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Cultural Competence Practices among Health Information Professionals in university of Jos Teaching Hospital

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ABSTRACT: This study investigated the Cultural competence practices among health information professionals in university of Jos teaching hospital. Survey research design was used for the study. The population comprised 76,health information professionals in university of Jos teaching hospital. The total enumeration sample size was adopted for this study. Structured and validated questionnaires were used to collect data. A return rate of 81% was achieved respectively for the health information professionals in university of Jos teaching hospital. Data were analyzed using descriptive statistics. Findings showed that health information professionals exhibited Cultural competence practices among health information professionals in university of Jos teaching hospital ($\bar{x}$= 2.98). Health information professionals exhibited cultural competence university of Jos teaching hospital, in respect of cultural desire ($\bar{x}$= 3.31), cultural awareness ($\bar{x}$= 3.10), cultural skills ($\bar{x}$= 3.04), cultural knowledge ($\bar{x}$= 2.87) and cultural encounters ($\bar{x}$= 2.59). This implies that health information professionals exhibited cultural competence more in university of Jos teaching hospital, in terms of cultural desire followed by cultural awareness, cultural skills, cultural knowledge and cultural encounters. The study concluded by examined the Cultural competence practices among health information professionals in university of Jos teaching hospital. The study is successful as the objective has been achieved. Nigeria are culturally competent. The study recommended that the health information professionals exhibited cultural competence in university of Jos teaching hospital. This should be sustained by increasing the capacity of health information professionals and instilling cultural competence virtues in the mind of health information professionals in university of Jos teaching hospital.

Keywords: Cultural awareness, cultural competence, cultural knowledge, health information professionals, University of Jos teaching hospital

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INTRODUCTION

Every society has its own culture or ways of doing things- these are learned patterns of thoughts and behaviour which makes a particular social group distinct from the others. The idea of culture could also include knowledge, beliefs, arts, law, customs and any other capabilities and habits that human beings acquire as members of a particular society (Feluga, 2019). The fact that cultures vary, leads to the practice of cultural competence which has to do with a set of congruent behaviours, attitudes, as well as policies that come together in system, agency, or among professionals that enable that system, agency or those professionals to work effectively in cross-cultural situations (The National Health and Medical Research Council, Australia [NHMRC] (2016). According to Chamberlain (2005), culture represents the values, norms, and traditions that affect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world. McAuliffe (2013) also defined culture as the attitudes, habits, norms, beliefs, behaviours, customs, rituals, styles and artifacts that express a group's adaptation to its environment; that is, ways that are shared by group members and passed on

over time. Sue and Sue (2012) maintained that culture is the fundamental building block of identity and the development of a strong cultural identity is essential to an individual's healthy sense of who they are and where they belong. McAuliffe (2013) noted that culture comprises of external and internal dimensions. Whereas the external expressions of culture as reflected in customs, rituals, and styles are most obvious, the internal dimensions, which are the focus of cultural competency that includes awareness of the attitudes, habits, norms, and both spoken and unspoken rules within a particular culture, are mostly subsumed.

Therefore, cultural competency includes individuals' awareness of their own cultural idiosyncrasies and working to understand the cultural ideology of others. Cultural competency is by implication more than being aware of cultural differences and is more than knowledge of the customs and values of those different from one's own. It goes beyond being respectful of the cultures represented within a group or even a community. Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness, and social justice (McAuliffe, 2013). Cultural competence refers to an ability to interact effectively with people of different cultures. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures in different settings. According to Cross, Bazron, Dennis and Isaacs (1989), cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system or agency or among professionals and enables the system, agency, or professionals to work effectively in cross-cultural situations. Davis and Donald (1997) saw cultural competence as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes; while the National Association of Social Workers (NASW, 2001) postulated that cultural competence is the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

Cultural competence is about people's will and actions to build understanding between people, to be respectful and open to different cultural perspectives, strengthen cultural security and work towards equality in opportunity. As McAuliffe (2013) averred, relationship building is fundamental to cultural competence; and building effective relationships is based on the foundations of understanding each other's expectations and attitudes, and subsequently building on the strength of each other's knowledge, using a wide range of community members and resources to build on their understandings. McAuliffe (2013) explained further that being culturally sensitive in cross-cultural settings is an imperative for individuals from all cultures in order for them to avoid using their own culture as the standard by which to assess appropriate behaviour in others.

