in patient-centred care.

Finally, future research should analyse the political and policy dynamics shaping cultural competence in Malta. Given the susceptibility of organisational priorities to external pressures, as revealed in the qualitative findings, research focused on policy design could identify mechanisms for ensuring the sustained integration of cultural competence as a fundamental institutional principle, irrespective of short-term political or demographic fluctuations.

6.5. Concluding Remarks

As Malta continues to evolve into an ever-shifting cultural kaleidoscope, its healthcare system must progress alongside it. Importantly, this study highlights that meaningful progress will require both systemic change and sustained practitioner

commitment. Encouragingly, the openness, and readiness expressed by many participants provide a strong foundation on which future improvements can be built. Looking ahead, there is a clear opportunity for Malta's healthcare system to harness this momentum, transforming cultural competence from a scattered and mainly individual-led efforts into a coordinated, system-wide standard that reflects and serves the rich diversity of its catchment population.

Reflecting on this research journey, I was initially drawn to the topic of cultural competence after encountering situations where the application of local clinical guidelines felt misaligned with the needs of culturally diverse patients. These moments raised concerns about possible mismanagement and inequity in care delivery, especially when I had to make decisions without any structured guidance or prior training in handling such complexity. The absence of formal education on cultural competence during my training stood in sharp contrast to the real-world demands of a diverse healthcare environment. Conducting this research allowed me to explore these issues more systematically, deepening my understanding of how both individual practitioners and healthcare systems navigate cultural diversity. It also highlighted the disconnect between self-perceived competence and practical readiness, a finding that resonated strongly with my own experiences. This project challenged me not only academically but also personally, encouraging greater self-reflection and a more critical view of institutional readiness. It has reinforced my commitment to advocate for a more inclusive and responsive healthcare system, one that recognises cultural competence as a clinical priority rather than an optional skill.

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Appendix

Appendix A: Thematic Coding System and Article Mapping

Code	Category	Description
Communication & Systemic Barriers		
COM-1	Language Barriers	Miscommunication, lack of multilingual resources
COM-2	Interpreter Utilization	Low use of trained interpreters, reliance on family members
COM-3	Cultural Mistrust & Misunderstandings	Patients' health beliefs conflict with biomedical care
SYS-1	System Navigation	Bureaucratic barriers, difficulty accessing care
SYS-2	Financial & Time Constraints	Short consultation times, financial obstacles
Knowledge Gaps		
KNW-1	Deficiencies in Cultural Competency Training	Inconsistent and superficial training
KNW-2	Limited Health Literacy	Patients struggle to understand healthcare processes
Systems-level Interventions		
SOL-1	Centralized Care Models	Refugee health centres, coordinated care models
SOL-2	Language & Accessibility Solutions	Expanding interpreter services, multilingual resources
SOL-3	Workforce Diversity & Representation	Hiring ethnically diverse staff, integrating cultural brokers
Health Professional Interventions		
PRO-1	Enhancing Cultural Competency Training	Structured, mandatory, experiential learning
PRO-2	Cross-Cultural Communication Skills	Training in trauma-informed care and shared decision-making
Patient-Centered Interventions		
PAT-1	Health Literacy & Education	Providing structured health education
PAT-2	Community Engagement & Support Networks	Strengthening partnerships and peer support
PAT-3	Reducing Financial & Logistical Barriers	Assistance with medications, transport, and healthcare access

Appendix B: Summary of selected articles

Title	Author	Publication Year	Study Type	Aim	Context
Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community.	Smith, et al.	2017	Mixed method study	To explore if PHC services are culturally appropriate	Australia
Barriers to primary care among immigrants and refugees in Peterborough, Ontario: a qualitative study of provider perspectives.	Sundareswaran et al.	2024	Qualitative study	To evaluate barriers in accessing PHC by newcomers, from the service providers' perspective	Canada
Canadian residents' perceptions of cross-cultural care training in graduate medical school.	Singh et al.	2017	Quantitative Study	To determine medical residents' self-assessed preparedness and attitudes toward providing cross-cultural care.	Canada
Caring for refugees in general practice: Perspectives from the coalface	Farley et al.	2014	Qualitative study	to ascertain the experiences of PHC providers working with newly arrived refugees	Australia

(Table continues)

Title	Author	Publication Year	Study Type	Aim	Context
Cultural competency training of GP Registrars-exploring the views of GP Supervisors	Watt et al.	2015	Qualitative study	To evaluate the views of GP supervisors on culturally competent training and practice	Australia
General practitioner experiences in delivering early medical abortion services to women from culturally and linguistically diverse backgrounds: A qualitative-descriptive study.	Singh et al.	2023	Qualitative study	To ascertain GP interactions with women from CALD backgrounds when providing EMA	Australia
General Practitioners' experiences of asthma management in culturally and linguistically diverse populations.	Alzaye, et al.	2019	Qualitative study	To explore GPs perspective about asthma management in CALD popluation	Australia
GP and registrar involvement in refugee health - a needs assessment.	Duncan et al.	2013	Qualitative study	To assess the GPs' needs and attitudes in treating refugees	Australia

(Table continues)

Title	Author	Publication Year	Study Type	Aim	Context
Impacts of Educating for Equity Workshop on Addressing Social Barriers of Type 2 Diabetes with Indigenous Patients.	Crowshoe et al.	2018	Quantitative Study	To assess participants' change in knowledge, attitude, and approach when managing Type 2 Diabetes in Indigenous patients after a workshop	Canada
Improving cultural respect to improve Aboriginal health in general practice: a multi-methods and multi-perspective pragmatic study.	Liaw et al.	2015	Mixed method study	To capture the gap in healthcare access	Australia
Primary healthcare providers' knowledge, practices and beliefs relating to preventive sexual and reproductive health care for women from refugee and asylum-seeking backgrounds in Australia: a national cross-sectional survey.	Davidson et al.	2024	Quantitative Study	To identify HCP characteristics when discussing sexual and reproductive health with immigrants	Australia
Rites of passage: Improving refugee access to general practice services	Cheng et al.	2015	Qualitative case study	To explore the factors influencing access to GP in Afghan refugees'	Australia

