Experience of migrant care and needs for cultural competence training among public health workers in Korea

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Abstract
Objective: This study explored the experiences of public health workers (PHWs) providing health care for migrants living in Korea and clarified needs for cultural competence training.

Design and Sample: Twenty-six PHWs from five public health centers in Gwangju city, South Korea, participated in this exploratory qualitative study.

Methods: Five semi-structured focus group interviews of PHWs were conducted from September to December 2016. A directed content analysis approach was conducted using four categories: perceived characteristics of migrants, interaction between PHWs and migrants, interaction between PHWs and organizations/systems, and cultural competence training needs.

Results: PHWs perceived that migrants lacked autonomy in health decisions and awareness of health behaviors. PHWs experienced difficulties in communicating and in establishing trusting relationships. They found clients hard to reach and easy to miss, a lack of continuity in health care programs, and inadequate human and material resources. They preferred passive teaching methods to activity-based simulation. PHWs believed essential training should be provided through e-learning to all PHWs, including management.

Conclusion: PHWs reported experiencing multiple challenges from a lack of preparedness for culturally competent care and their clients’ vulnerability. Development of cultural competence training is suggested through e-learning that reflects the PHWs’ experiences and provides systematic support.

KEYWORDS
cultural competency, migrants, public health care provider

1 | BACKGROUND

Korea has recently emerged as a destination country for migration (Kim, 2014). Consequently, foreigners living in Korea comprised 2.8% (approximately 1,410,000) of the population by the end of 2016 (Statistics Korea, 2017a). Multicultural families, mainly through the marriage of Korean men and foreign women (from China [40.7%], Vietnam [26.9%], Japan [7.3%], the Philippines [7.1%], and other Asian countries) (Chung et al., 2016), influence the birth and socialization of the future Korean population. Marriage migrant women (MMW) are the first migrants permitted to immigrate to Korea as spouses of Korean nationals. Their entrance from various countries into Korean homes and communities became a catalyst for migrant social integration policies (Kim, 2014).

By comparison, the number of migrants in Europe has been increasing steadily, comprising an average of 8.7% (Deville et al., 2011). European nurses providing health care for migrants reported various challenges in communication, cultural understanding, and professional preparation.
challenges, such as differences in expectations between service providers and recipients, difficulties in communication and establishing trusting relationships, nurses’ lack of education, deficiencies in organizational cooperation and communication and human and material resources, and legal and ethical dilemmas (Kalengayi, Hurtig, Nordstrand, Ahlm, & Ahlberg, 2015; Lyberg, Viken, Haruna, & Severinson, 2012). The migrant health poses a new challenge in the European health care field.

Multicultural family health is key in achieving the goal of the Korean Health Plan 2020 (HP2020; Ministry of Health and Welfare [MOHW], 2011). A public health center (PHC) provides primary health care for local residents in each district. As of 2015, there were 254 PHCs and approximately 20,000 public health workers (PHWs) in Korea. PHWs comprise various professionals such as nurses (50.3%), medical technicians (30.8%), western and oriental medical doctors (12.1%), dieticians (3.5%), dentists (2.8%), and pharmacists (1.6%) (Statistics Korea, 2017b).

Literature finding suggests health services are not always delivered to recipients as intended by the provider, because recipients’ values, beliefs, and expectations influence when they accept services (Schim & Doorenbos, 2010). Cultural competence refers to PHWs’ abilities in providing care for migrant residents. Cultural competence has been defined as “a multidimensional learning process that integrates transcultural skills in the cognitive, practical, and affective dimensions that aim to achieve culturally congruent care” (Jeffreys, 2015, p. 25). Health workers’ cultural competence can reduce health disparities for migrants and indigenous peoples and decrease health care costs (Leininger & McFarland, 2006). However, the most effective way to educate health professionals in cultural competence is still uncertain (Horvat, Horey, Romios, & Kis-Rigo, 2014). According to previous Korean studies (Jang & Lee, 2014; Kim & Song, 2016; Lee, Kim, & Lee, 2012; Yang, Kwon, & Lee, 2012), 80.2%–92.9% of PHWs provided services to migrants, while only 14.3%–40.9% received cultural competence training. Jang and Lee (2014) indicated 95.3% of dental hygienists reported a need for additional training in culturally competent care. However, these studies were quantitative, revealing a lack of research on PHWs’ migrant care experiences and cultural competence training needs. The aforementioned HP2020 focuses on improving public health services for migrants, but lacks emphasis in developing PHW cultural competence (MOHW, 2011).

