Determinants of Xenophobic Attitudes Towards Displaced Migrants Among Healthcare Workers

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Abstract: *Displacement increases inequalities by preventing access to basic rights, especially the right to health. This cross-sectional study explains the level of xenophobic attitudes of healthcare professionals towards displaced migrants and related factors. A total of 436 health workers across varied health professions completed a Socio-demographic Information Form, a Xenophobia Scale, and a Cultural Intelligence Scale. Approximately 60% of the participants were female, with an average age of 29.7±7.32 years. The mean score obtained from the Xenophobia Scale, which has a maximum score of 66, was 52.8±11.03. The results showed that knowing a foreign language, having immigrant friends, receiving training on the healthcare needs of immigrants, and possessing high motivation scores were associated with reduced xenophobic attitudes. In contrast, immigrants having inadequate income or an elevated metacognition score was linked to xenophobic attitudes ($p<0.05$). In order to prevent inequalities in health and to ensure that displaced populations have access to the right to health, these findings are taken into consideration in the planning of social work interventions.*

Keywords: *Health workers, displaced migrant, xenophobic attitude, cultural ıntelligence, predictors*

Over the past decade, displacement reached record numbers, while complex geopolitical, economic, and environmental factors contributed to escalating current challenges (Popescu & Libal, 2018; McAuliffe & Triandafyllidou, 2021). In 2020, an estimated 3.6% of the world's population—roughly 281 million individuals—lived as international migrants. Of this global movement, about 89.4 million were forcibly displaced due to armed conflicts, violations of human rights, or both natural and human-induced disasters (WHO, 2022). Highlighting the growing urgency of this issue, the International Organization for Migration (IOM, 2023) announced during the African Climate Summit that the era of climate-driven migration has officially begun. By 2022, sub-Saharan Africa witnessed a notable rise in internal displacement, with approximately 16.5 million people uprooted—a 17% increase from the prior year. Alarmingly, the frequency of disasters in the region nearly tripled, contributing to a record-breaking 7.4 million people displaced within sub-Saharan Africa alone (Internal Displacement Monitoring Centre [IDMC], 2023).

Research shows that displaced communities are at greater risk due to their forced or involuntary displacement and vulnerability (Oxford Monitor of Forced Migration, 2020; Shen et al., 2021). It is well known that migrants who are forced to leave their countries experience poor living conditions, poverty, lack of access to healthy water and food, stigmatization, discrimination, low levels of education, language barriers, inadequate social support systems and difficulties in accessing basic human rights, especially the right to health (Bogic et al., 2015; Chang, 2019; Ellis et al., 2022; Esses, 2021; Hacker et al., 2015; Oberg, 2019; Quinn, 2014; Şimşek et al., 2018; WHO, 2021;

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Williams & Hampton, 2005). In addition to the factors mentioned, it has been shown that racism, xenophobia, and discrimination are some of the main determinants of health and health inequalities, and it is therefore important to address these factors to improve health outcomes (Ostapczuk et al., 2009; Abubakar et al., 2022; Devakumar et al., 2022). The incidence of depression, anxiety, post-traumatic stress disorder, suicidal and self-harming behavior, schizophrenia, and other psychotic disorders due to traumatic events experienced before, during, and after migration is high among refugee and migrant groups (Bogic et al., 2015; Dehnel et al., 2022; Kurt et al., 2023; Peconga & Thøgersen, 2019; Richa et al., 2020; Rousseau & Frounfelker, 2019; Şimşek et al., 2018; Sirin & Rogers- Sirin, 2015; WHO, 2022; Williams & Hampton, 2005).

Xenophobia, which is the subject of this study, is defined as emotional, attitudinal, and behavioral prejudices against immigrants, refugees, asylum seekers, and people perceived as foreigners (Yakushko, 2009). Medical xenophobia is defined as the negative attitudes and behaviors exhibited by healthcare professionals and toward groups such as migrants and refugees (Crush & Tawodzera, 2011). Studies have shown that xenophobic attitudes towards displaced migrants affect their access to health services, especially sexual and reproductive health services (Delgado-Gallegos et al., 2020; Sheppard et al., 2014; Zihindula et al., 2017).

