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Developing a Cultural Competency Scale for Primary Health Care Professionals

Birinci Basamak Sağlık Çalışanlarına Yönelik Kültürel Yeterlilik Ölçeği Geliştirme

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ABSTRACT

Culturally competent healthcare professionals are important in improving the quality of health care. The lack of a measurement tool in the literature that evaluates the cultural competence of the multidisciplinary team in primary health care is noteworthy. The aim of this study is to develop a Primary Health Care Professionals' Cultural Competency Scale (PHCP-CCS) by adapting the Nurse Cultural Competency Scale (NCCS) developed by Perng and Watson (2012), and to examine the various factors affecting cultural competency in Turkey. A total of 231 health professionals, including family doctors, family health nurses and community health professionals, participated in this study. In the item analysis, the correlations of the items with the total score varied between .60 and 82. Exploratory factor analysis revealed a three-factor structure that explained 73.5% of total variance. Items 1-8 of the PHCP-CCS were included under the heading "Cultural Skills," items 9-16 under "Cultural Knowledge" and items 17-20 under "Cultural Sensitivity." Cronbach's Alpha coefficient for the overall scale was .84 and was calculated as .78, .76 and .87 for the respective factors. The experiences of the participants were grouped and compared for discriminant validity. It was found that being able to speak different languages, having contact with friends and neighbors from different cultures, and being educated about serving people from various cultures increased the cultural competency of primary health professionals. In addition, the PHCP-CCS scores of all the primary health professionals who were happy to be working with migrants and refugees were considerably higher. The results show that PHCP-CCS is a measurement tool that can be used to determine cultural competency among primary health care workers. In addition, the scale is also suitable for use in the clinical field for all professionals providing health services to the individual, families and the community.

Keywords: Primary health care professional, Cultural Competency Scale, validity, reliability

ÖZ

Kültürel yeterliğe sahip olan sağlık profesyonelleri, sağlık hizmetlerinin kalitesini iyileştirmede önemlidir. Birinci basamak sağlık hizmetlerinde multidisipliner ekibin kültürel yeterliliğini değerlendiren bir ölçüm aracının literatürdeki eksikliği dikkat çekmektedir. Bu çalışmanın amacı, Perng ve Watson (2012) tarafından geliştirilen Hemşire Kültürel Yeterlilik Ölçeği'ni uyarlayarak Birinci Basamak Sağlık Çalışanları için Kültürel Yeterlilik Ölçeği (BBSÇ-KYÖ) geliştirmek ve Türkiye'de birinci basamak sağlık profesyonellerinin kültürel yeterliliğini etkileyen çeşitli faktörleri incelemektir. Bu çalışmaya aile hekimi, aile sağlığı hemşiresi ve Toplum Sağlığı Merkezi'nde çalışan sağlık profesyonelleri olmak üzere 231 sağlık profesyoneli katılmıştır. Yürütülen madde analizinde maddelerin toplam puanla olan korelasyonlarının .60 ile .82 arasında değiştiği görülmüştür. Açımlayıcı faktör analizi sonucunda toplam varyansın %73.5'ini açıklayan üç faktörlü bir yapı ortaya çıkmıştır. BBSÇ-KYÖ'nün 1-8 maddeleri "Kültürel Beceri", 9-16 maddeleri "Kültürel Bilgi" ve 17- 20 maddeleri "Kültürel Duyarlılık" olarak isimlendirilen faktörler altında yer almıştır. Cronbach Alpha katsayıları toplam puan için .84, faktörler için ise sırasıyla .78, .76 ve .87 olarak tespit edilmiştir. Ayırt edici geçerlik için katılımcıların deneyimleri gruplandırılarak karşılaştırılmıştır. Farklı bir dil konuşabilen, farklı kültürden arkadaş ve komşuyla daha sık iletişime geçen ve farklı kültürlere yönelik hizmet vermeyle ilgili eğitim alan birinci basamak sağlık profesyonellerinin kültürel yeterliliğinin daha yüksek olduğu bulunmuştur. Bunların yanı sıra, göçmenler ve mültecilerle çalışmaktan memnun olduğunu belirten tüm birinci basamak sağlık profesyonellerinin BBSÇ-KYÖ puanlarının belirgin derecede yüksek olduğu saptanmıştır. Elde edilen sonuçlar, BBSÇ-KYÖ'nün birinci basamak sağlık çalışanlarının kültürel yeterliliğini değerlendirmede kullanılabilir bir ölçüm aracı olduğunu göstermektedir. Ayrıca ölçek, bireye, aileye ve topluma sağlık hizmet sunumu gerçekleştiren tüm profesyoneller için de klinik alanda kullanıma uygundur.

Anahtar Kelimeler: Birinci basamak sağlık çalışanı, Kültürel Yeterlilik Ölçeği, geçerlik, güvenirlik

The number of international migrants around the world rose from 244 million in 2015 to 258 million in 2018, according to a report by the International Organization for Migration. This number represents 3.4% of the world's total population. The number of refugees, asylum-seekers and internally displaced people has drastically increased across many regions of the world. During the last 3.5 years, the number of refugees has increased by 45% due to the conflict in Syria (IOM, 2018).