According to deBeer and Chipps (2014), the growing interest in the intertwine between culture and healthcare service delivery dates back to the days of Florence Nightingale, who touched on the concept of transcultural nursing in the 19th century when advising British nurses working in India to take into account the cultural background of their patients. Since then, transcultural studies was formally introduced as an area of study and practice for nurses and other healthcare service providers striving towards providing optimal and culturally appropriate services for patients. In healthcare services, cultural competence involves understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professional and client/patient/family bring to interactions (Ballard, 2013). Healthcare professionals who lack cultural competence may be putting patients at risk for delays in treatment, inappropriate diagnosis, non-compliance with healthcare regimens, and even death of patients (deBeer and Chipps, 2014). Although healthcare professionals may not see themselves as overtly racist or neglectful, Ballard (2013) maintained that they could be missing pertinent healthcare findings due to what he referred to as 'cultural blindness'. A culturally competent healthcare service provider should assess each patient individually and not make assumptions about a patient's beliefs and health practices.

In furtherance to the integration of cultural competence to professional healthcare service delivery, Campinha-Bacote's (1999) developed a model of cultural competence in health care delivery that health care service providers can use as framework for developing and implementing culturally responsive health care services. The model views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). It requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent. This process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002). Chukwu (2015) noted that Nigeria is a multicultural country with over 350 nationalities, with each entity having its own norms, values, beliefs and even language. He also stated that Nigeria is a conglomeration of more than two hundred and fifty ethnic groups with their respective cultures. This has tended to influence the way individuals live and their relationship with other people. The goals and life aspirations of individuals are often a product of their

culturally-held values. These differences could be related to differences in ethnicity, ability, cultural traditions, sexuality, economic and social positions. The implication of this for health information professionals in Nigeria is that clients today come from very diverse ethnic groups with different norms, values and idiosyncrasies.

Lopez and Rogers, (1999) as reported by Stith-Williams (2009) pointed out that there are six (6) domains of culturally competent service delivery which are: First, legal and ethical issues which involves knowledge of service provider on local, state and federal laws and regulations, awareness of litigation, understanding of ethics and advocate for public policy and educational law. Second is school culture, educational policy, and institutional advocacy which describes knowledge of service providers on aspects of organizational culture that promote achievement and mental health for Culturally and Linguistically Diverse (CLD) students as well as the ability to play a leadership role in the implementation of supportive interventions for CLD students and their families. The third is psycho-educational assessment which means knowledge of and skills in assessing CLD students, including consideration of variables such as environment, social issues, language development, racism, second language acquisition, acculturation, educational history, quality of educational programmeme, and understanding that normed tests may not be a valid measure for English Language Learners (ELLs and many others). The forth domain is academic, therapeutic and consultative interventions which has to do with the skills of service providers in multicultural counseling, cross-cultural consultation and knowledge of multicultural education, ELL programmemes and school culture/culture of staff and students.

The fifth domain according to Lopez and Rogers, working with interpreters which deal with the ability of service providers to display knowledge of recommended systemic practices, including guidelines from professional organizations and national and state policies, and plans for hiring, training and managing interpreters. The final domain is research which emphasizes the knowledge of service providers on research related to culture, language issues, ability to conduct research that is sensitive to cross-cultural issues and awareness of Emic-Etic distinctions (Emic is the behaviours or views that are common to an ethnic or minority group; while Etic is in relation to the aspects of human functioning that are more universal to people across cultures). However, this study considered cultural competence as propounded by Campinha-Bacote (2003) regarding the relationship between the health care providers and patients. In the hospital setting, cultural competence has to do with the ability of the health care professionals to provide a culturally appropriate care. It is a broad concept used to describe a variety of interventions that aim at improving the accessibility and effectiveness of health care services for people from racial and ethnic minorities.

This means that healthcare providers should make every effort to understand the culture of their patients and that of their profession (Williamson and Harrison, 2010). The justification for this is that it has been observed that healthcare professionals face challenges in their quest to provide healthcare delivery (de Beer and Chipps, 2014). In giving health care services, Betancourt and Green (2010) state that cultural competence is the ability of health providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. It would also require paying attention to the understanding of illness and treatment of the patients which may include healing methods alongside western medicine. In other words, cultural competence is perceived to be the capacity to provide care to diverse patients taking into cognizance their distinct values, beliefs, and behaviours. It would also involve adjusting methods of care delivery in order to meet the social, cultural, and linguistic needs of the diverse patients.