Cultural intelligence is the ability to adapt to the values, beliefs, attitudes, and body language of people from different cultures and to use this knowledge effectively to interact with empathy and understanding in various contexts (Ang et al., 2015). Earley and Ang (2003) discussed cultural intelligence in four dimensions. These are metacognitive, cognitive, behavioral, and motivational intelligence dimensions. The three sub-dimensions of metacognitive cultural intelligence, which refers to the cognitive control of the processes used to obtain and understand information, are awareness, planning and control. Awareness is being in tune with what is happening in ourselves and others, planning is taking the time to prepare for an intercultural encounter, and controlling is monitoring our interactions to see if our plans and expectations are appropriate (Livermore, 2009). Cognitive cultural intelligence reflects the knowledge of practices and customs in different cultures gained from education and personal experiences. Those with high cognitive and cultural intelligence have knowledge of the similarities and differences between cultures. Motivational cultural intelligence triggers effort and energy to function in new cultural environments. Behavioral cultural intelligence constitutes the entirety of one's behaviors in intercultural communication (Ang &Van Dyne, 2008). It has been found that the lack of adequate knowledge and training of health personnel about cultural differences causes inequality while providing health services (Dias et al., 2012). It has been reported that white, skilled, heteronormative dominant identities have higher access to health services than other cultures (Braveman, 2006).

Social workers play a crucial role in supporting displaced populations and addressing xenophobic attitudes. Knowing the factors that explain xenophobia is important in order to determine community-based social work interventions. Therefore, this study aims to examine the relationship between health professionals' xenophobic attitudes towards displaced migrants and cultural intelligence, as well as other selected factors.

Methods

The sample size for this cross-sectional study consisted of 436 health workers across all of Türkiye. Participants were recruited using a non-probability sampling method, specifically purposive sampling, by reaching out to all relevant professional organizations. A total of 48 health professional chambers and associations across 21 provinces in Turkey were identified and individually contacted to request support for the study. Additionally, healthcare professionals actively engaged in practice were directly reached out to for participation. These organizations facilitated the sharing of a link to an online survey, allowing data collection to take place from August to September 2023.

Data Collection Tools

In this study, the Sociodemographic Information Form, Xenophobia Scale, and Cultural Intelligence Scale were used. The Sociodemographic Information Form included 15 questions, including age, gender, occupation, educational status, marital status, knowledge of a second language, and thoughts about displaced migrant patients.

Xenophobia Scale

The Xenophobia Scale developed by Van Der Veer and colleagues (2011) and its psychometric properties were conducted in Turkey (Özmete et al., 2018). There are 11 items on the scale with a 6-point Likert type response scale (1=strongly disagree, 6=strongly agree). The lowest score that can be obtained from the scale is 11, and the highest score is 66. Higher total scores obtained from the xenophobia scale indicate a negative attitude. In the psychometric evaluation of the scale in Turkey, Cronbach's alpha value was found to be 0.876 (Özmete et al., 2018). In this study, the Cronbach's alpha value of the Xenophobia Scale was calculated as 0.907.

Cultural Intelligence Scale

The Cultural Intelligence Scale was developed by Ang et al. (2007). It comprises a total of 20 items, which are graded on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), assessing how effectively individuals are able to function in culturally diverse settings. The scale has four sub-dimensions, namely Metacognition, Cognition, Motivation and Behaviour. The Cronbach's alpha reliability coefficient of the scale, which underwent a validity and reliability study in Türkiye as Turkish Form, was found to be 0.85 for the entire scale. Furthermore, the reliability study conducted by the test-retest method (İlhan & Çetin, 2014) revealed no significant difference between the two measurements. In this study, the Cronbach's alpha reliability coefficient of the Cultural Intelligence Scale was calculated as 0.91.