Turkey has recently become a major junction or port of call for the flow of migration incoming from Syria into Europe and the United States as a result of the Syrian conflict (IRRA, 2018). Furthermore, many people from different parts of the world have migrated to Turkey to find work, education, shelter and better health care. The proportion of foreign nationals residing in Turkey was 11.9% in 2018 (TSI, 2018). The number of migrants flowing into Turkey increased by 23.8% in 2018 compared to the previous year. It is reported that 35% of immigrants live in Istanbul, 12.4% live in Ankara, and 6.4% live in Antalya (TSI, 2019). The frequent interactions of health professionals with individuals from this diverse influx of cultures cause difficulties that may result from problems with communication due to differences in language, as well as adaptation problems deriving from differences in beliefs and norms (Turkish Medical Association, 2014; Yağmur & Aytekin, 2018). It is therefore crucial for health professionals to show sensitivity and develop cultural competency so that they might effectively address the health needs of individuals from different cultures.

Cultural competency is described as a dynamic, developmental process which seeks to provide effective health care services in diverse societies. Developing cultural competency is a continuous life-long process for health care professionals (Cai, Kunaviktikul, Klunklin, Sripusanapan, & Avant, 2017; Shen, 2015). The lack of cultural competence in healtcareinstitutions leads to the dissatisfaction of individuals coming from different cultures. Health professionals with cultural blindness, prejudice, lack of knowledge, lack of skills and insensitivity can prevent people from coming to health institutions to benefit from health services. Such behaviors can also cause negative feelings in clients (Papadopoulos, 2006; Shen, 2015). It is therefore necessary to make an assessment of the level of cultural competence among health professionals and to improve problematic areas if necessary. In this context, a valid and reliable cultural competence measurement tool that covers cultural knowledge, skills and sensitivity can be considered to meet the needs in the field. Developing such a scale will be useful in de-

termining health professionals' levels of cultural competence and make it possible to achieve the required improvements. The aim of this study was to develop the multidisciplinary Primary Health Care Professionals' Cultural Competency Scale (PHCP-CCS) and to determine the various factors that are related to cultural competency in a city in Turkey that has a high influx of migrants.

Cultural Competency in Health Care

Cultural competency is an important component of providing culturally responsive and effective care in health care services, reducing inequalities, addressing racism, and improving patient satisfaction and health outcomes in health care services (Papadopoulos, 2006; Repo, Vahlberg, Salminen, Papadopoulos, & Leino-Kilpi, 2017; Shen, 2015). Cultural competency is regarded as a prerequisite for ethical relationships between health care workers and patients (Campinha-Bacote, 2002). Culturally competent health care professionals are potentially important in improving the quality of health care, ensuring better health outcomes for individuals from different communities and increasing accessibility (Beach et al., 2005; Gallagher & Polanin, 2015; Truong, Paradies, & Priest, 2014). Both national and international laws as well as professional codes of ethics stipulate that all individuals have the right to receive equal and good quality care that is appropriate to their cultural needs. For this reason, ensuring the delivery of good quality care for individuals from diverse societies is both a legal and a moral obligation (Repo et al., 2017).

Cultural competency in health care has three components: linguistic competency, workforce diversity, and workforce cultural competency (Baldwin, 2003). Linguistic competency requires the health care professional to be able to communicate with the patient in the patient's native language, even at the lowest level. Workforce diversity emphasizes the need to address sensitive communities and support them in their selection of health care professionals. It also draws attention to the principle that healthcare professionals from diverse cultures should be given opportunities to participate in the recruitment of health care staff. Workforce cultural competency stresses that health care professionals should uphold and act on the belief that an individual should be provided with care that is in compliance with the individual's own cultural requirements. The components of cultural competency ensure better health care outcomes for individuals and lead to improvements in health care services by reducing health inequalities (Gallagher & Polanin, 2015).

Individuals receiving care from health professionals who do not know how to provide culturally oriented care often experience dissatisfaction, lack of confidence, anger and conflict (Tanrıverdi, 2016). While the cultural competency concept is predominantly mentioned in connection with nurses in the literature, it should apply to all health care institutions and workers. The health care centers used primarily and most frequently by individuals from diverse cultures are primary health care institutions. Factors such as education level, years of employment, receiving training on multiculturalism, communication and interaction skills, knowledge of foreign languages, having friends or neighbors from different cultures, and providing care for international patients are reportedly associated with the cultural competency of health care professionals (Meydanlioglu, Arikan, & Gozum, 2015; Repo et al., 2017).

The cultural values, beliefs, and practices of individuals who receive health care services are integral parts of health care. In the globalizing world, health care professionals who work in both primary health care services and clinical areas should acknowledge the necessity of and responsibility for providing people-centered care for entire societies and ethnic groups. For this reason, more importance has been placed recently on efforts to train health care professionals in the cultural knowledge and skills that will help them respond to the cultural requirements of different cultural communities (Jeffreys, 2000).