Health information professionals would, therefore, take into account their patients' cultural beliefs, behaviours, and needs in order to provide quality health services. de Beer and Chipps (2014) opine that healthcare professionals who lack cultural competence may be putting patients at risk for delays in treatment, inappropriate diagnosis, non-compliance with healthcare regimens, and even death. Schwarzenthal, Schachner, Juang, and van de Vijver (2020) pointed out that cultural competence is the complex integration of knowledge, attitudes and skills that enhance cross-cultural communication and effective interactions with others. The knowledge of cultural beliefs and customs according to Kumar, Bhattachary, Sharma and Thiyagarajan (2019), helps to facilitate healthcare providers' job, affords improved care and contributes in averting misunderstandings among care providers, staff, patients, and their families. The scholars conclude that it is a very useful approach in family practice as it helps to improve health care to racial/ethnic minor groups while reducing the disparities. Cultural competence originated in the US and it is focused on teaching the beliefs and characteristics of specific cultural and ethnic groups (Campinha-Bacote, 2003). This scholar then proposed a culturally competent process of health care that includes cultural awareness, cultural knowledge, cultural skill, encounter and desire. These processes of cultural competence in health care delivery are seen as one that health care providers can use as a framework for developing and implementing culturally responsive health care services. This model requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent. Therefore, the processes are perceived as ongoing because the healthcare provider is continuously striving to achieve the capability to effectively work within the cultural context of the client which includes the patient, community and

family. So, this study was hinged on Campinha-Bacote's (1998a) five (5) processes of cultural competence in the delivery of healthcare services.

The first process is cultural awareness in which the healthcare practitioner becomes aware of, appreciates, and becomes sensitive to the values, beliefs, life ways, practices, and problem-solving strategies of other cultures. During this process, the caregiver examines his/her own biases and prejudices toward other cultures in relation to his or her own cultural background. Without becoming aware of the influence of one's own cultural values, a health information practitioner might have the tendency to impose his/her own beliefs, values, and patterns of behaviour on other cultures (Leininger, 1978 cited in Campinha-Bacote, 2002). Hence, the goal of cultural awareness is to help one become aware of how one's background and that of their patient's differ. Next is cultural knowledge which is the process by which the healthcare professional seeks out and obtains education about various educational foundations about diverse ethnic groups and different cultures. In obtaining this knowledge base, the health information professional or health care provider must focus on the integration of three specific issues: "health-related beliefs and cultural values, disease incidence and prevalence, as well as treatment efficacy" (LavizzoMourey, 1996). The goal of cultural knowledge is to become familiar with culturally/ethnically diverse groups, worldviews, beliefs, practices, lifestyles, and problem-solving strategies and these can be done through reading about different cultures, attending continuing education courses on cultural competence, and attending cultural diversity conferences. The third process is cultural skill which involves learning how to do a competent cultural assessment. Health information practitioners who have achieved cultural skill can individually assess each patient's unique cultural values, beliefs, and practices without depending solely on written facts about specific cultural groups. It is important to remember that each patient is a member of a specific cultural group and this could affect the patient's health care beliefs. This is followed by cultural encounter which involves participating in cross-cultural interactions with people from culturally diverse backgrounds. It is the process that encourages the health care provider to directly engage in cross-cultural interactions with clients/patients from culturally diverse backgrounds (Campinha-Bacote, 2002). It is believed that by directly interacting with clients from diverse cultural groups, it could help in refining or modifying a healthcare provider's existing beliefs about a cultural group. This might also help in preventing possible stereotyping that may have occurred. An example of cultural encounter may include attending religious services or ceremonies and participating in important family events. Finally, cultural desire is in relation to the motivation of the health care provider to want to engage in the process of becoming "culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters" (Campinha-Bacote, 2002, p. 182). Cultural desire would include an honest passion to be open and flexible with others, to accept other people's differences and build on the similarities. It is also related to being willing to learn from others as cultural informants when providing care services to diverse groups. Cultural desire involves the concept of caring.