(Table continues)

Title	Author	Publication Year	Study Type	Aim	Context
Understanding quality use of medicines in refugee communities in Australian primary care: a qualitative study.	Kay et al.	2016	Qualitative study	To ascertain strategies aimed at optimizing medication in refugee communities	Australia

Appendix C: Permission to utilise the HPCCI tool

L-Università ta' Malta

Ruth Grech <ruth.buttigieg.11@um.edu.mt>

Permission for use of HPCCI

Joshua Schwarz <schwarjl@miamioh.edu> 2 November 2023 at 13:45
To: Ruth Grech <ruth.buttigieg.11@um.edu.mt>

Dear Ruth,

Thanks so much for requesting permission to use the HPCCI for your research project. My co-authors and I are happy to give you our permission to use it and all that we ask is that you properly cite our work in any working papers or publications that may result from its use.

I am attaching a copy of the tool, which really consists of the first 49 questions. The questions after that were designed to be more demographic in nature and tailored to the organizational context where we used the survey.

Please note that we scored each question on a 1 to 5 or 1 to 7 point scale, depending on the construct we were measuring. For respondents that chose the not sure or NA option, that was not included in the calculation for that question. Question 31 did not load on any of the dimensions validated for this tool so you should feel free to drop that one. Also, the following questions were reverse scored: 1, 2, 5, 8, 33, 34, 35, 36, 38, and 40. This way, higher scores were always associated with a higher level of cultural competence.

Also, question 8 specifically references the United States. You should feel free to change that to Malta, to better fit your context.

Let me know if you have other questions and we wish you the best of luck with your research.

Joshua

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[Quoted text hidden]

Generic HPCCI 11.15.20.docx
37K

Appendix D: HPCCI tool - Google Form

Healthcare Provider Cultural Competence Instrument (HPCCI)

My name is Ruth Grech and I am a post-graduate student at the University of Malta, reading for a Master of Science in Health Systems Management and Leadership. I am presently conducting research as part of my dissertation titled 'Malta - an ever-shifting cultural kaleidoscope. Exploring cultural competence in doctors working in primary health care'; this is being supervised by Dr Miriam Dalmas (miriam.dalmas@um.edu.mt). This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to assess cultural competence in the Maltese Primary Health Care sector. The study will involve 2 phases in a mixed-method approach. The first part of the study is a cross-sectional study amongst all the Specialists in Family Medicine working within Primary Health Care. The second part of the study involves semi-structured interviews amongst Specialists in Family Medicine within the organizational level of Primary Health Care.

Your participation in this study would help contribute to a better understanding of cultural knowledge, beliefs and behaviours of primary health care doctors at individual level. Only data necessary for the research will be asked and any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to fill in a questionnaire. The first part is a research tool used to assess cultural competence and the second part is a demographic questionnaire. The questionnaire is estimated to take around 15 minutes to complete. To ensure your anonymity, you will not be asked to write your name on the questionnaire or any personally identifiable data. Furthermore, your response to the following questionnaire will be considered as your voluntary consent for your participation in this study.

Data collected will be anonymised and only the researcher and supervisor will have access to. In special circumstances, the examiner(s) may access the data, for assessment purposes. Data will be stored in a password protected external hard disc.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected will be erased as long as this is technically possible, unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

If you choose to participate, please note that there are no direct benefits to you. Your participation does not entail any known or anticipated risks.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All data collected will be stored in an anonymised form and will be erased on completion of the study.

A copy of this information sheet is being provided to you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by e-mail; ruth.buttigieg.11@um.edu.mt. You can also contact my supervisor via email; miriam.dalmas@um.edu.mt.

* Indicates required question

Section I

The first group of questions examines your views about culture. To what extent do you agree or disagree with the following statements?

1. Race is the most important factor in determining a person's culture. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

2. People with a common cultural background think and act alike. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

3. Many aspects of culture influence health and health care. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

4. Aspects of cultural diversity need to be assessed for each individual, group, and organization. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

5. If I know about a person's culture, I don't need to assess their personal preferences for health services. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

6. Spiritually and religious beliefs are important aspects of many cultural groups. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Agree
- Strongly Agree
- No Opinion
- N/A

7. Individual people may identify with more than one cultural group. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Agree
- Strongly Agree
- No Opinion
- N/A

8. Language barriers are the only difficulties for recent immigrants to the Maltese Islands. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

9. I understand that people from different cultures may define the concept of "health care" in different ways. *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Somewhat Disagree
- ◯ Neutral
- ◯ Somewhat Agree
- ◯ Agree
- ◯ Strongly Agree
- ◯ No Opinion
- ◯ N/A

10. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Agree
- Strongly Agree
- No Opinion
- N/A

11. I enjoy working with people who are culturally different from me. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Agree
- Strongly Agree
- No Opinion
- N/A

Section II

The following set of questions is about your behaviors with your patients or clients. Please indicate how frequently you engage in each of the following behaviors.

12. I include cultural assessment when I do client or family evaluations. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

13. I seek information on cultural needs when I identify new patients and families in my practice. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

14. I have resource books and other materials available to help me learn about patients and families from different cultures. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

15. I use a variety of sources to learn about the cultural heritage of other people. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

16. I ask patients and families to give me their own explanations of health and illness. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

17. I ask patients and families to tell me about their expectations for health services. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

18. I avoid using generalizations to stereotype groups of people. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

19. I recognize potential barriers to service that might be encountered by different people. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

20. I act to remove obstacles for people of different cultures when I identify such obstacles. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

21. I remove obstacles for people of different cultures when patients and families identify such obstacles to me. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

22. I welcome feedback from patients and their families about how I relate to others with different cultures. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

23. I welcome feedback from co-workers about how I relate to others with different cultures. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

24. I find ways to adapt my services to my patients and their families' preferences. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

25. I document cultural assessments. *

Mark only one oval.