Measuring of Cultural Competency

The literature indicates that different tools have been developed to measure the inequalities experienced by individuals from diverse cultural backgrounds and how this affects health care outcomes (Cai et al., 2017; Rew, Becker, Cookston, Khosropour, & Martinez, 2003). The tools that have been applied to individuals and health care professionals from diverse cultures were primarily used to assess the cultural competency of nurses. Items appearing in the assessment tool developed by Perng and Watson (2012) for the purpose of evaluating cultural competence in nurses covered the domains of cultural sensitivity, cultural knowledge and cultural skills. Although the Nurse Cultural Competency Scale (NCCS) was developed for nurses, the items it measures contain general statements that can measure the cultural knowledge, skills and sensitivity of all health professionals. The NCCS is based on the three concepts of cultural knowledge, skills and sensitivity. It consists of 20 items. The original form of the instrument, drawn up as a Mokken type of scale and evaluated on the basis of a single

factor, was assessed as reliable. Participants can score between 20 and 100 points on the scale. Higher scores are interpreted as indicators of better cultural competency (Perng & Watson, 2012).

The NCCS was adapted to the Turkish language and culture by Gozum, Tuzcu, and Kirca (2016) and applied to nurses. In the Turkish adaptation of the NCCS, all the items and the single factor were found to be compatible with the original scale, and therefore no changes were made. Cronbach's Alpha coefficient for the NCCS-Turkish forms was found to be .96. As it consists of the basic components of cultural competency, the scale is suitable for all professionals working in the health care sector. After corresponding with Perng and conversations with Watson, it was concluded that NCCS can also be applied to primary healthcare professionals and it was therefore adapted in this study for use among this group of professionals. The NCCS items are related to the basic components of cultural competency, making the scale suitable for all professionals who provide health care with a holistic view of the individual, the family and the community, including psychologists, dieticians and physiotherapists. The aim of this study was to develop a Cultural Competence Scale (PHCP-CCS) for Primary Health Care Professionals by adapting the NCCS into the Turkish culture, and to determine the various factors affecting cultural competence in Turkey.

METHOD

Participants

Antalya province ranks third in Turkey in terms of receiving the greatest number of migrants. Many people from different parts of the world come to this city for tourism, shelter, education and health (TUSI, 2019). This study was carried out in Antalya since health professionals working in primary care in this province are in constant contact with individuals from different cultures. Included in the study were health care professionals working at the community health centers and family physicians and family health nurses working at family health centers in Antalya between November 2017-June 2018. Family health centers in Turkey provide individuals and families with basic health care services free of charge. A family physician and a family nurse or midwife work together at the family health center. The centers offer free and easily accessible health services. Community health centers provide vaccination services for migrants and refugees as well as outpatient services in places where these groups of people live

collectively. There were 600 family physicians and 600 family health nurses working at 210 family health centers in Antalya. As the number of professionals working at the community health centers varies, the health professionals designated by the Provincial Directorate of Health through the relevant district directorates in Antalya were included in the scope of the study. The convenient sampling method was employed (Cohen, Manion, & Morrison, 2007). Based on this method, participants who could be reached via e-mail were invited to participate and data collection was continued until a sufficient number was reached. E-mails were sent to the entire population, and data belonging to the 231 people who completely filled out the e-questionnaires were considered for evaluation (the response rate was 19.25%).

The average age of the participants was 42.06 (*SD* = 7.41) and 69.7% were females. The mean number of years the individuals were employed in the profession was 19.65 (*SD* = 8.57), while the mean number of years of employment in primary health care services was 12.36 (*SD* = 8.55). Out of the total, 39% of the participants were family physicians, 28.6% were family health nurses, and 32.4% were health care professionals working at the community health centers.

Measures

Descriptive Information Form. This form was structured by the authors based on the literature, and it included questions related to the demographic characteristics and cultural backgrounds of the participants. Except for age, socio-demographic characteristics such as gender, years of employment in the profession, and years of employment at the community health center or family health center were evaluated on the basis of responses given to close-ended questions. Questions referring to information on cultural backgrounds ("Can you speak any language other than Turkish?" "Have you ever lived, worked, or studied in any country other than Turkey?" "Have you ever paid a brief visit for business or tourism to any country other than Turkey?" "Have you ever had a friend/spouse/relative/neighbor who is foreign or from a different culture and who is in close contact with you?" "Have you ever received professional or in-house training on health care delivery to cultures that are not the dominant culture in your location?") were answered with a "Yes/No" option. The questions related to the frequency of interaction with friends or neighbors who are foreign or from different cultures and the frequency of encountering individuals/families from different cultures in the field of health care were answered with the options "1=Never," "2=Rarely," "3=Often," and "4=Very Of-

ten." The level of satisfaction with working with migrants and refugees was measured with options ranging from very content to least content.

Primary Health Care Professionals' Cultural Competency Scale (PHCP-CCS). All the items of the Primary Health Care Professionals' Cultural Competency Scale (PHCP-CCS) were taken from the Nurse Cultural Competency Scale (NCCS) (Gozum et al., 2016; Perng & Watson, 2012) and modified. An examination of the NCCS items indicated that the scale measures general concepts that are suitable not only for nurses but for all health professionals. In adapting the scale, certain concepts in the items were modified. These modifications were as follows: "client/patient" was replaced with "individual/family/community" (2,3,4,5,6,8,10,12,13,14,15,16,18,19,20), "nursing initiatives" (2,8,13,14) was replaced with "health care initiatives" (8) and "care needs" (13), "nursing goals" (16), and "nursing knowledge" (20) with "health care service, health care goals, and health needs." Following these changes, the Turkish questionnaire was named the "PHCP-CSS" and submitted to eight experts for an evaluation of content validity.