Statement of the problem

In Nigeria, it has been observed that a cultural competence practice of the health information practitioners is poor. Studies have also revealed that cultural competence practices by the health information department are below the expectations of the public. For instance, Omisore and Agbabiaka (2016), Ajisebute (2016), Bamigbade (2014) and Ejumudo (2013) found out from their various studies that the problems of the health information professionals stem from issues such as patients queue up for hours at the health information management department before getting to register which results in serious delays in the delivery of health care. Peter et al. (2020) also observed that there is the problem of influx of non-professionals with little skills and competencies in the health information management department. Cultural competence reflects the development of skills that facilitate healthcare practitioners to embrace socio-cultural factors which would involve identifying and bridging communication styles to accommodate culturally diverse patients. It also has to do with paying attention to the understanding of illness and treatment of the patients which may include healing methods alongside western medicine. In practicing cultural competence, health information professionals aim at improving the accessibility and effectiveness of health care services for people from racial and ethnic minorities. Given this background, one can affirm that if health information professionals take into account patients' cultural beliefs, behaviours and their needs, provision of quality and efficient health services can be guaranteed. In view of this, the goal of this study is to investigate cultural competence practices among health information professionals in university of Jos teaching hospital.

Objective of the study

The main objective of the study is to investigate the Cultural competence practices among health information professionals in university of Jos teaching hospital. The specific objective is to:

1. Examine the level of cultural competence practices among health information professionals in

University of Jos teaching hospital.

METHODOLOGY

The survey research design was adopted in this study. The Population of this study was 76**.** Total enumeration sampling technique was adopted for the study. The instruments that were used for the collection of data for this study was self-structured questionnaire. Data generated for the study were analyzed with descriptive statistics such as percentage distribution, mean and standard deviation. All of these were achieved through the use of Statistical Package for the Social Sciences (SPSS) version 25.0 developed by IBM.

RESULTS

This section is as follows: analysis of the research questions, and discussion of findings. In order to investigate the Cultural competence practices among health information professionals in university of Jos teaching hospital.

Table 1 depicts that generally, health information professionals exhibited Cultural competence practices among health information professionals in university of Jos teaching hospital ($\overline{x}$= 2.98). Health information professionals exhibited cultural competence university of Jos teaching hospital, in respect of cultural desire ($\overline{x}$= 3.31), cultural awareness ($\overline{x}$= 3.10), cultural skills ($\overline{x}$= 3.04), cultural knowledge ($\overline{x}$= 2.87) and cultural encounters ($\overline{x}$= 2.59). This implies that health information professionals exhibited cultural competence more in university of Jos teaching hospital, in terms of cultural desire followed by cultural awareness, cultural skills, cultural knowledge and cultural encounters.

In terms of cultural desire, health information professionals exhibited cultural competence in university of Jos teaching hospital, by desiring to treat all patients equally irrespective of their culture ($\overline{x}$= 3.45), genuinely having the passion to welcome patients from other cultures ($\overline{x}$= 3.38) and by being motivated to accept different behaviours from patients of diverse culture ($\overline{x}$= 3.19). Health information professionals exhibited cultural competence in university teaching hospital in university of Jos teaching hospital. In respect of cultural awareness, health information are sensitive to problem-solving strategies of patients from other culture ($\overline{x}$= 3.15), responsive to ways of life of patients from other cultures ($\overline{x}$= 3.11) and being sensitive to practices of patients from other cultures ($\overline{x}$= 3.02).

Health information professionals exhibited cultural competence in university of Jos teaching hospital, in respect of cultural skills by adapting their communication style to different patients' cultures ($\overline{x}$= 3.16), using active listening skills for patients from other cultures ($\overline{x}$= 3.11) and by implementing processes that promote patients cultural inclusion in their hospitals ($\overline{x}$= 2.94). Health information professionals exhibited cultural competence in university of Jos teaching hospital, in respect of cultural knowledge by being educated about various worldviews of different cultures of patients ($\overline{x}$= 3.04), familiar with culturally diverse patients ($\overline{x}$= 2.96) and by attending cultural diversity conferences that promotes better healthcare services delivery ($\overline{x}$= 2.67). Finally, health information professionals exhibited cultural competence in university of Jos teaching hospital, in terms of cultural encounters by responding to greetings by patients from other cultures ($\overline{x}$= 3.19), contributing to the growth and development of other cultures where the patients belong and by attending religious activities of patients from different cultures ($\overline{x}$= 2.58).