Procedures

Ethics committee approval was obtained from Istanbul Bilgi University Ethics Board on May 22, 2023 (Project No: 2023-20507-090). The research data were collected between 6 August 2023 and 10 September 2023. The research was conducted

online and the study questionnaire was sent to active healthcare professionals via various social media platforms, e-mail or messaging applications via google forms. The questionnaires were disseminated via WhatsApp groups of healthcare professionals. The informed consent form emphasized that the participant's data would be protected in confidentiality and that participation was voluntary.

Statistical Analysis

The research data were analyzed using statistical analysis techniques. The skewness and kurtosis indexes of the Xenophobia Scale, Cultural Intelligence Scale, and its sub-dimensions fell within the acceptable range of -1.5 to +1.5, indicating a normal distribution. Bivariate associations were estimated using chi-square tests (for categorical variables), and t-tests or analyses of variance were used for continuous variables. Risk factors significantly associated with any of the outcomes of interest and covariates significantly associated with both risk factors and outcomes at $p < 0.05$ were retained for the multiple regression model to examine the relationships between dependent and independent variables by controlling the confounding factors. Model fit was assessed using the Durbin–Watson test.

Results

Background Characteristics of the Respondents

As shown in Table 1, 60.1% of the 436 participants were female, with a mean age of 29.7±7.32 years. A total of 39% of the health workers were currently married, 48.6% had obtained a master's degree, 22.2% had obtained a bachelor's degree, 18.8% had obtained an associate's degree, 6% had received a doctorate degree, and 4.4% had obtained a high school degree. Of the participants, 33% were nurses or midwives, 18.8% were physicians, 18.3% were mental health professionals (psychiatrist, psychiatric assistant, psychiatric nurse, social worker, psychologist), 12.2% were medical secretaries, 11.2% were other health professionals (pharmacist, dietician, audiometrist, laboratory, etc.), and 6.2% were health technicians. The health professionals involved in the study have professional experience ranging from one to 39 years, with a median of four years. The majority of respondents (70.6%) indicated that they had freely chosen their profession. Furthermore, 67.7% reported working throughout the day without breaks, and 35.2% mentioned that their salaries covered their expenses adequately. More than half of the participants (50.7%) noted that they were monolingual, knowing only their native language.

In the study, about 60% of healthcare workers believe that diseases could be transmitted from migrant patients. Additionally, 53% of respondents indicated that the current interpreter support for migrant patients was inadequate. Notably, nearly 73% of respondents admitted to lacking migrant friends. Furthermore, a significant majority (93.1%) reported receiving no training on the healthcare needs of migrants. Despite this, 45.4% of respondents did not perceive the influx of migrants as problematic, expressing confidence in the country's ability to provide adequate assistance.

Table 1. *Socio-Demographic Charecteristics of Healthcare Workers (n=436)*

Charecteristics	n (%)
Gender	
Female	262 (60.1%)
Male	171 (39.2%)
Does not want to specify	3 (0.7%)
Age group	
18-29 years old	285 (65.4%)
30-39 years old	103 (23.6%)
40-49 years old	37 (8.5%)
50 and above	11 (2.5%)
Marital status	
Never married	206 (47.3%)
Currently married	170 (39%)
In a relationship	48 (11%)
Divorced/widow	12 (2.7%)
Education status	
High school	19 (4.4%)
Associate degree	82 (18.8%)
Bachelor's degree	97 (22.2%)
Master's degree	212 (48.6%)
Doctorate degree	26 (6%)
Profession	
Nurse or midwife	144 (33%)
Physician	82 (18.8%)
Mental health*	80 (18.3%)
Medical secretary	53 (12.2%)
Other*	49 (11.2%)
Health technician	27 (6.2%)
Freely chose profession	
Yes	308 (70.6%)
No	128 (29.4%)
Got breaks during the work day	
Yes	141 (32.3%)
No	295 (67.7%)
Salary covered expenses	
Yes	153 (35.2%)
No	283 (64.8%)
Knowing another language	
Yes	215 (49.3%)
No	221 (50.7%)
Thoughts of disease transmission	
Yes	261 (59.9%)
No	175 (40.1%)
Translator competence	
Insufficient	231 (53%)
Partially sufficient	181 (41.5%)
Definitely enough	24 (5.5%)
Being a friend of migrant	
Yes	119 (27.3%)
No	317 (72.7%)
Having training of migrants' health needs	
Yes	30 (6.9%)
No	406 (93.1%)
Thoughts about migrants	
I don't see it as a problem, but I believe our country has already provided sufficient assistance.	198 (45.4%)
I want them all to go	135 (31%)
I think we should help because they are in a difficult situation.	103 (23.6%)