Effective primary health care provision for migrants requires a framework of education and practice be established within the context of the Korean sociocultural environment, which requires an understanding of the PHWs’ situation and prioritization of their cultural competence training needs. This study aimed to explore PHWs’ experiences in providing health care services for migrants living in Korea and to clarify PHW’s cultural competence training needs.

1.1 Conceptual framework

This study was guided by the King’s Conceptual System for Nursing (King, 1981), encompassing nurse’s perceptions, goals, needs, and values, which are expected to influence the interaction process. This system provides a comprehensive view of three interacting systems: personal (individual), interpersonal, and social (institutions and organizations). King defines nursing as “a process of human interaction between nurse and client whereby each perceives the other in the situation…” (King, 1981, p. 144). King’s theory has been used as a conceptual framework for nursing education (Meleis, 2012). Utilizing the concepts in King’s model—perception, growth and development, interpersonal systems, social systems (organization), and interaction—facilitates understanding of the situation and training needs of PHWs.

This study was also guided by the conceptual framework presented by Horvat et al. (2014) in a systematic review, including four domains: training content, pedagogical approach (teaching-learning method), structure (delivery and format, frequency), and participants. Together, these two models helped frame the study, explore the personal systems of PHWs (perceptions in providing health care services for migrants), and clarify their cultural competence training needs (content, pedagogical approach, structure, and participants). The interpersonal and social systems explored comprise interactions between PHWs and migrants and between PHWs and organizations, respectively (Figure 1).

1.2 Research questions

1. What do PHWs report as the main characteristics of migrants using PHCs?
2. What do PHWs report regarding their interaction with migrants when providing health care services?
3. What do PHWs report regarding their interactions with organizations/systems when providing health care services to migrants?
4. What needs for cultural competence training do PHWs report?

![Figure 1](image-url) Conceptual framework of the study
2 | METHODS

2.1 | Design and sample

This exploratory qualitative research study investigated PHWs’ experience in providing health care services for migrant residents and clarified their cultural competence training needs. Twenty-six PHWs (4–6 PHWs per PHC) were recruited from five PHCs. Five of the eight PHWs participating as steering committee members for this research project were recruited using purposive sampling, one PHW from each PHC. Then, these five PHWs recruited 3–5 PHWs at their respective PHCs using snowball sampling. Inclusion criteria were PHWs working at the PHC with experience providing health services for migrants. All contacted PHWs participated in the study.

2.2 | Data collection and procedure

We used five focus group interviews to explore the PHWs’ perceptions of providing health care services for migrants and to clarify their cultural competence training needs. This method facilitates interactions among participants, which can help them to express and clarify their perspectives. It is often used to determine the perceptions of participants and to assess training needs (Krueger & Casey, 2009). The interviews were conducted from September to December 2016 in Gwangju city, South Korea. Following each interview, the principal investigator and a research assistant transcribed the contents and performed the preliminary analyses. Data were collected until there was redundancy in the preliminary findings.

Five PHWs who were steering committee members of this research project reviewed the interview guide, ensuring its appropriateness and clarity. The interviews were conducted in the PHC’s break rooms (three groups) and university’s seminar rooms (two groups), according to the interviewees’ preferences. The participants were informed that all information would be kept confidential and that any identifying information would be removed from the transcripts. Participants completed informed consent forms and demographic forms.

The 70- to 90-min interview started with the following questions: “In what situations did you encounter migrants?” “How was your caring experience with migrants?” “What kind of training do you think is necessary to provide effective services for migrants?” It then continued to specific questions, such as “What contents would you like to include in the training program?” The same questions were used in the five focus group interviews. All interviews were audiorecorded and were conducted by the first author, who has extensive experience in nurse’s cultural competence and migrant care, using an interview guide. Two research assistants participated in the interviews and wrote field notes. Participants were interviewed once.

2.3 | Analytic strategy

Content analysis is a pragmatic method for extending knowledge of human experience. There are three distinct approaches, conventional, directed, and summative, and the main differences among the approaches are coding schemes and origins of codes (Hsieh & Shannon, 2005). We utilized directed content analysis because we used the conceptual framework of this study to develop initial coding. First, using King’s Conceptual System for Nursing (King, 1981), we identified coding categories from the key concepts: perception, growth and development, interpersonal systems, social systems (organization), and interaction. Next, operational definitions for each category were determined using the theory. Perception was defined as the perceived characteristics of migrants. Interpersonal systems and interaction were defined as interaction between PHWs and migrants. Social systems and interaction were defined as interaction between PHWs and organizations/systems. Growth and development were defined as cultural competence training needs.