- ◯ Never
- ◯ Few Times
- ◯ Sometimes
- ◯ Often
- ◯ Somewhat Often
- ◯ Very Often
- ◯ Always
- ◯ Not Sure
- ◯ N/A

26. I document the adaptations I make with patients and their families. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

27. I learn from my co-workers about people with different cultural heritages. *

Mark only one oval.

- Never
- Few Times
- Sometimes
- Often
- Somewhat Often
- Very Often
- Always
- Not Sure
- N/A

Section III

The next group of questions asks your thoughts on the health care provider-patient relationship. As some of the patients might not be able to respond, we ask questions related to the patient/client and their family. Please indicate how frequently you engage in each of the following behaviors.

28. When there are a variety of treatment options, how often do you give the client and their family a choice when making a decision? *

Mark only one oval.

- Never
- Rarely
- Sometimes
- Often
- Very Often
- N/A

29. When there are a variety of treatment options, how often do you make an effort to give the client and their family control over their treatment? *

Mark only one oval.

- Never
- Rarely
- Sometimes
- Often
- Very Often
- N/A

30. When there are a variety of treatment options, how often do you ask the client and their family to take responsibility for their treatment? *

Mark only one oval.

- Never
- Rarely
- Sometimes
- Often
- Very Often
- N/A

Section IV

The next set of questions focus on practice orientation. There are no right or wrong answers. Please select the answer that best describes your level of agreement with the statement.

31. The health care provider is the one who should decide what gets talked about during a visit. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

32. It is often best for the client and their family that they do not have a full explanation of the client's medical condition. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

33. The client and their family should rely on their health care providers' knowledge and not try to find out about their condition(s) on their own. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

34. When health care providers ask a lot of questions about a client and their family's background, they are prying too much into personal matters. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

35. If health care providers are truly good at diagnosis and treatment, the way they relate to client and their family is not that important. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

36. The client and their family should be treated as if they are partners with the health care provider, equal in power and status. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

37. When the client and their family disagree with their health care provider, this is a sign that the health care provider does not have the client and their family's respect and trust. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

38. A treatment plan cannot succeed if it is in conflict with a client and their family's lifestyle or values. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

39. It is not that important to know a client and their family's culture and background in order to treat the client's illness. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

Section V

The next group of questions asks about your views on the health care provider-patient relationship. Please select the answer that best describes your level of agreement with the statement.

40. As a health care provider, I understand how to lower communication barriers with patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

41. I have a positive communication style with patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

42. As a health care provider, I am able to foster a friendly environment with my patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

43. I attempt to demonstrate a high level of respect for patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

44. As a health care provider, I consistently assess my skills as I work with diverse groups of patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

45. I attempt to establish a genuine sense of trust with my patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

46. I make every effort to understand the unique circumstances of each client and her/his family. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

47. I value the life experience of each of my patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

48. The use of effective interpersonal skills is very important in working with my patients and their families. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

Section VI

Demographic Questionnaire. The last section of questions asks for general information about your background and experience. For each question, check the answer that best describes you/your experience.

49. Age *

Mark only one oval.

- 25-34
- 35-44
- 45-54
- 55-64
- >65

50. Number of years working within the primary health care *

Mark only one oval.

- <5
- 5-9
- 10-14
- 15-19
- 20-24
- 25-29
- >30

51. Gender *

Mark only one oval.

- ◯ Male
- ◯ Female
- ◯ Others
- ◯ Prefer not to answer

52. Job Grade *

Mark only one oval.

- ◯ GP
- ◯ Senior GP
- ◯ Principal GP
- ◯ Other: _____

53. Occupational Sector *

Mark only one oval.

- ◯ Private
- ◯ Public
- ◯ Both

54. Medical school education *

Mark only one oval.

- ◯ National
- ◯ International

55. Specialist training *

Mark only one oval.

- National
- International

56. Have you had any Cultural Competence training? *

Mark only one oval.

- Yes
- No

57. How important do you consider cultural competence training is? *

Mark only one oval.

- Not important
- Important
- Very important

58. Would you participate in non-compulsory training in cultural competent? *

Mark only one oval.

- Yes
- No
- Maybe

59. Do you think that compulsory training in cultural competence should be implemented? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe

Appendix E: Semi-Structured Interview Questions

Semi-Structured Interview Questions for Physician Healthcare Professionals on Doctors' Cultural Competence in Primary Healthcare Settings

General background
Can you start by telling me a bit about your role and how long you have been in this position?
Can you share your experience with diverse patient populations?
Do you think that people from minority groups experience health inequalities? Can you delve a bit more into the issue?
In your opinion, are there any challenges related to dealing with patients from diverse cultural backgrounds? Can you give examples and how are these challenges being addressed?
Do you think that your culture affects your leadership?
What does cultural competence mean to you?
Organizational Policies and Practices
Would you say that cultural competence is essential in Primary health care?
How is cultural competence prioritized within Primary health care?
Are there specific initiatives or programs to promote diversity and inclusion? Are there any aspects of healthcare services that you are currently working on or would like to work on to decreased health disparities amongst patients from a minority group?
What are the main challenges primary health care faces in promoting cultural competence?
How have you worked to overcome these challenges?
Are there any innovative approaches you are considering to enhance cultural competence?
Assessing Cultural Competence Training
Have you had any formal training in cultural competence? Do you think it is relevant in your line of work? What do you think are your personal training requirement? Are you aware of the training needs of professionals within your remit?
Do you feel confident that your level of cultural competence can help professionals within your remit to deliver culturally appropriate care?
Are there any training opportunities provided to staff/GP trainees to enhance cultural competence? If yes what kind of training and development opportunities are available to staff to improve cultural competence?