Procedure

The data were collected using online questionnaires, the Descriptive Information Form and PHCP-CSS, which had been modified to address health professionals working at the community health centers and family health centers. Family physicians and family health nurses were contacted directly or via family physicians and family health nurse associations in the province where the study was conducted.

The SPSS software package (version 21.0) was used for a statistical analysis of the data (SPSS Inc., Chicago, IL). To fully characterize the sampling, frequency and percentage values were used for demographic characteristics and cultural backgrounds.

The content validity index, exploratory factor analysis and discriminant validity were used to test validity. For discriminant validity, an investigation was carried out to see whether some background features of the participants made a difference in the PHCP-CCS score.

The mean scores on the overall scale and factor total scores were calculated in order to reveal the relationships between the scales and factors. The variables were investigated using visual (histograms, probability plots) and analytical methods (Kolmogorov-Si-

mirnov test) to determine whether or not they were normally distributed. Since the Kolmogorov-Smirnov test *p* value was 0.007, it was seen that the data did not show normal distribution (Hayran & Hayran, 2018). Also, the fact that probability plots were not between the values ±1.5 indicated the lack of normal distribution. It was therefore decided that nonparametric tests could be used. The Mann-Whitney U test and Kruskal-Wallis analysis were conducted to establish discriminant validity. The Dunn-Bonferroni test was employed to identify the group from which the significance came. Cronbach's Alpha coefficient was calculated for reliability. The statistical significance level was determined to be $p < .05$.

Ethical approval was obtained from Akdeniz University, Faculty of Medicine, Clinical Research Ethics Committee (dated August 8, 2017 and numbered 500), official authorization was received from Antalya Public Health Directorate (dated October 4, 2017 and numbered 12394646/771/E162), and informed consent was obtained from the family physicians and family health nurses.

RESULTS

Validity: Content Validity Index, Factor Structure and Discriminant Validity

The agreement on expert opinions was evaluated using the Content Validity Index (CVI). The group of experts consisted of eight faculty members, including seven public health nursing specialists and one psychiatric nursing specialist. The scores given by the experts, registering between 1-4 points for each item using the Lawshe method, were transferred to an Excel table. Inter-rater agreement was calculated on the basis of the Content Validity Index-CVI (Erdoğan, Nahcivan, & Esin, 2014). According to this calculation, the CVI value of the PHCP-CCS was.92.

Principal components analysis with varimax rotation was applied to 20 items of the PHCP-CCS (See Table 1). To determine the suitability of the data for factor analysis, Bartlett's sphericity test and the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy (MSA) were applied. KMO and Bartlett were found to be .95 and 4144.2, respectively ($df = 190$, $p < .001$).

Table 1. Validity Analysis of the PHCP-CCS

Items	Factor 1	Factor 2	Factor 3	Corrected item-total correlation
Cultural Skills (Eigen value = 11.869, Variance = 29.018)				
1. I can teach and guide colleagues about the differences and similarities of diverse cultures.	**.82**	.32	.17	.75
2. I can teach and guide colleagues about planning nursing interventions for individuals-families-communities from different cultures.	**.84**	.31	.14	.74
3. I can use examples to illustrate communication skills with individuals-families-communities from different cultures.	**.73**	.03	.37	.60
4. I can teach and guide colleagues about the communication skills for individuals-families-communities from different cultures.	**.85**	.26	.17	.73
5. I can explain the influences of cultural factors on beliefs/ behavior regarding health/illness to individuals-families-communities from diverse ethnic groups.	**.71**	.37	.17	.72
6. To me, collecting information on each individual's-family's-community's beliefs/behavior about health/illness is very easy.	**.58**	.58	.14	.76
7. I can teach and guide colleagues about cultural knowledge of health and illness.	**.66**	.49	.14	.75
8. I can teach and guide colleagues to display appropriate behavior when they implement nursing care for individuals-families-communities from different cultures.	**.64**	.45	.31	.80
Cultural Knowledge (Eigen value 1.833, Variance 26.791)				
9. I am familiar in health and/or illness-related cultural knowledge and/or theory.	.43	**.66**	.20	.75
10. I can explain the influence of culture on individuals' -families'-society's beliefs/behavior about health/illness.	.27	**.76**	.26	.75
11. I can list the methods or ways of collecting health, illness, and cultural-related information.	.39	**.73**	.26	.81
12. I can compare health/illness beliefs among individuals -families-communities from different cultures.	.24	**.77**	.36	.79
13. I can easily identify the care needs of individuals-families-communities from different cultures	.28	**.72**	.37	.78
14. When implementing nursing activities, I can fulfil the needs of individuals -families-communities from different cultures	.36	**.64**	.43	.80
15. I can explain the possible relationships between the health/ illness beliefs and culture of individuals -families-communities.	.24	**.74**	.35	.77
16. I can establish nursing goals according to each individual's-family's-community's cultural background.	.30	**.70**	.43	.82
Cultural Sensitivity (Eigen value 1.009, Variance 17.747)				
17. I usually actively strive to understand the beliefs of different cultural groups.	.31	.23	**.77**	.66
18. When caring for individuals -families-communities from different cultures, my behavioral response usually will not differ much from their cultural norms.	.11	.30	**.81**	.60
19. I can employ the communication skills necessary for individuals-families-communities from different cultures.	.19	.45	**.71**	.71
20. I usually discuss differences between their health beliefs/ behavior and nursing knowledge with each individual-family-community.	.27	.42	**.69**	.73