Initially, three researchers read the transcribed data to gain an overall understanding of the experiences expressed by PHWs. Next, each researcher independently highlighted the text addressing experiences of migrant care and cultural competence training needs and coded the text into the predetermined categories (perceived characteristics of migrants, interaction between PHWs and migrants, interaction between PHWs and organizations/systems, and cultural competence training needs). After coding, each researcher examined the data for each category to determine whether subcategories were needed. For the cultural competence training needs category, the main components of the conceptual framework by Horvat et al. (2014) were used as subcategories (e.g., training contents, teaching and learning methods). Then, a final analysis of each interview was conducted, comparing the three independent analyses and reaching a consensus. Methodological rigor was established using the criteria of credibility and confirmability (Creswell, 2017). Credibility was assured through peer debriefings during the research team meetings. Confirmability was established by returning the categories, subcategories, and elements to six participants to ensure that the findings were consistent with the provided data.

2.4 | Ethical considerations

This study was approved by the ethical review board at the author’s institution. We met with five PHC managers, explained the purpose of the study, and gained permission to conduct the interviews. Both a verbal and written explanation were given to potential participants about the study purpose, the volunteer nature of interview participation, and the fact that there would be no disadvantage should they decline to participate. Informed consent was obtained from all participants. To differentiate between participants in the recordings and results, numbers were assigned and all identifying information was deleted. Participants received a small gift for participating.

3 | RESULTS

Twenty-six female PHWs, with an average of 13.43 (SD = 8.22) years’ work experience, participated in this study. Their mean age was 41.77 years (SD = 8.32). Education levels included associate (15.4%), Bachelor of Science in nursing (73.1%), and Masters’ (11.5%) degrees.
Most participants were registered nurses (77.0%) or dietitians (11.5%). Only two participants (7.7%) reported having received training about migrant care.

### 3.1 Perceived characteristics of migrants

The main characteristics of migrants reported by the participants included lack of autonomy in health decisions and lack of awareness of health behaviors (Table 1).

#### 3.1.1 Lack of autonomy in health decisions

PHW participants reported that migrants showed passive, dependent, and withdrawn attitudes in the context of their health rights. When migrants visit PHCs, they usually need help from their husbands or families, and PHWs mainly communicate with these intermediaries. PHWs perceived that MMW lacked personal expression and let husbands decide about their health, as the following quote demonstrates:

**PHWs, public health workers.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Elements</th>
</tr>
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| Perceived characteristics of migrants | Lack of autonomy in health decisions | • Being neglected in communication with PHWs  
• Passive position  
• Lack of personal expression  
• Let husband make decisions about her health problems |
|                                   | Lack of awareness of health behaviors | • Health services are only used when sick  
• Poor hygiene  
• Low participation in health care programs  
• Inadequate health knowledge |
| Interaction between PHWs and migrants | Limited communication due to language barriers | • Questionable feelings about unclear communication  
• Frustration due to not conveying desired meanings |
|                                   | Difficulty in establishing trusting relationships | • Short contact time  
• Lack of understanding due to language barriers and cultural differences  
• Frequent dropouts or denial of service |
| Interaction between PHWs and organizations/systems | Hard to reach and easy to miss | • Difficulty in identification, enrollment, and retention of migrants in health services  
• Lack of information sharing and cooperation between related organizations  
• Missing more vulnerable migrants  
• Difficult to track health information |
|                                   | Lack of continuity in health care programs | • Not the main program of public health centers  
• Frequent job rotation  
• Differences in managers’ perceptions about the need for programs targeted at migrants  
• Lower outcomes compared to input of resources and effort |
|                                   | Inadequate human and material resources | • Inadequate policy and support for migrant-related services  
• Lack of PHWs’ preparation  
• Lack of qualified interpreter services  
• Limited multilingual materials |
| Cultural competence training needs | Training content | • Necessity of culturally congruent care  
• Improvement of awareness about migrants and reduction of prejudice  
• Understanding of various cultures  
• Difficulties experienced by migrants  
• Simple communication skills  
• Useful multilingual expressions  
• Information on related organizations |
|                                   | Teaching and learning method | • Prefer passive teaching methods (e.g., lectures)  
• Case study  
• Short reflection journal |
|                                   | Structure | • Provide as an essential continuing education  
• Computer- or smartphone-based delivery  
• Frequency and duration: 5–12 sessions of 20–30 min |
|                                   | Subjects | • PHWs  
• Social workers  
• Administrative officers  
• Managers |
Usually, wives are foreign nationals. So, they cannot do anything to lead, and a spouse comes … Even if they come with their husbands, they just stand beside them without talking. (Participant 7)