*Psychiatrist, psychiatric assistant, psychiatric nurse, social worker, psychologist
**Pharmacist, dietician, audiometrist, lab, etc.

As shown in Table 2, the mean score of the Cultural Intelligence Scale was 96.2±19.2. After controlling for the number of items, the mean scores for the sub-dimensions of the Cultural Intelligence Scale were as follows: Metacognition, Behavior, Motivation, and Cognition, respectively ($p < 0.05$).

Table 2. *Scores From the Cultural Intelligence Scale and Subscales*

Scales	Total score±SD	Range	# Items per scale	Average Score/ Item±SD
Cultural Intelligence	96.2±19.2	20-140	**20**	
Metacognition	22.5±5.3	4-28	4	5.6±1.06
Cognition	24.9±7.92	6-42	6	4.2±1.32
Motivation	23.7±6.56	5-35	5	4.7±1.31
Behaviour	25.1±6.15	5-35	5	5.0±1.23

Bivariate Analysis

The scores obtained by the participants on the Xenophobia Scale ranged from 13 to 66, with a mean score of 52.8 ± 11.03. In bivariate analyses, it was observed that higher scores on the xenophobic attitude scale were associated with female gender, age between 18 and 29 years, employment as a midwife or nurse, lack of voluntary choice of profession, working in shifts, having insufficient income to cover expenses, being monolingual, lacking immigrant friends, not receiving training on immigrant healthcare needs, fearing disease transmission from immigrants, and perceiving interpreter support for immigrant patients as inadequate ($p<0.05$). The scores obtained from the Xenophobic Attitude Scale were not found to be significantly associated with either marital status or years of experience in the profession ($p>0.05$).

As illustrated in Table 3, there is a notable positive correlation between metacognition score and xenophobic attitude score. This indicates that as the metacognition score increases, the xenophobic attitude score also rises ($p < 0.05$). Conversely, there is a significant inverse relationship between motivation scores and xenophobia scores. This indicates that as motivation scores increase, xenophobic attitude scores decrease ($p<0.05$). Nevertheless, no significant relationship was found between the cognition and behaviour subtests and the xenophobic attitude ($p>0.05$).

Table 3. *Relationships Between the Xenophobia Scale and the Cultural Intelligence Scale*

	Xenophobia Attitude Scale	
Cultural Intelligence Scale	r	p
Metacognition	0.224**	<0.001
Cognition	0.991	0.001
Motivation	-0.159**	0.001
Behaviour	0.008	0.860

Multiple Regression Analysis

Presented are the results of multiple regression analyses conducted to ascertain the impact of independent variables associated with xenophobic attitudes in bivariate analyses and to control for confounding factors are presented in Table 4. As can be seen in Table 4, the following variables were found to decrease the xenophobia score independently: knowing a language other than the native language, having immigrant friends, receiving training on the health service needs of migrants, and motivation, which is a subtest of the Cultural Intelligence Scale. Conversely, the following variables were found to increase the xenophobia score independently: thoughts that immigrants will transmit diseases, the income not meeting the expenses, and metacognition. The gender of the respondents, their age (18-29), their educational status, their voluntary choice of profession, their working style, their occupational group, the adequacy of the interpreter when providing services to immigrant patients, and their thoughts about migrants, which were found to have a significant relationship in single analyses, were not effective alone and were found to be confounding variables ($p>0.05$). The variables in the table account for approximately 33.4% of the change in the xenophobia score ($R^2= 0.334$).