It was found that the PHCP-CCS was loaded on three factors and explained 73.5% of the total variance. The factor loadings of each item were between .58 and .85. In order to determine the factor structure of the PHCP-CCS, factor analysis was performed using the varimax rotation method. There were three factors above Eigenvalue 1 (11.869, 1.833, 1.009). Approximately 29% of total variance was explained by the cultural skills factor, 27% by cultural knowledge, and 17.7% by the cultural sensitivity factor. The total correlations between the scores of each item and the scale were calculated to be between .60 and .82 (p <.05).

The participants' descriptive features and discriminant validity results are presented in Table 2. Thirty-eight percent of the participants spoke a second language, 9.1% had lived, worked, or studied outside Turkey for at least three months, and 50.6% had traveled abroad for business or tourism. In addition, 78.4% of the participants communicated with friends/spouses/relatives/neighbors from a different culture often or very often; 46.3% encountered individuals/families from different cultures in primary health care institutions often or very often; 4.8% had received training in health care delivery to different cultures; and 55.8% had experience in providing services for migrants or refugees.

The total score from the PHCP-CCS was 60.44 (SD:16.79) (min. 20, max. 100). Although the PHCP-CCS score of the family physicians was lower, no difference was found between the cultural competency scores of the professionals in primary health care services. An investigation was conducted in terms of discriminant validity to see if some background features of the participants made a difference on the PCCP-CCS score. Total PHCP-CCS scores were higher in those who spoke a language other than Turkish (p < .05), those who were in more frequent contact with friends and neighbors from different cultures (p < .05) and those who have received in-service training on service delivery to different cultures (p < .001). The PHCP-CCS scores of all the primary health professionals who expressed that they were content working with migrants and refugees were considerably higher (p < .001). According to the post hoc Dunn-Bonferroni test, differences were found between those who said they were not content with working with migrants and refugees and those who said they were content and that this aspect of their work did not bother them (See Table 2).

Table 2. Cultural Backgrounds of the Healthcare Professionals Working in Primary Health Care Services and PHCP-CCS Scores

Variables	N	%	Mean (SD)	Statistic	p-value
Assignment					
Family Physician	90	39.0	57.91 (17.67)		
Family Health Nurses	66	28.6	63.18 (14.09)		
Physician working at community health centers	16	6.9	61.37 (18.46)		
Nurse / midwife / health officer working at community health centers	44	19.0	60.90 (18.84)	5.25[a]	.26
Other health staff working at community health centers	15	6.5	61.26 (13.79)		
Speaking a different language except Turkish					
Yes	88	38.1	63.14 (16.12)	.5281[b]	.04*
No	143	61.9	58.78 (17.03)		
At least three months experience with living, working, going to school outside of Turkey					
Yes	21	9.1	62.47 (17.78)	.2037[b]	.56
No	210	90.9	60.24 (16.72)		
Visits to a country other than Turkey for business or tourism					
Yes	117	50.6	60.11 (17.42)	.6558[b]	.86
No	114	49.4	60.78 (16.19)		
Frequency of communications with friends-neighbors from different cultures					
Never/rarely	181	78.4	59.25 (16.55)	.2016[b]	.05*
Often/ very frequent	50	21.6	64.74 (17.13)		
The frequency of contacts with people from different cultures in the workplace					
Never/rarely	124	53.7	59.12 (16.76)	.1293[b]	.20
Often/ very frequent	107	46.3	61.98 (16.77)		
In-service training related to serving different cultures					
Yes	11	4.8	78.54 (13.37)	.466[b]	.00*
No	220	95.2	59.54 (16.45)		
Opinions about working with migrants & asylum seekers					
I have no experience	102	44.2	59.92 (16.77)		
I am not happy to be working with them	75	32.5	56.08 (16.98)	14.6[a]	.00**
I am happy to be working with them	16	6.9	71.62 (13.77)		
It doesn't matter to me	38	16.5	65.76 (14.47)		

*Statistically significant at $p < .05$ level. [a]Kruskal Wallis analysis; [b]Man Whitney U analysis
**Statistically significant at $p < .01$ level.

Reliability

Scale item means, standard deviations, factor-total correlations, and Cronbach coefficients were assessed. Cronbach's Alpha coefficient for the PHCP-CCS, which consisted of 20 items, was found to be .84. The correlation of each factor with the overall scale score was calculated as between .78 and .93 ($p < .05$). It was observed that there were

significant, moderate and high-level positive relationships between the inter-factor correlations on the PHCP-CCS (.73 between cultural skills and cultural knowledge, .55 between cultural skills and cultural sensitivity, .73 between cultural knowledge and cultural sensitivity). Internal consistency of the PHCP-CCS was .84, and the reliability of the factors of the scale were respectively .78, .76 and .87 (See Table 3).