3.1.2 | Lack of awareness of health behaviors

PHW participants perceived that migrants were less likely to practice health behaviors because of a lack of health care awareness. They observed poor hygiene, inadequate health knowledge, low participation in health care programs, and recognition that health services are used only when sick. This finding may be related to diverse education levels, languages, and cultural backgrounds, and divergent health care policies in their countries of origin, as the following quote exemplifies:

Even if I explain the risk or severity of a disease, they do not listen seriously. When I say, “Your condition is bad, you should go to the hospital,” they answer, “I see,” and that’s the end. There are a lot of cases like this. (Participant 13)

3.2 | Interaction between PHWs and migrants

PHW participants experienced limited communication due to language barriers and difficulty establishing trusting relationships (Table 1).

3.2.1 | Limited communication due to language barriers

The primary difficulty in delivering primary health care services was language barriers, limiting the expression and understanding of PHWs and migrants. Unclear communication proved frustrating:

They just pretend to understand because they have no other way… We just ask each other saying, “What? What?” They say, “I got it.” … But when we look at their faces, we can determine that they did not understand at all … In such a situation, we are also very uncomfortable. (Participant 8)

3.2.2 | Difficulty in establishing trusting relationships

Short contact time, lack of understanding due to language barriers and cultural differences, and frequent dropouts or denial of service led to difficulties in establishing trusting relationships, instigating negative feelings of wanting to do better, but being unable:

I treated migrants in the Korean way… I’d like to do something better for them, but the other side may not … I want to listen to the stories in the migrants’ minds, but I could not go deeper … At that time, they might think, “PHW does not know me anyway,” … so it also becomes hard for them to reveal their mind. (Participant 4)

3.3 | Interaction between PHWs and organizations/systems

The interaction with organizations/systems is characterized by a lack of continuity in health care programs and inadequate human and material resources, and migrants tend to be hard to reach and easy to miss (Table 1).

3.3.1 | Hard to reach and easy to miss

There was difficulty in the identification, enrollment, and retention of migrants in health care services. Moreover, other important issues were a lack of information sharing and cooperation between related organizations, exclusion of more vulnerable migrants, and difficulties in tracking key health information, especially infectious diseases:

Even if I want to find a foreign couple or a multicultural family in a vaccination room, I cannot reach them. I cannot find a place to manage them. I once called the immigration office, but it was useless. Even in the district office, we cannot know if they’re residents in our area. (Participant 15)

MMW’s husband told me not to come (for a home visit), saying that I do not want to make my wife become unnecessarily excited and we will take care of it by ourselves. Even if there was a need for any help or the MMW desired it, her husband blocked the meeting itself, so she finally rejected me. (Participant 3)

3.3.2 | Lack of continuity in health care programs

Health care programs for migrants are often temporary or one-time procedures, lacking adequate support. This lack may be related to programs not being PHCs’ main focus, frequent job rotation, and differences in managers’ perceptions regarding the need for targeted programs for migrants. Moreover, the migrants’ low interest and participation led to lower outcomes compared to resource and effort inputs, presumably discouraging PHWs from continuing health care programs for migrants:

To be honest, I do not want to do it because it is a very difficult. I think it’s necessary … but there are so many difficult things … Like other health programs, we purposely recruit the target population … when we run the program, the target persons respond well, so the program expands … It is meaningful … But that is really not possible. (Participant 18)

3.3.3 | Inadequate human and material resources

The lack of human and material support also hinders the activation of multicultural services, including deficits in relevant policy or support for migrant services, PHW preparation, qualified interpreters,
and multilingual materials. Participants expressed an urgent need to expand interpreter services to improve communication.