Semi-Structured Interview Questions for Non-Physician Healthcare Professionals on Doctors' Cultural Competence in Primary Healthcare Settings

General Background
Can you tell me about your role and how long you have been in this position?
What has been your experience working alongside doctors when providing care to diverse patient populations?
In your opinion, do you think doctors working in primary health care are adequately prepared to meet the needs of patients from different cultural backgrounds? Can you explain why or why not?
What challenges do you think doctors face when working with patients from diverse cultural backgrounds? How do these challenges impact patient care and doctor-patient relationships?
Doctors' Cultural Competence
In your experience, how would you rate the cultural competence of doctors in your primary health care setting?
Do you believe that doctors' cultural competence has a direct impact on patient outcomes, particularly for minority or underserved groups? Can you provide any examples?
Are there specific areas where you think doctors' cultural competence could be improved? If so, what are they?
How open are doctors to feedback on improving their cultural competence, especially when working with diverse patient populations?
Participation in Training Initiatives
Are doctors in your primary health care setting encouraged to participate in cultural competence training? If so, what kind of training is offered?
In your opinion, do you think doctors attend cultural competence training initiatives? Are there any barriers to participation that you've observed?
In your opinion, are the cultural competence training programs provided to doctors sufficient to meet the diverse needs of your patient population? If not, what improvements would you suggest?
How do you think training initiatives for doctors in cultural competence could be improved to better support their professional development and enhance patient care?
Have you noticed any changes in doctors' approach to cultural competence after participating in training initiatives? If so, could you provide examples?
Innovative Approaches and Future Directions
Are there any innovative approaches or new strategies that you think could be implemented to improve doctors' cultural competence in your setting?
How do you think the organization could better support doctors in developing their cultural competence?
What role do you think doctors should play in shaping or promoting cultural competence policies within your organization?

Appendix F: PHC's Temporary Approval

Primary HealthCare
7 Sqaq Harper,
Furjana
FRN 1940

Telephone: + 356 21239993
Telefax: + 356 21222856

e: dpo.phc@gov.mt

Primary HealthCare
7 Harper Lane,
Floriana
FRN 1940

Telephone: + 356 21239993
Telefax: + 356 21222856

e: dpo.phc@gov.mt

23/01/24

Ruth Grech
Bugella, Xuxa Str, Kercem,
Gozo

Re: Your request to carry out a study within the Primary HealthCare

Dear Ms Grech,

Your request to carry out the research within the department has been **temporarily granted** provided that you furnish our department with a copy of the approval from the University Research Ethics Committee (UREC) or FREC ***prior*** to the actual commencement of your study.

Please be informed that as per GDPR, we cannot provide you with a list of data subjects' (clients/patients/staff) personal contact details so in your methodology you should take this into consideration and make it clear within your application with UREC.*

Following approval from the Research Ethics Committee, we will furnish you with a final permission and you may proceed. If the department does not receive a copy of the approval from the Research Ethics Committee, this temporary permission to conduct the study/research will automatically be declared as void.

Dr DPO,
Primary HealthCare

May we suggest that you offer the invitation for participation through an intermediary such as a Charge Nurse/Principal GP/Podiatrist/physiotherapist etc.

Appendix G: Faculty Research Ethics Committee (FREC) approval

L-Università ta' Malta

Research Ethics and Data Protection Form

University of Malta staff, students, or anyone else planning to carry out research under the auspices of the University, must complete this form. The UM may also consider requests for ethics and data protection review by External Applicants.

Ahead of completing this online form, please read carefully the University of Malta Research Code of Practice and the University of Malta Research Ethics Review Procedures. Any breach of the Research Code of Practice or untruthful replies in this form will be considered a serious disciplinary matter. It is advisable to download a full digital version of the form to familiarise yourself with its contents (https://www.um.edu.mt/research/ethics/resources/umdocuments/). You are also advised to refer to the FAQs (https://www.um.edu.mt/research/ethics/faqs).

Part 1: Applicant and Project Details

Applicant Details

Name: Ruth

Surname: Grech

Email: ruth.buttigieg.11@um.edu.mt

Applicant Status: Student

Please indicate if you form part of a Faculty, Institute, School or Centre: * Faculty of Health Sciences

Department: * Department of Health Systems Management and Leadership

Principal Supervisor's Name: * Dr Miriam Dalmas

Principal Supervisor's Email: * miriam.dalmas@um.edu.mt

Co-Supervisor's Name:

Study Unit Code: * HSM5011

Course Title: * Master of Science in Health Systems Management and Leadership

Student Number: * 0006093G

Project Details

Title of Research Project: * Malta – an ever-shifting cultural kaleidoscope. Exploring cultural competence in doctors working in primary health care.

Project description, including research question/statement and method, in brief: *

The motivation for this study stems from the challenges primary health care (PHC) professionals encounter in the face of the ever-shifting demographics within the Maltese Islands.

The main aim of this research is to assess cultural competence in the Maltese PHC sector, including both the public and the private sectors. This is to be done by targeting doctors at two levels: the level of the individual PHC doctor and that of the leaders within the healthcare organizations.

The objectives of this study are the following:

1. To explore cultural knowledge, beliefs, and behaviors of PHC doctors during interactions with patients
2. To identify primary care doctors' deficits and strengths in cultural competence
3. To establish multicultural awareness at healthcare organization level
4. To make recommendations for implementing multicultural training for PHC doctors.

Methodology:

As the research aims to elicit the perceived cultural competence at different levels of doctors working in PHC workforce and the readiness to adapt to diversity at an organizational level, a mixed method approach will be utilized.

The project design will involve two phases. The first phase will be a survey based, cross-sectional study aiming at assessing the perceived level of cultural competence at the individual doctor's level. The second phase will involve semi-structured interviews with selected doctors working at organizational level.