Table 3. Descriptive Statistics, Reliability Coefficients and Relations between Factors of the PHCP-CCS

	$\bar{X}$	*SD*	Min	Max	Correlations between factors and total score			
					1	2	3	4
1. PHCP-CCS Total Points	60.44	16.79	20.00	100.00	(.84)			
2. Cultural Skills	22.91	7.33	8.00	40.00	.90*	(.78)		
3. Cultural Knowledge	23.96	7.42	8.00	40.00	.93*	.73*	(.76)	
4. Cultural Sensitivity	13.56	3.77	4.00	20.00	.78*	.55*	.73*	(.87)

*Spearman's rho correlation was significant at the 0.01 level. Cronbach's Alpha values were indicated in parentheses.

DISCUSSION

In this study, the NCCS developed by Perng and Watson (2012) and adapted to Turkish by Gozum et al. (2016) was modified for multidisciplinary health care professionals in primary health care and the scale was tested to determine validity and reliability. The factors which might be associated with the cultural competency of health care professionals in primary health care services in Antalya, a city in Turkey with a high inflow of migrants, were also examined. PHCP-CCS is suitable for all professionals who provide health care with a holistic view of the individual, the family and the community. In this sense, it can also be used safely by social workers, clinical psychologists, health psychologists, and social psychologists interacting with health workers. Our findings demonstrated that the PHCP-CCS exhibits satisfactory evidence in favor of reliability, internal consistency and construct. The internal consistency of the PHCP-CCS was found to be as high as the English and Turkish versions of the NCCS (Gozum et al., 2016; Perng & Watson, 2012).

Content validity was investigated in the study, where the CVI was computed on the basis of the ratings of eight specialists. The content validity of the PHCP-CCS was excellent, a finding that was in line with what is suggested in the literature (Erdoğan et al., 2014). Apart from the displacement of the items described below, the factor structure of the PHCP-CCS was largely similar to the original. The determinants of cultural competency, namely, cultural skills, cultural knowledge, and cultural sensitivity, were found to be considerably disaggregated, compatible with the theory and conceptually defining the

intended construct. The term "Patient" is used in the NCCS because nurses provide care for the patient. In primary care, the term "individual-family and community" was substituted for "patient", since health services are provided to the individual, family and community. The statement designed to measure cultural knowledge in the NCCS ("I can use examples to illustrate communication skills with patients from different cultures") was found to overlap better with the items in cultural skills on the PHCP-CCS such as "I can use examples to illustrate communication skills with individuals-families-communities of different cultures." Likewise, items 10, 14, and 16, which were originally composed to measure cultural skills, were grouped under the cultural knowledge section. While item 18 and item 19 were originally created for the cultural skills section, they fit in better with the cultural sensitivity factor in the PHCP-CCS. In examining the factor loads of each item, it was seen that many items were loaded with two factors with a value of above .30. However, since the difference between the two loaded factors was greater than .10, it was considered appropriate to remain at the highest factor (Karaman, Atar, & Aktan, 2017). Although the sixth item was loaded with the same value in both the cultural knowledge and the cultural skills factors, and since the content was compatible with cultural skills and had been included in the original scales under this factor, it was decided that it would be kept under this factor (Erkuş, 2007; Gozum et al., 2016; Perng & Watson, 2012). The items in the NCCS and NCCS-Turkish form were exclusively related to nursing care, but the goal of the modifications for the PHCP-CCS was to ensure that the items covered all professionals in the public health field as well. It was observed that the fields where the items in the modified NCCS-Turkish form were grouped in the PHCP-CCS were directly related to the theoretical construct. It was therefore concluded that the item created to measure skills might be essentially perceived as cultural sensitivity. When PHCP-CCS is used in other samples and in clinical areas, the suitability of the three-factor structure can be tested by confirmatory factor analysis. The fact that the level of the relationship of all three factors with the overall scale was found to be "high" and "very high" indicates good internal consistency. A medium level relationship between cultural skills and cultural sensitivity, and a high relationship level between the other factors are indicators that the factors are supportive but not of the same structure. As a result, the concept of cultural competency is a holistic construct containing cultural knowledge, skills, and sensitivity. As the scoring of all items was performed in the same manner, the total score for all 20 items should be taken into consideration in assessing the competency of multidisciplinary health professionals.

The mean of the total scores of the participants on the PHCP-CSS indicated that the cultural competency levels of health professionals in primary care were slightly higher than the mean. While no statistically significant difference was found, the cultural sensitivity of nurses working at the family health centers was better than the rest. In Turkey, periodic follow-ups of mothers and children are conducted by nurses working at the family health centers. The more frequent encounters with individuals from different cultures due to these periodic follow-ups of migrant mothers and children might have enhanced the cultural competency of the nurses working at the family health centers. In addition, it may be argued that this outcome might be due to the fact that cultural competency skills are some of the core competencies for public health nursing (Public Health, 2011). Perng and Watson (2012) found the cultural competency levels of nurses to be lower than medium level (mean= 44.08). Gozum et al. (2016) calculated the cultural competency score average of the nurses working at hospitals in Antalya, which has a high migrant population, to be 75.34. This score is higher than what was found in this study. It is thought that this difference is due to the presence of an international patients' department and interpreters in the hospitals, whereas these facilities were lacking in the primary care institutions where the study was conducted.