Table 4. *Multiple Regression Results Regarding Socio-Demographic Variables Explaining Xenophobia and Cultural Intelligence Scale Sub-Dimensions*

	B.	Std.	Beta	t	p
Constant	30,368	6,601		4,601	<0.001
Gender (Female)	1,254	0.943	0.057	1,330	0.184
Age (18-29)	-0.113	0.063	-0.075	-1,794	0.074
Education status	-0.006	0.467	-0.001	-0.012	0.990
Income not covering expenses	-1.483	0.597	-0.104	-2,483	0.013
Choosing profession willingly	-0.333	0.656	-0.021	-0.507	0.612
Working without shifts	-0.623	0.493	-0.053	-1.265	0.207
Professional group	0.406	0.318	0.053	1,278	0.202
Not know another language	2,430	0.954	0.110	2,547	0.011
Thinking that disease will be transmitted	-5.751	0.942	-0.256	-6,104	<0.001
Adequacy of interpreter support	0.203	0.758	0.011	0.268	0.789
Not having a migrant friend	5,291	1,062	0.214	4,982	<0.001
Those without training on migrant health	6,488	1,775	0.149	3,654	<0.001
Thoughts about migrants	0.028	0.664	0.002	0.042	0.966
Metacognition	2,482	0.451	0.239	5,501	<0.001
Motivation	-1.022	0.380	-0.122	-2,686	0.008
$R=0.578$; $R^2=0.334$; Durbin and Watson=2.09					

Discussion

The aim of this study was to identify factors explaining xenophobic attitudes toward displaced populations and to develop recommendations for social work interventions. The Xenophobic Attitude Scale, with a maximum score of 66, was determined to have a score of 52.8 ± 11.03. A review of the literature reveals that the mean scores of healthcare professionals in Turkey on the Xenophobia Scale typically range from 50.03 to 56.20 (Aker & Kartal, 2023; Basaran & Saylıgil, 2022; Gündüz, 2019). The analysis of theories that explain xenophobic attitudes suggests that individuals may develop prejudice by perceiving their communities as superior to others. Furthermore, communities with low social trust may exhibit heightened xenophobic tendencies, and economic competition for scarce resources may fuel xenophobia. These findings are supported by the findings of Tajfel (1981), Ekici and Yucel (2015), and Bobo and Hutchings (1996).

In the study, it was found that metacognition and motivation, which are sub-dimensions of the Cultural Intelligence Scale, independently explained the xenophobic attitudes of healthcare professionals towards displaced migrants. Metacognitive cultural intelligence is defined as the state of being aware of other cultures that are not one's own in intercultural environments (Ang & Van Dyne, 2008). This suggests that the level of metacognitive cultural intelligence is effective in questioning the facts of one's own culture in intercultural interactions. From this perspective, metacognitive cultural intelligence is considered an important stage that will help individuals develop their intuitions and individual norms in the direction of the new culture while interacting socially (Flavell, 1979; Nelson, 1996). Metacognitive cultural intelligence, or the capacity to be aware of and evaluate one's own cultural perspectives, can prompt individuals to adhere more strongly to the norms and values of their own group. This may result in increased discrimination against other groups and heightened xenophobia (Brown, 2000; Valles Martínez, 2022). Discrimination theory states that individuals tend to favourably distinguish their own groups and in this process may show prejudice

and discrimination against other groups. Increasing metacognitive cultural intelligence may increase the tendency of individuals to see their own culture as superior, which may lead to the strengthening of negative attitudes toward other cultures (Abrams & Hogg, 1988; Rubin & Hewstone, 1998). In a study conducted by Uludağ and Mumcu (2023) involving 225 nurses, it was observed that as the metacognitive cultural intelligence score increased, the qualified care behaviors of nurses decreased. Another study conducted with nurses determined that there was no relationship between metacognitive intelligence and respect for different cultures (Durna & Altay, 2023). It is thought that it would be useful to examine this relationship with qualitative research.