The research tool that will be used for measuring cultural competence in the quantitative phase is the Healthcare Provider Cultural Competence Instrument (HPCCI) and permission to use this tool was granted. This is a validated tool and a demographic questionnaire will be constructed along it. Piloting of the questionnaire will be done and distribution will be done electronically through an intermediator. The questionnaire will be distributed to all members of the Malta College of Family Doctors and the intermediator will be the president of the Malta College of Family Doctors. General Practitioner (GP) trainees and foundation doctors will be excluded from the study.

For the qualitative method, open-ended questions will be initially used to cover personal views and beliefs in relation to cultural competence and then follow up questions will be employed to establish organizational viewpoints, barriers, and prospects of implementation of policies with regards to cultural diversity. The researcher will be conducting the semi-structured interviews. The interviews will be recorded during the interview and transcription will be done at a later stage.

Will project involve collection of primary data from human participants? Yes / Unsure

Explain primary data collection from human participants:

a. Salient participant characteristics (e.g. min-max participants, age, sex, other): *

Specialists in Family Medicine working within the Maltese PHC is the target population for this study.

b. How will they be recruited (e.g. sampled, selected, contacted, etc.): *

The questionnaire will be designed on an online survey platforms (Google Forms) and the link will be distributed to all the members within the Malta College of Family Doctors (MCFD). This is to be done electronically through an intermediator. In order to ensure anonymity no personal identifiable data will be included in the demographic questionnaire. The demographic questionnaire will help exclude doctors who are not Specialist in Family Medicine.
Sampling of experts will be utilized for the qualitative aspect that will seek to interview leaders within the department. Interviews are to be conducted by the researcher.

c. What they will be required to do and for how long: *
For the first phase, participants will need to fill a 15-minute questionnaire which will be composed of the Healthcare Provider Cultural Competence Instrument (HPCCI) tool along a demographic questionnaire. No personal identifiable data will be included.
In the second phase, participants will participate in a semi-structured interview. The interview will take approximately 30 minutes and will be held at a place and time convenient for participant.

d. If inducements/rewards/compensation are offered: *
There will be no inducements/rewards/compensations

e. How participants/society may benefit: *
There will be no immediate benefit to the participants and society. However, this study will help understand the perceived cultural competence within PHC and serve to equip doctors with knowledge and skills on how to interact with individuals from different cultures. This will ultimately lead to a more inclusive healthcare and improved health outcomes within society.

f. Is the participant's identity recorded at any stage of the research (e.g. in consent forms, records, publications): *
All the data in the questionnaires will be anonymous. In order to ensure anonymity, the questionnaire will be designed on an online platform (Google Forms) and the link is to be distributed by email. An intermediary will be responsible for the distribution of the link. Furthermore, no personal identifiable data will be collected.
The personal details of participants, participating in the semi-structured interviews will be recorded in the consent form. Data from the interviews will be pseudonymised. The transcripts will be given a code and these will be stored separately from the codes and personal details. All personal identifiable data will be deleted by July 2025 and all the other data will be deleted once the research is complete.

g. The manner in which you will manage and store the data: *
For the questionnaire, all data will be anonymous and stored offline on a password-protected external hard drive.
Interviews will be conducted by the researcher. For the interviews, the audio recordings will be given a code and a keyfile will be created. The coding key will be then encrypted and stored separately from the coded recordings. Transcripts of the recording will also be coded. All the data will be stored offline on a password-protected external hard drive. Data will be only accessed by the researcher. The coded data may be accessed by the supervisor and the examiners. In exceptional circumstances only, will the personal data be accessed by the supervisor and the examiners.

Will project involve collection of primary data from animals? No

Part 2: Self Assessment and Relevant Details

Human Participants

1. Risk of harm to participants: No / N.A.

2. Physical intervention: No / N.A.

3. Vulnerable participants: No / N.A.

4. Identifiable participants: No / N.A.

5. Special Categories of Personal Data (SCPD): No / N.A.

6. Human tissue/samples: No / N.A.

7. Withheld info assent/consent: No / N.A.

8. 'opt-out' recruitment: No / N.A.

9. Deception in data generation: No / N.A.

10. Incidental findings: No / N.A.

Unpublished secondary data

11. Human: No / N.A.

12. Animal: No / N.A.

13. No written permission: No / N.A.

Animals

14. Live animals, lasting harm: No / N.A.

15. Live animals, harm: No / N.A.

16. Source of dead animals, illegal: No / N.A.

General Considerations

17. Cooperating institution: Yes / Unsure
As per approval from the DPO, currently the request to carry out the research within the department was temporarily granted. Prior to the commencement of the study, the department needs a copy of the approval from the University Research Ethics Committee (UREC) or FREC.

18. Risk to researcher/s: No / N.A.

19. Risk to environment: No / N.A.

20. Commercial sensitivity: No / N.A.

Other Potential Risks

21. Other potential risks: No / N.A.

22. Official statement: Do you require an official statement from the F/REC that this submission has abided by the UM's REDP procedures?
No / N.A.