DISCUSSION

This section of the research work presents the discussions of the findings of this study in light of existent literature reviewed. The study investigated the Cultural competence practices among health information professionals in university of Jos teaching hospital.

Research question: How do health information professionals exhibit Cultural competence practices among health information professionals in university of Jos teaching hospital?

Findings of this study revealed that generally health information professionals exhibited cultural competence in university of Jos teaching hospital. Health information professionals exhibited cultural competence in university of Jos teaching hospital, in terms of cultural desire by desiring to treat all patients equally irrespective of their culture, genuinely having the passion to welcome patients from other cultures and by being motivated to accept different behaviours from patients of diverse culture. Health information professionals exhibited cultural competence in university of Jos teaching hospital, in respect of cultural awareness by being sensitive to problem-solving strategies of patients from other culture, responsive to ways of life of patients from other cultures and by being sensitive to practices of patients from other cultures.

Health information professionals exhibited cultural competence in university of Jos teaching hospital, in respect of cultural skills by adapting their communication style to different patients' cultures, using active listening skills for patients from other cultures and by implementing processes that promote patients' cultural inclusion in their hospitals. Health information professionals exhibited cultural competence in university of Jos teaching hospital,

Table 1: Cultural competence of health information professionals

Variables	SA (4) Freq. (%)	A (3) Freq. (%)	D (2) Freq. (%)	SD (1) Freq. (%)	Mean $\bar{x}$	Standard Deviation (SD)
Cultural Desire (Mean = 3.31, SD = 0.66)						
I desire to treat all patients equally irrespective of their culture.	37 (53.3)	30 (41.5)	1 (2.2)	2 (3.0)	3.45	0.69
I genuinely have the passion to welcome patients from other cultures.	32 (41.5)	34 (54.8)	4 (3.7)	-	3.38	0.56
I am passionate about how patients from other cultures feel about my service delivery.	24 (37)	35 (55.6)	8 (5.9)	2 (1.5)	3.28	0.64
I am willing to learn from cultures of my patients.	27 (38.5)	31 (52.6)	9 (6.7)	3 (2.2)	3.27	0.69
I am motivated to accept different behaviours from patients of diverse culture.	17 (34.1)	35 (52.6)	15 (11.1)	3 (2.2)	3.19	0.71
Cultural Awareness (Mean = 3.10, SD = 0.75)						
I am sensitive to problem-solving strategies of patients from other culture.	24 (28.1)	30 (60)	14 (10.4)	2 (1.5)	3.15	0.65
I am responsive to ways of life of patients from other cultures.	20 (27.4)	31 (58.5)	16 (11.9)	3 (2.2)	3.11	0.69
I am sensitive to values of patients from other cultures.	22 (32.6)	29 (53.3)	9 (6.7)	10 (7.4)	3.11	0.83
I am conscious of beliefs of patients from other cultures.	20 (29.6)	30 (55.6)	14 (10.4)	6 (4.4)	3.10	0.76
I am sensitive to practices of patients from other cultures.	19 (27.4)	26 (54.1)	16 (11.9)	9 (6.7)	3.02	0.82
Cultural Skills (Mean = 3.04, SD = 0.68)						
I can adapt my communication style to different patient, cultures.	20 (29.6)	33 (57.8)	16 (11.9)	1 (0.7)	3.16	0.65
I can use active listening skills for patients from other cultures.	20 (22.2)	36 (67.4)	13 (9.6)	1 (0.7)	3.11	0.58
I can clearly identify areas of conflict or concern of patients from different cultures.	21 (18.5)	28 (65.9)	16 (11.9)	5 (3.7)	2.99	0.68
I can assess individual patient's unique cultural values, without depending solely on written facts about specific cultural groups.	23 (23.7)	26 (53.3)	17 (20)	4 (3.0)	2.98	0.75
I can implement processes that promote patients cultural inclusion in my hospital.	15 (20)	25 (57.8)	25 (18.5)	5 (3.7)	2.94	0.73
Cultural Knowledge (Mean = 2.87, SD = 0.74)						
I am educated about various worldviews of different cultures of patients.	20 (18.5)	33 (68.9)	15 (11.1)	2 (1.5)	3.04	0.60
I am familiar with culturally diverse patients.	14 (17)	29 (63)	25 (18.5)	2 (1.5)	2.96	0.65
I read about different cultures of patients.	23 (20.7)	26 (56.3)	14 (17.8)	7 (5.2)	2.93	0.77
I attend continuing education courses on cultural competence to know how to serve patients better.	21 (19.3)	29 (42.2)	11 (31.9)	9 (6.7)	2.74	0.85
I attend cultural diversity conferences that helps better healthcare services delivery.	13 (17.8)	29 (39.3)	17 (34.8)	11 (8.1)	2.67	0.86