In this study, it was found that xenophobic attitudes decreased as motivation scores increased. Research shows that individuals with higher motivational cultural intelligence are more likely to have positive attitudes towards people from other cultures and to engage in intercultural interaction (Ang et al., 2007). Motivational cultural intelligence refers to the fact that individuals in intercultural environments direct all their energy towards understanding and learning this culture (Ang & Van Dyne, 2008). Individuals with this level of intelligence enjoy being in different cultural environments and are eager to experience new cultures (Ang et al., 2007). In contrast, individuals with higher levels of xenophobia are more likely to have negative attitudes towards people from other cultures and avoid intercultural interactions (Stephan & Stephan, 2000). Another study by Chen et al. (2012) revealed that motivational cultural intelligence positively affects interactions between people from different cultural backgrounds. This study indicated that individuals with high motivational cultural intelligence have the ability to communicate and co-operate more effectively across different cultures. Research shows that cultural competence and cultural intelligence are important to improve the quality of health care (Majda et al., 2021). Therefore, developing motivation-based cultural intelligence can be an effective way to reduce xenophobia and enhance intercultural understanding.

No relationship was found between the scores obtained from the Cognition and Behaviour sub-dimensions of the Cultural Intelligence Scale and xenophobic attitudes. Although there are studies showing the positive effect of cultural intelligence level on the implementation of innovative approaches in the work of health workers, interpersonal relationships and mental well-being of the employee (Jain, 2022), studies examining the relationship between xenophobic attitudes of health workers towards displaced migrants and cultural intelligence level was limited.

Xenophobic Attitude and Sociodemographic Variables

In order to control for confounders, multiple regression analysis was used in this study to determine the independent effect of all independent variables that were found to be significantly related in bivariate analyses. Apart from the cultural intelligence discussed above, socio-demographic determinants explaining xenophobic attitudes were found. Firstly, the xenophobic attitude of healthcare professionals who did not receive training on the healthcare needs of migrants was significantly higher. It was concluded that intercultural education received by nursing students in Spain and Portugal was effective in reducing negative attitudes towards the immigrant population and providing care (Ugarte Gurrutxaga et al., 2020). This finding shows the importance of training healthcare workers regarding the health needs of displaced people within the scope of social work interventions.

In the current study, the xenophobic attitude score of healthcare professionals who thought that migrants would infect them was found to be significantly higher. This finding is similar to the results of other studies (Ahuja et al., 2020; Bil et al., 2019; Prati & Pietrantoni, 2016; Rzymski & Nowicki, 2020; Troisi, 2020). It shows that as the perception of disease threat increases, ethnocentric attitudes increase, and disease avoidance sensitivity may affect xenophobic attitudes (Navarrete & Fessler, 2006). Stigmatization and discrimination in healthcare settings continue to be a public health problem. As an example, according to the results of a quantitative study investigating HIV-related stigma and discrimination among 44 African migrant women in Belgium, 25% of the women reported that they were subjected to stigma and discrimination in health institutions, and 15% reported that they witnessed behaviors they perceived as stigmatizing and discriminatory (Arrey et al., 2017). This finding suggests that it is important for social workers to develop mechanisms to disseminate evidence-based knowledge about the ways diseases are transmitted and protected.