Part 3: Submission

Which F/REC are you submitting to? * Faculty of Health Sciences

Attachments:

- HPCCI_tool_permission.pdf (size: 230.6 KB, uploaded on: 26/03/2024 12:05:35)
- Primary_HC_approval.pdf (size: 185.1 KB, uploaded on: 26/03/2024 12:05:35)
- HPCCI_tool.docx (size: 38.7 KB, uploaded on: 26/03/2024 12:05:36)
- Interview_questions.docx (size: 14.5 KB, uploaded on: 26/03/2024 12:05:36)
- Dr_Zammit_Intermediary.pdf (size: 469.1 KB, uploaded on: 28/03/2024 17:08:10)
- Ms_Camilleri_Dr_Sammut.pdf (size: 1.2 MB, uploaded on: 28/03/2024 17:08:11)
- Consent_Interview_updated.docx (size: 101.3 KB, uploaded on: 25/04/2024 13:29:34)
- Information_letter_interview_updated.docx (size: 100.9 KB, uploaded on: 25/04/2024 13:29:34)
- Information_letter_quantitative_updated_MD_edit.docx (size: 100.7 KB, uploaded on: 25/04/2024 13:29:34)

- [x] Information and/or recruitment letter*
- [x] Consent forms (adult participants)*
- [ ] Consent forms for legally responsible parents/guardians, in case of minors and/or adults unable to give consent*
- [ ] Assent forms in case of minors and/or adults unable to give consent*
- [x] Data collection tools (interview questions, questionnaire etc.)
- [ ] Data Management Plan
- [ ] Data controller permission in case of use of unpublished secondary data
- [x] Licence/permission to use research tools (e.g. constructs/tests)
- [ ] Any permits required for import or export of materials or data
- [x] Letter granting institutional approval for access to participants
- [ ] Institutional approval for access to data
- [ ] Letter granting institutional approval from person directly responsible for participants
- [x] Other

Please feel free to add a cover note or any remarks to F/REC

Declarations: *

- [x] I hereby confirm having read the University of Malta Research Code of Practice and the University of Malta Research Ethics Review Procedures.
- [x] I hereby confirm that the answers to the questions above reflect the contents of the research proposal and that the information provided above is truthful.
- [x] I hereby give consent to the University Research Ethics Committee to process my personal data for the purpose of evaluating my request, audit and other matters related to this application. I understand that I have a right of access to my personal data and to obtain the rectification, erasure or restriction of processing in accordance with data protection law and in particular the General Data Protection Regulation (EU 2016/679, repealing Directive 95/46/EC) and national legislation that implements and further specifies the relevant provisions of said Regulation.

Applicant Signature: * Ruth Grech

Date of Submission: * 25/04/2024

If applicable: Date collection start date 01/06/2024

dministration

REDP Application ID FHS-2024-00131

Current Status Approved

If a submitted application needs to be amended, it can be withdrawn, edited, and resubmitted, and it will retain the same reference number. There is no need to submit a new application.

Appendix H: PHC full approval

Primary HealthCare
FRN 1940

PRIMARY HEALTHCARE

7 Harper Lane,
Floriana
FRN 1940

Website: http://www.health.gov.mt

Telephone: + 356 21239993
Telefax: + 356 21222856

30 April 2024

Ruth Grech
Bugella, Xuxa Str, Kercem,
Gozo

Re: Your request to carry out a study within the Primary Health Department

Dear Ms Grech,

I am pleased to inform you that your request to carry out the research within the department has been **fully approved**.
May I inform you that as we have to abide to the Data Protection Law, **we cannot provide you with a list of data subjects' (clients/patients/staff) personal contact details.*** The data subjects also have to sign an informed consent form that also includes a data protection statement (unless it is an anonymous questionnaire) prior to participating (see E below). Any modifications of this approach would have to be first discussed with the data protection officer. Where statistics are involved, only data in terms of age, sex etc can be forwarded to you but not names of individuals.

May I bring to your attention that the researcher is obliged to apply necessary safeguards as a condition for carrying out this research, namely -

A. The personal data (of data subjects) accessed or given are only to be used for that specific purpose to conduct the research and for no other purpose;
B. At the end of the research, all personal data should be destroyed;
C. All references to personal data should be omitted in the report unless an informed consent is specifically obtained from the person being identified in the research report;
D. Participation in the research being conducted should be at the discretion of the individual, and they can refuse any participation whatsoever if they so wish;
E. If data subjects (patients/staff) are going to be interviewed, video recorded or given a non-anonymous questionnaire to fill, an informed consent form should be signed by the participating data subject and a privacy policy statement read to them; Faces should be hidden or digitally modified as to conceal identity;
F. Any other measure deemed fit by the respective Head, depending on the research to be carried out.

I sincerely wish you every success in your studies.

Yours truly,

Dr Mario Vella, Data Protection Officer, Primary HealthCare
f/ CEO, Data Controller, Primary HealthCare

**May I suggest that you offer the invitation for participation through any officer in charge (e.g. Nursing officer/Senior GP/service provider)*

Appendix I: Quantitative and Qualitative Information Letters

L-Università ta' Malta

University of Malta
Msida MSD 2080, Malta

Tel: +356 2340 2340

www.um.edu.mt

Date: 25/04/2024

Information letter

Dear Sir/Madam,

My name is Ruth Grech and I am a post-graduate student at the University of Malta, reading for a Master of Science in Health Systems Management and Leadership. I am presently conducting research as part of my dissertation titled '**Malta - an ever-shifting cultural kaleidoscope. Exploring cultural competence in doctors working in primary health care**'; this is being supervised by Dr Miriam Dalmas (miriam.dalmas1@um.edu.mt). This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to assess cultural competence in the Maltese Primary Health Care sector. The study will involve 2 phases in a mixed-method approach. The first part of the study is a cross-sectional study amongst all the Specialists in Family Medicine working within Primary Health Care. The second part of the study involves semi-structured interviews amongst Specialist in Family Medicine within the organizational level of Primary Health Care.

Your participation in this study would help contribute to a better understanding of cultural knowledge, beliefs, and behaviors of primary health care doctors at individual level. Only data necessary for the research will be asked and any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to fill in a questionnaire. The first part is a research tool used to assess cultural competence and the second part is a demographic questionnaire. The questionnaire is estimated to take around 15 minutes to complete. To ensure your anonymity, you will not be asked to write

your name on the questionnaire or any personally identifiable data. Furthermore, your response to the following questionnaire will be considered as your voluntary consent for your participation in this study.