3.4 | Cultural competence training needs

3.4.1 | Training content

PHW participants wanted to learn about the necessity of culturally congruent care, improved awareness and reduced prejudice regarding migrants, understanding various cultures, difficulties experienced by migrants, simple communication skills, useful multilingual expressions, and information on related organizations:

We are saying that Southeast Asian people are "lazy" in the expression of the Korean way, but they are not lazy. It is the culture of their countries ... I would like to have some of these things in my education. (Participant 2)

3.4.2 | Teaching and learning method

A passive teaching method (e.g., lecture, audiovisuals) was preferred to activity-based teaching methods (e.g., simulation). Participants particularly mentioned the need for lectures, case studies, and short reflection journaling:

Theoretical education does not facilitate its acceptance. I want to see various cases using PowerPoint or video. I do not think it will be boring if I watch videos and solve quizzes. (Participant 3)

3.4.3 | Structure

PHW participants stated that multicultural service education should be introduced as an essential job-training course. They also preferred computer-based e-learning offered during work hours. A visiting nurse found smartphone apps easy to carry and allowed users to refer to needed information during home visits. Participants suggested a training program with 5-12 sessions of 20-30 min.

3.4.4 | Subjects

PHW participants stated that educational targets should include not only PHWs but also various personnel involved in delivering primary health care services to migrants, such as social workers, administrators, and managers. In order to change into a culturally competent organization, they emphasized that top managers should be educated:

I think it would be better to apply it to all those who come in contact with migrants. It is not optimal if only staff members are aware of this ... Top managers can also encounter migrants, and when they change, the whole thing can change. (Participant 25)

4 | DISCUSSION

Exploring the experiences of PHWs providing health care services for migrants living in Korea and their needs for cultural competence training may enable public health professionals to understand the situation of PHWs in Korean society. PHWs commonly perceived that health services for migrants were difficult and challenging, but necessary. They also desired adequate cultural competence training.

First, PHWs reported that MMW lacked autonomy in health decisions, with husbands communicating and making decisions about sensitive and invasive treatments. They perceived MMW as passive, deferring treatment decisions to their husbands and seeking treatment only when sick. In previous studies, primary health care nurses also stated that migrants lacked basic knowledge about their bodies and were less likely to seek voluntary screening and immunization (Kalengayi et al., 2015; Lyberg et al., 2012). Health literacy is the degree to which a person has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2010). PHWs' perceptions of migrants' "lack of autonomy in health decisions" and "lack of awareness of health behaviors" are related to limited health literacy. Therefore, health literacy should be addressed in cultural competence training, such as how to collect assessment data, when and how to use interpreters, and how to communicate clearly (Andrulis & Brach, 2007).

Second, in their interactions with migrants, PHWs experienced difficulty in establishing trusting relationships because of language barriers. This is a common problem for health care workers providing services to migrants (Sandhu et al., 2013; Taylor, 2005). Language barriers can cause PHWs to focus on superficial physical illnesses and overlook ill-defined diseases such as stress and mental health problems (Suphanchaimat, Kantamaturapo, Putthasri, & Prakongsai, 2015). Thus, language barriers and difficulty establishing trusting relationships can greatly impact the delivery of holistic primary care services (Dauvin et al., 2012). Eipperle (2015) asserts that being open, sensitive, respectful, and having holding knowledge about frequently encountered cultural groups is fundamental for integrating cultural care into a holistic nursing approach and developing cultural competence. Moreover, it is necessary to listen more by allocating more time, and to verify that both providers and migrants understand (Devillé et al., 2011; Lyberg et al., 2012; Sandhu et al., 2013).

Third, in interactions with organizations and systems, PHWs recognized a lack of continuity in health care programs, inadequate human and material resources, and that migrants were hard to reach and easy to miss. PHWs had difficulty in the identification, enrollment, retention, and subsequent management of migrants. There was no system to identify migrant residents in their jurisdictions, and the linkage between related agencies was not smooth. Swedish primary health care nurses also indicated deficiencies in the structure, coordination, and implementation of migrant health services (Kalengayi et al., 2015). In particular, health education and health promotion, which are difficult to access for vulnerable migrants, are required to actively approach...
the target migrant groups (Devillé et al., 2011). Moreover, frustrating prior experiences pose obstacles to ongoing programs. As PHWs change jobs every 2–3 years, health programs for migrants are often reduced or discontinued depending on the replacement for the person in charge. Norwegian public health nurses found that programs addressing migrant women’s mental health and adjustment were terminated or entrusted to volunteers because of budget cuts (Lyberg et al., 2012).