In the analysis made with the assumption that knowledge of a language other than the mother tongue may enhance cultural competency, it was found that health professionals who could speak a language other than Turkish had higher cultural competency scores. The findings of our study are consistent with Repo et al. (2017). By decreasing racial and ethnic differences and facilitating culturally competent communication, knowledge of one or more foreign languages acts as a facilitator of quality care (Cruz, Estacio, Bagtang, & Colet, 2016; Meydanlioglu et al., 2015; Repo et al., 2017). Gozum et al. (2016) reported that the cultural competency scores of nurses who knew other languages besides their mother tongue were lower than those who did not; this outcome may have been due to the fact that the nurses did not speak the languages spoken by the migrants.

According to the findings of this study, health professionals' frequently establishing contact with friends or neighbors from different cultures in their private lives was one of the major factors positively affecting cultural competency levels. It was observed that the individuals who had more frequent encounters with different cultures became familiar with other cultures more easily and engaged in intercultural interaction more readily;

this finding was compatible with other studies in the literature (Cruz et al., 2016; Cruz et al., 2017; Gozum et al., 2016; Meydanlioglu et al., 2015; Repo et al., 2017). Encountering diverse cultures is a key element of transcultural nursing (Campinha-Bacote, 2002). The cultural encounter is the crucible that directly engages health care workers in interactions with patients from diverse cultural backgrounds. Such interactions make it easier for nurses to improve their existing beliefs concerning certain cultural groups, thereby preventing emergent prejudices and stereotypes (Campinha-Bacote, 2002; Cruz et al., 2016).

The training the health professionals in this study received regarding the delivery of health care to diverse cultures was found to be a key determinant of their cultural competency level. In the literature, such training is reported to have a positive effect on cultural competency (Cerezo, Galceran, Soriano, Camps, & Moral, 2014; Cruz, Machuca Contreras, Ortiz López, Zapata Aqueveque, & Vitorino, 2018; Truong et al., 2014). It has been additionally reported that training not only improves knowledge, skills, and attitudes related to cultural competency but also contributes greatly to patient outcomes (Downing, Kowal, & Paradies, 2011; Truong et al., 2014). Jeffreys (2000) has pointed out that both undergraduate education and postgraduate education and training play major roles in the improvement of cultural awareness and skills. Development of cultural competency is a gradual and ongoing process, and for this reason, such training should have continuity and be assessed with different measurements (Campinha-Bacote, 2002; Loftin, Hartin, Branson, & Reyes, 2013).

It was observed in the study that those who were content with working with migrants and refugees had higher cultural competency levels than those who did not have experience or were not happy with working with migrants and refugees. This finding is proof that the PHCP-CCS exhibited good selectivity. The findings of our study were compatible with other studies (Cruz et al., 2018; Gozum & Aydın, 2004; Repo et al., 2017). This may indicate that any experience in delivering care to individuals from different cultures may enhance the cultural competency levels of health professionals.

The results of this study provide evidence that the PHCP-CCS is a reliable instrument for determining the cultural competency level of primary health care professionals. Internal consistency findings confirmed that the PHCP-CCS was reliable for use by primary care professionals. Evaluation at the item level indicates which areas are strong

and which should be developed. The evaluation of the PHCP-CCS scores of the participants (See Table 3) determined that cultural knowledge and skills were at a moderate level. Cultural sensitivity of the participants was at a higher level than the other two factors.

In summary, the PHCP-CCS exhibited evidence of good reliability and validity at a statistically excellent level in our sample. This study validates the PHCP-CCS and supports its use as a brief, practical, and simple instrument. On the other hand, the study has certain limitations. The sampling represented a city of the Mediterranean region of Turkey and therefore the results cannot be necessarily extrapolated to other populations of this region or elsewhere in Turkey. Since the response rate in this study was low, the descriptive results cannot be generalized, even to Antalya. The fact that the research was composed of participants selected with the convenient sampling method is a limitation in terms of the generalizability of the findings. In this regard, conducting research to cover all professionals working in primary care can provide stronger support for the validity and reliability of the measurement. Another limitation is that the sixth item was loaded on both factors. This item is important for this scale and it might be recommended that the translation and analysis be reviewed at a later date.

The authors of the study believe that due to the lack of a measure for assessing cultural competency in primary care, a trial of the PHCP-CSS carried out in different countries may enhance the assessment of the cultural competency of health care professionals. The PHCP-CCS can be a tool for facilitating cross-cultural comparisons. Based on the study findings, it can be said that health care professionals may be able to improve their cultural competences with in-house training programs, learning a foreign language and by being encouraged to make friends with people from diverse cultures and to welcome cultural contacts.

The PHCP-CCS is suitable for use in descriptive study designs to determine the cultural competence levels of primary health care professionals. It can also be used as a pre-test and post-test assessment tool to assess the impact of in-service training to improve the cultural competence of health professionals.