Table 1 contd.

Cultural Encounters (Mean = 2.59, SD = 0.79)						
I respond to greetings by patients from other cultures.	27 (28.9)	33 (63.7)	7 (5.2)	3 (2.2)	3.19	0.63
I contribute to the growth and development of other cultures where my patients belong.	15 (11.9)	35 (48.1)	11 (30.4)	9 (9.6)	2.62	0.82
I attend religious activities of patients from different cultures.	8 (14.8)	29 (38.5)	19 (36.3)	14 (10.4)	2.58	0.87
I attend meetings of patients from other cultural background.	8 (10.4)	16 (26.7)	29 (46.7)	17 (16.3)	2.31	0.87
I participate in the association of patients from other cultures.	7 (5.9)	17 (29.6)	29 (49.6)	17 (14.8)	2.27	0.78
Average Overall Mean					**2.98**	**0.72**

Source: Field Survey 2022; Freq. = Frequency
KEY: SA=Strongly Agree, A=Agree, D=Disagree, SD=Strongly Disagree***Decision Rule if mean is 1 to 1.74 = Strongly Disagree; 1.75 to 2.49 =Disagree; 2.50 to 3.24 =Agree; 3.25 to 4= Strongly Agree

in respect of cultural knowledge by being educated about various worldviews of different cultures of patients. Finally, health information professionals exhibited cultural competence in university of Jos teaching hospital, in terms of cultural encounters by responding to greetings by patients from other cultures, contributing to the growth and development of other cultures where the patients belong and by attending religious activities of patients from different cultures. This finding is in line with that of Ahmed, Manalili, Lorenzetti, Barbosa, Lantion, Lu, Quan, and Santana, (2018) carried out in Canada on how to measure cultural competence when evaluating patient-centered care. It found that monitoring and evaluating patient centered care for ethno-cultural communities allows for improvements to be made in the delivery of culturally competent healthcare. The finding is also in line with that of Aragaw, Yigzaw, Tetemke, and G-Amlak (2015) on cultural competence among maternal healthcare providers in Ethiopia which revealed that overall competency level of healthcare providers was 57.3% though vary in different subscales or stages. This finding is in contrast with that of Okonkwo, Ekpeyoung, Ndep and Nja (2020) who examined managerial competencies in a survey of healthcare managers in a tertiary hospital in Calabar, South-South Nigeria that revealed that less than 50% of operational and middle managers rated themselves as experts in all the five cultural competency domains.

Conclusion

The study conducted a thorough investigation into the cultural competence practices among health information professionals at the University of Jos Teaching Hospital. The research aimed to assess the level of cultural competence within this specific group of healthcare practitioners, acknowledging the critical role they play in managing health-related information. The study's success is evident as it accomplished its objectives, likely involving an in-depth analysis of professionals' awareness, communication skills, and integration of cultural competence into their daily responsibilities. By demonstrating the achievement of these objectives, the study suggests that health information professionals within the University of Jos Teaching Hospital exhibit a commendable degree of cultural competence. Moreover, the assertion that Nigerians, in general, are culturally competent implies a broader societal context, potentially indicating a positive cultural awareness and sensitivity among the population. This study contributes valuable insights to the intersection of healthcare, cultural competence, and information management within the specific context of the University of Jos Teaching Hospital and, by extension, offers implications for healthcare practices in Nigeria.

Recommendation

Based on the finding of the study, the following recommendation was made:

1. This study ascertained that health information professionals exhibited cultural competence in university of Jos teaching hospital. This should be sustained by increasing the capacity of health information professionals and instilling cultural competence virtues in the mind of health information professionals in university of Jos teaching hospital.

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