Data collected will be anonymised and only the researcher and supervisor will have access to. In special circumstances, the examiner(s) may access the data, for assessment purposes. Data will be stored in a password protected external hard disc.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected will be erased as long as this is technically possible, unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

If you choose to participate, please note that there are no direct benefits to you. Your participation does not entail any known or anticipated risks.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All data collected will be stored in an anonymised form and will be erased on completion of the study.

A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by e-mail; ruth.buttigieg.11@um.edu.mt. You can also contact my supervisor via email: miriam.dalmas@um.edu.mt.

Sincerely,

Ruth Grech

ruth.buttigieg.11@um.edu.mt

Dr Miriam Dalmas

miriam.dalmas@um.edu.mt

L-Università ta' Malta

University of Malta
Msida MSD 2080, Malta

Tel: +356 2340 2340

www.um.edu.mt

Date: 25/04/2024

Information letter

Dear Sir/Madam,

My name is Ruth Grech and I am a post-graduate student at the University of Malta, reading for a Master of Science in Health Systems Management and Leadership. I am presently conducting research as part of my dissertation titled **'Malta - an ever-shifting cultural kaleidoscope. Exploring cultural competence in doctors working in primary health care'**; this is being supervised by Dr Miriam Dalmas (miriam.dalmas@gov.mt). This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to assess cultural competence in the Maltese Primary Health Care entity. The study will involve 2 phases in a mixed-method approach. The first part of the study is a cross-sectional study amongst the Specialists in Family Medicine working within Primary Health Care. The second part of the study involves semi-structured interviews amongst Specialist in Family Medicine working within the organizational level of Primary Health Care.

Your participation in this study would help contribute to a better understanding of cultural knowledge, beliefs, and behaviors of primary health care doctors at organizational level. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to participate in semi-structured interviews. The interview is estimated to take approximately 30 minutes and it will be audio recorded. Interviews are to be carried by the researcher.

Data collected will be stored in a pseudonymised form, meaning that the recordings will be given a code and a keyfile will be created. The coding key will be then encrypted and stored separately from the coded

recordings and transcripts. They will be stored in a password protected external hard disc and will be only accessed by the researcher. The coded data may be accessed by the supervisor and the examiners. In exceptional circumstances only, will the personal data be accessed by the supervisor and the examiners. Should you choose to participate, you will only be asked to share data that is necessary for the research. Your identity and personal information will not be revealed in any publications, reports or presentations arising from this research.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

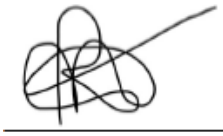
If you choose to participate, please note that there are no direct benefits to you. Your participation does not entail any known or anticipated risks.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All personal identifiable data will be deleted in July 2025 and all the stored data will be destroyed once research is complete.

A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by e-mail; ruth.buttigieg.11@um.edu.mt. You can also contact my supervisor via email: miriam.dalmas@um.edu.mt.

Sincerely,



Ruth Grech

ruth.buttigieg.11@um.edu.mt

Dr Miriam Dalmas

miriam.dalmas@um.edu.mt

Appendix J: Participants' Consent Form

L-Università ta' Malta

University of Malta
Msida MSD 2080, Malta

Tel: +356 2340 2340

www.um.edu.mt

Participant's Consent Form

Malta - an ever-shifting cultural kaleidoscope. Exploring cultural competence in doctors working in primary health care.

I, the undersigned, give my consent to take part in the study conducted by Ruth Grech. This consent form specifies the terms of my participation in this research study.

1. I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.
2. I also understand that I am free to accept to participate, or to refuse or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.
3. I understand that I have been invited to participate in a mixed method research in which the researcher will perform semi-structured interviews to assess cultural competence in the Maltese Primary Health Care entity. I am aware that the interview will take approximately 30 minutes and will be audio recorded. I understand that the interview is to be conducted in a place and at a time that is convenient for me.
4. I understand that my participation does not entail any known or anticipated risks.
5. I understand that there are no direct benefits to me from participating in this study.
6. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased.
7. I understand that all data collected will be stored in a pseudonymised form in a password protected external hard disc. All personally identifiable data will be erased by July 2025 and all data collected will be erased on completion of the study.
8. I have been provided with a copy of the information letter and understand that I will also be given a copy of this consent form.
9. I am aware that, by marking the first-tick box below, I am giving my consent for this interview to be audio recorded and converted to text as it has been recorded (transcribed).

MARK ONLY IF AND AS APPLICABLE

- ☐ I agree to this interview being audio recorded.
- ☐ I do not agree to this interview being audio recorded.

10. I am aware that, by marking the first tick-box below, I am asking to review extracts from my interview transcript that the researcher would like to reproduce in research outputs, before these are published. I am also aware that I may ask for changes to be made, if I consider these to be necessary.

MARK ONLY IF AND AS APPLICABLE

- ☐ I would like to review extracts of my interview transcript that the researcher would like to reproduce in research outputs before these are published.
- ☐ I would not like to review my interview transcript extracts that the researcher would like to reproduce in research outputs before these are published.

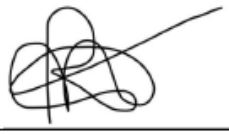
11. I am aware that extracts from my interview may be reproduced in these outputs, either in anonymous form, or using a pseudonym [a made-up name or code – e.g. respondent A].
12. I am aware that my identity and personal information will not be revealed in any publications, reports or presentations arising from this research.