Another explanatory factor found in the study was that healthcare workers with migrant friends had lower levels of xenophobia than those without migrant friends. When the literature is examined, social psychologist Allport's (1954) social contact hypothesis suggests that interpersonal contact between members of different racial or cultural groups can reduce prejudice and increase positive attitudes towards each other and thus reduce conflict between these groups. Indeed, friendships with members of minority groups are associated with lower levels of discriminatory attitudes (McLaren, 2003). A longitudinal study conducted with school students in Germany, Belgium, and England showed that social contact between host majority members and migrant minority members increased the positive attitudes of majority members towards migrants (Binder et al., 2009). Pagotto et al. (2010), in a study conducted in a hospital in Italy, showed that social interaction in the workplace between 167 health workers and foreign patients increased empathy and was effective in reducing general prejudices against migrants.

In this study, it was determined that knowing a language other than the native language independently decreased the xenophobic attitude score. It was found that students who received bilingual education in 3 different schools in Spain were more open to differences and new opportunities, had higher awareness, and opposed discrimination (Doherty et al., 2022). It shows that multilingual individuals are more open to ethnic outgroups and that this is associated with cognitive flexibility and a change in worldview (Mepham & Martinovic, 2017).

Another factor explaining the xenophobic attitude is the economic status of healthcare workers. It was found that those whose salaries covered their expenses/salaries above their expenses scored lower than those whose salaries did not cover their expenses/who did additional work. Looking at the literature, it has been shown that those with low economic status and unemployed exhibit more xenophobic attitudes towards refugees (Al Haj & Mielke, 2010; Hjerm et al., 2011; Mayadas & Elliott, 1992). In Greece, it was revealed that the economic crisis fuelled hostile attitudes and racist behaviors toward migrants (Carastathis, 2015). During the COVID-19 pandemic, it was revealed that the association of the virus with China and the emphasis on its economic consequences led to an increase in negative views and xenophobia towards Asian Americans in the United States (Dhanani & Franz, 2021).

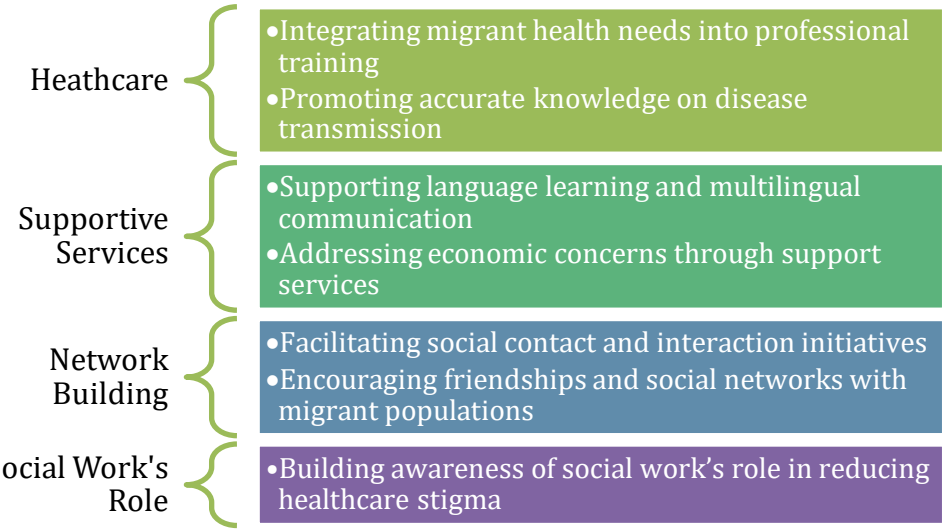
The variables of gender (female), age (18-29), educational status, voluntary choice of profession, type of work, occupational group, adequacy of interpreter when providing services to migrant patients, and thoughts about migrants, which were found to be significant in bivariate analyses, did not predict xenophobic attitude and were found to be confounders. Although there are studies in the literature showing the relationship between the variables mentioned with xenophobic attitudes, no comparison was made because their independent effects were not determined by multiple analyses (Beller, 2020; Deumert, 2010; Güngör et al., 2021; Zeisset, 2016).