Participants also reported inadequate human and material resources. Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) defined cultural sensitivity as “the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population’s relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs” (p. 11). Previous studies examining the cultural sensitivity of educational materials for minority populations (Friedman & Kao, 2008; Wolff et al., 2016) emphasized guidance through culturally appropriate resources to assist migrants with important health decisions and to encourage engagement in healthy lifestyle behaviors. Since there are no trained interpreters in the PHCs, migrants working in multicultural family support centers or migrant leaders helped with interpretation. However, erroneous translation by nonprofessional interpreters can negatively impact treatment (Schouler-Ocak et al., 2015). In the United States and Europe, similar problems are also observed, such as excessive workloads and shortages in workforce training, time, and trained interpreter resources (Kalengayi et al., 2015; Suphanchaimat et al., 2015; Taylor, 2005).

Fourth, most participants had not received necessary cultural competence training. They desired training content to address improved awareness of migrants, knowledge of various cultural characteristics, communication methods, useful multilingual expressions, information on related organizations, and reducing prejudice. PHWs aspired to provide health services based on their understanding of migrants’ cultural characteristics, behavior patterns, and difficulties experienced due to cultural differences. One participant enthusiastically expressed that Koreans tend to be prejudiced against migrants, which highlights the importance of training to reduce prejudice and increase cultural sensitivity and knowledge of cultural characteristics (Je, Son, & Kim, 2015).

Participants’ preferred lectures, case studies, and e-learning, within a mandatory course with 5–12 sessions of 20–30 min. Berlin, Nilsson, and Törnkvist (2010) indicated the effectiveness of an educational method combining theory, practice, seminars, activities, and discussion because cultural competence is not easily conveyed through lectures. Previous studies on educational intervention to promote cultural competence among health care workers used various methods, such as lectures, discussions, case studies, role play, videos, and practicum. Training was provided both on- and off-line with between 6 and 15 sessions (Je et al., 2015; Kutob et al., 2013; Park & Kweon, 2013; Park & Park, 2013; Thom, Tirado, Woon, & McBride, 2006). Kutob et al. (2013) suggested learning through examples of diverse languages, races, and cultures to help health care providers recognize their ethnic and cultural identities and emphasize the importance of increasing cultural humility through continuous self-evaluation about cultural identity, rather than increasing specific knowledge.

Moreover, PHWs suggested the consideration of individual and organizational situations and preferences in selecting training methods. For example, some participants preferred computer-based e-learning, while visiting nurses preferred smartphone-based e-learning. They also preferred passive methods, such as lectures and audiovisuals, rather than simulation methods requiring active participation. This finding differs from a previous finding that clinicians perceived case-based behavioral simulation as the most helpful and video as the least helpful training methods (Aggarwal et al., 2016). We assumed that PHWs prefer lectures, which are familiar, rather than an unfamiliar simulation method. Aggarwal et al. (2016) suggested that both active and passive training programs could be designed based on learners’ preferences. Moreover, participants proposed that training should be part of a mandatory course offered in their organizations to encourage active participation.

Finally, PHW participants recommended the extension of cultural competence training to all personnel interacting with migrants, including PHC managers. Considering its multilevel nature, culturally competent care in primary health care settings necessitates thoughtful, integrated, and appropriate changes at both organizational and individual levels (Fung, Lo, Srivastava, & Andermann, 2012). Cultural competence training for PHWs could be an impetus transforming PHCs into a culturally appropriate organization.

In this study, focus groups enabled PHWs to ponder, reflect, and listen to others’ migrant care experiences and training needs. Through this interaction, we were able to grasp PHWs’ migrant care experiences and cultural competence training needs. This study has some limitations. Participants were limited to PHWs in one city. PHWs in another town might not agree with the results. The educational background of most participants was nursing. PHWs with different educational backgrounds might report other experiences and training needs. Because participants knew each other, the possibility of group think cannot be excluded.

5 | CONCLUSION

Our findings establish initial evidence for migrant care experience and cultural competence training needs from Korean PHWs’ perspectives. They reported multiple challenges in providing care to migrants and a lack of preparedness for culturally competent care. To maximize the effectiveness of cultural competence training, a program should be developed that reflects PHWs’ actual situation and learning preferences. Further study should develop e-learning programs and evaluate their effectiveness in improving PHWs’ cultural competence and migrants’ health outcomes.

ACKNOWLEDGEMENTS

This research was supported by Basic Science Research Program through the National Research Foundation of Korea (NRF) funded
by the Ministry of Science, ICT & Future Planning (2016R 1C 1B 1009977).

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