I have read and understood the above statements and agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____



Ruth Grech

ruth.buttigieg.11@um.edu.mt

Dr Miriam Dalmas

miriam.dalmas@um.edu.mt

Appendix K: Full Inter-Item Correlation Matrices

Reliability Statistics (Awareness/Sensitivity)		
Cronbach's Alpha	**Cronbach's Alpha Based on Standardized Items**	**N of Items**
.689	.717	11

Inter-Item Correlation Matrix											
	a1	**a2**	**a3**	**a4**	**a5**	**a6**	**a7**	**a8**	**a9**	**a10**	**a11**
a1	1.000	.543	.292	.331	.432	-.111	.322	.274	.533	.182	-.005
a2	.543	1.000	-.215	.113	.241	-.249	.101	.172	.308	.116	.040
a3	.292	-.215	1.000	.405	.340	-.089	.112	.103	.248	.139	-.174
a4	.331	.113	.405	1.000	.478	.007	.255	.166	.444	.169	.117
a5	.432	.241	.340	.478	1.000	.140	.258	.235	.548	.264	.143
a6	-.111	-.249	-.089	.007	.140	1.000	.102	.168	.059	.345	.270
a7	.322	.101	.112	.255	.258	.102	1.000	.077	.257	.193	-.070
a8	.274	.172	.103	.166	.235	.168	.077	1.000	.149	.084	.015
a9	.533	.308	.248	.444	.548	.059	.257	.149	1.000	.441	.092
a10	.182	.116	.139	.169	.264	.345	.193	.084	.441	1.000	.373
a11	-.005	.040	-.174	.117	.143	.270	-.070	.015	.092	.373	1.000

Reliability Statistics (Behaviours)

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.928	.931	16

Inter-Item Correlation Matrix																
	b1	**b2**	**b3**	**b4**	**b5**	**b6**	**b7**	**b8**	**b9**	**b10**	**b11**	**b12**	**b13**	**b14**	**b15**	**b16**
b1	1.00	.729	.613	.548	.399	.415	.496	.274	.338	.329	.377	.339	.410	.496	.293	.345
b2	.729	1.00	.654	.607	.305	.409	.484	.496	.474	.541	.532	.473	.595	.626	.408	.517
b3	.613	.654	1.00	.782	.438	.447	.445	.391	.345	.312	.407	.291	.453	.647	.474	.521
b4	.548	.607	.782	1.00	.407	.493	.483	.413	.399	.281	.310	.240	.388	.634	.491	.376
b5	.399	.305	.438	.407	1.00	.796	.346	.228	.554	.496	.491	.481	.437	.562	.494	.313
b6	.415	.409	.447	.493	.796	1.00	.491	.462	.542	.489	.561	.577	.539	.464	.392	.303
b7	.496	.484	.445	.483	.346	.491	1.00	.561	.322	.333	.457	.372	.363	.383	.201	.370
b8	.274	.496	.391	.413	.228	.462	.561	1.00	.371	.398	.408	.412	.404	.423	.197	.341
b9	.338	.474	.345	.399	.554	.542	.322	.371	1.00	.855	.637	.384	.545	.499	.498	.297
b10	.329	.541	.312	.281	.496	.489	.333	.398	.855	1.00	.679	.479	.561	.435	.442	.310
b11	.377	.532	.407	.310	.491	.561	.457	.408	.637	.679	1.00	.762	.555	.358	.229	.470
b12	.339	.473	.291	.240	.481	.577	.372	.412	.384	.479	.762	1.00	.597	.400	.285	.646
b13	.410	.595	.453	.388	.437	.539	.363	.404	.545	.561	.555	.597	1.00	.540	.449	.499
b14	.496	.626	.647	.634	.562	.464	.383	.423	.499	.435	.358	.400	.540	1.00	.814	.614
b15	.293	.408	.474	.491	.494	.392	.201	.197	.498	.442	.229	.285	.449	.814	1.00	.400
b16	.345	.517	.521	.376	.313	.303	.370	.341	.297	.310	.470	.646	.499	.614	.400	1.00

Reliability Statistics (Patient-centred communication)

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.923	0.924	3

Inter-Item Correlation Matrix			
	c1	**c2**	**c3**
c1	1.000	.839	.695
c2	.839	1.000	.872
c3	.695	.872	1.000

Reliability Statistics (Practice orientation)		
Cronbach's Alpha	**Cronbach's Alpha Based on Standardized Items**	**N of Items**
0.781	0.798	9

Inter-Item Correlation Matrix									
	d1	**d2**	**d3**	**d4**	**d5**	**d6**	**d7**	**d8**	**d9**
d1	1.000	.295	.487	.203	.494	.468	.076	.350	.044
d2	.295	1.000	.356	.570	.412	.392	.113	.565	.108
d3	.487	.356	1.000	.304	.517	.490	.381	.249	-.064
d4	.203	.570	.304	1.000	.495	.264	.336	.463	.238
d5	.494	.412	.517	.495	1.000	.380	.144	.368	.217
d6	.468	.392	.490	.264	.380	1.000	.286	.438	.034
d7	.076	.113	.381	.336	.144	.286	1.000	.105	.267
d8	.350	.565	.249	.463	.368	.438	.105	1.000	.122
d9	.044	.108	-.064	.238	.217	.034	.267	.122	1.000

Reliability Statistics (Self-assessment)		
Cronbach's Alpha	**Cronbach's Alpha Based on Standardized Items**	**N of Items**
0.844	0.863	9

Inter-Item Correlation Matrix									
	e1	**e2**	**e3**	**e4**	**e5**	**e6**	**e7**	**e8**	**e9**
e1	1.000	.397	.309	.344	.526	.336	.187	.091	.064
e2	.397	1.000	.828	.451	.414	.562	.582	.522	.410
e3	.309	.828	1.000	.424	.256	.660	.513	.424	.492
e4	.344	.451	.424	1.000	.141	.657	.143	.319	.590
e5	.526	.414	.256	.141	1.000	.343	.515	.314	.122
e6	.336	.562	.660	.657	.343	1.000	.308	.491	.618
e7	.187	.582	.513	.143	.515	.308	1.000	.574	.316
e8	.091	.522	.424	.319	.314	.491	.574	1.000	.590
e9	.064	.410	.492	.590	.122	.618	.316	.590	1.000