The findings of this study should be considered within the framework of its limitations. This cross-sectional study aimed to examine the relationship between xenophobic attitudes of health professionals towards displaced migrants and cultural intelligence. Cross-sectional studies do not explain causality, but aim to reveal the relationship. Despite its limitations, the findings of this study provide substantial insights into the design of efficacious social work interventions to mitigate xenophobic attitudes among healthcare professionals towards displaced migrants.

Implications for Social Work Practice

Several implications for social work practice emerged from the study including those related to heathcare, network building, supportive services, and awareness of social work's role in reducing stigma. See Figure 1.

Figure 1. *Implications for Social Work Practice*



Integrating Migrant Health Needs İnto Professional Training

The study demonstrates that healthcare workers who receive training on the specific healthcare needs of migrants exhibit lower levels of xenophobia. Social work practice should prioritize the integration of migrant health needs and cultural competence into both undergraduate and ongoing professional training programs for healthcare workers. This approach ensures that healthcare professionals are better prepared to address the unique challenges faced by migrant populations.

Promoting Accurate Knowledge on Disease Transmission

The dissemination of accurate information regarding the transmission of disease is of paramount importance in the mitigation of xenophobic attitudes and fears pertaining to health. It is incumbent upon social workers to implement educational initiatives that provide healthcare professionals with clear, evidence-based information regarding the transmission and management of diseases. The objective of this strategy is to mitigate the unjustified apprehensions regarding contagion, which can potentially give rise to discriminatory conduct towards migrants.

Supporting Language Learning and Multilingual Communication

A correlation was identified between the ability to speak an additional language and a lower propensity for xenophobic attitudes. This suggests that language learning may facilitate greater openness to other cultures. It is recommended that social workers advocate for and provide support to healthcare workers in the acquisition of additional languages or fundamental communication skills that facilitate interaction with diverse populations. Such programs can facilitate more positive engagement between healthcare workers and migrant patients, which may in turn lead to improved health outcomes.

Addressing Economic Concerns Through Support Services

The findings indicated a correlation between financial stress and higher levels of xenophobic attitudes, suggesting that economic insecurity can intensify discriminatory tendencies. Social work interventions should consider incorporating economic support services, such as career counseling or financial literacy workshops, into their scope of services for healthcare professionals, particularly those experiencing financial strain. These efforts can indirectly contribute to a reduction in xenophobia by alleviating one of its contributing factors.

Facilitating Social Contact and Interaction Initiatives

In alignment with the social contact hypothesis, which postulates that interpersonal contact between disparate cultural groups can attenuate prejudice, social workers can orchestrate programs to augment constructive interactions between healthcare professionals and migrant communities. Potential avenues for such initiatives include joint cultural events, community health seminars, or mentorship programs that facilitate empathy through direct engagement with migrants, thereby reducing bias and fostering understanding.

Encouraging Friendships and Social Networks With Migrant Populations

The study indicates that healthcare professionals with migrant friends demonstrate lower levels of xenophobia. Social workers can facilitate opportunities for healthcare providers to form social connections with migrant communities, such as through community engagement programs, volunteer initiatives, or professional exchange networks. Encouraging such friendships may serve as an effective instrument in reducing prejudice.

Building Awareness of Social Work's Role in Reducing Healthcare Stigma

Social workers have the potential to serve as pivotal advocates for anti-stigmatization practices within healthcare settings. They should endeavor to develop protocols and policies that actively discourage discrimination and promote respectful, equitable care for all patients, regardless of background. Such practices can facilitate the delivery of healthcare services with cultural competence and empathy, which are essential elements in a socially inclusive healthcare system.

Conclusion

In conclusion, these implications highlight the critical role of social work in addressing xenophobia within healthcare environments. By incorporating these strategies, social work practice can contribute to a more equitable healthcare system that respects the rights and dignity of displaced populations.

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