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APPENDIX: ENGLISH FORM OF PHCP-CCS

PRİMARY HEALTH CARE PROFESSİONALS' CULTURAL COMPETENCY SCALE

	EVALUATION **Please read each item and mark it by placing an X or ✓ symbol in one of the answer option "strongly agree ", " agree ", "undecided", "disagree ", "strongly disagree ".**	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
CSk	1. I can teach and guide colleagues about the differences and similarities of diverse cultures.					
CSk	2. I can teach and guide colleagues about planning nursing interventions for person-family-society from different cultures.					
CSk	3. I can use examples to illustrate communication skills with person -family-society from different cultures.					
CSk	4. I can teach and guide colleagues about the communication skills for person -family-society from different cultures.					
CSk	5. I can explain the influences of cultural factors on beliefs/behavior toward health/illness to person -family-society from diverse ethnic groups.					
CSk	6. To me, collecting information on each person -family-society's beliefs/ behavior about health/illness is very easy.					
CSk	7. I can teach and guide colleagues about the cultural knowledge of health and illness.					
CSk	8. I can teach and guide colleagues to display appropriate behavior, when they implement nursing care for person -family-society from different cultures.					
CK	9. I am familiar in health and/or illness related cultural knowledge and/or theory.					
CK	10. I can explain the influence of culture on person -family-society's beliefs/ behavior about health/illness.					
CK	11. I can list the methods or ways of collecting health, illness, and cultural-related information.					
CK	12. I can compare health/illness beliefs among person -family-society from different cultures.					
CK	13. I can easily identify the care needs of individual-family-society from different cultures					
CK	14. When implementing nursing activities, I can fulfil the needs of person -family-society from different cultures					
CK	15. I can explain the possible relationships between the health/illness beliefs and culture of person -family-society.					
CK	16. I can establish nursing goals according each person-family-society's cultural background.					
CSens	17. I usually actively strive to understand the beliefs of different cultural groups.					
CSens	18. When caring for person -family-society from different cultures, my behavioral response usually will not differ much from the their cultural norms.					
CSens	1. I can teach and guide colleagues about the differences and similarities of diverse cultures.					
CSens	2. I can teach and guide colleagues about planning nursing interventions for person-family-society from different cultures.					

CSk = cultural skills; CK = cultural knowledge; CSens = cultural sensitivity

APPENDIX: TURKISH FORM OF PHCP-CCS

BİRİNCİ BASAMAKTA ÇALIŞAN SAĞLIK PERSONELİNİN KÜLTÜREL YETERLİLİK ÖLÇEĞİ

	DEĞERLENDİRME **Lütfen her bir maddeyi okuyup "kesinlikle katılıyorum" "katılıyorum" "kararsızım" "katılmıyorum" "kesinlikle katılmıyorum" yanıt seçeneklerinden birine X veya ✓ sembolü yerleştirerek işaretleyiniz.**	Kesinlikle katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle katılmıyorum
KBc	1-Meslektaşlarıma, çeşitli kültürlerin farklılık ve benzerliklerini öğretebilir ve rehberlik edebilirim.					
KBc	2-Meslektaşlarıma, farklı kültürlerden gelen birey-aile-topluma yönelik sağlık hizmetlerini nasıl planlayacaklarını öğretebilir ve rehberlik edebilirim.					
KBc	3-Farklı kültürlerden gelen birey-aile-toplum ile iletişim kurma becerilerini göstermek için örneklerden yararlanabilirim.					
KBc	4-Farklı kültürlerden gelen birey-aile-toplum ile iletişim kurma becerilerini meslektaşlarıma öğretebilir ve rehberlik edebilirim.					
KBc	5-Kültürel faktörlerin, sağlık hastalık konusundaki inanç/davranışlar üzerindeki etkilerini farklı etnik geçmişi olan birey-aile-topluma açıklayabilirim.					
KBc	6-Her birey-aile-toplumun sağlık/hastalık konusundaki inanç/davranışları ile ilgili bilgileri toplamak benim için kolaydır.					
KBc	7-Meslektaşlarıma, sağlık ve hastalıkla ilgili kültürel bilgileri öğretebilir ve rehberlik edebilirim.					
KBc	8-Meslektaşlarıma, farklı kültür gruplarından olan birey-aile-topluma sağlık hizmeti verirken nasıl uygun davranış sergileyeceklerini öğretebilir ve rehberlik edebilirim.					
KB	9-Sağlık ve hastalıkla ilgili kültürel bilgi ya da kuramları biliyorum.					
KB	10-Kültürün, birey-aile-toplumun sağlık/hastalık konusundaki inanç/ davranışları üzerindeki etkisini açıklayabilirim.					
KB	11-Sağlık, hastalık ve kültürle ilgili bilgi toplama yöntemlerini biliyorum.					
KB	12-Farklı kültürel geçmişi olan bireyler-aileler-toplumlar arasındaki sağlık ve hastalık inançlarını karşılaştırabilirim.					
KB	13-Farklı kültürel geçmişi olan bireyin-ailenin-toplumun sağlık hizmeti gereksinimlerini kolaylıkla belirleyebilirim.					
KB	14-Sağlık hizmeti verirken, farklı kültürel geçmişi olan birey-aile-toplumun gereksinimlerini karşılayabilirim					
KB	15-Birey-aile-toplumun sağlık/hastalık inancı ile kültürü arasındaki ilişkiyi açıklayabilirim.					
KB	16-Sağlık hizmetlerinin hedeflerini, birey-aile-toplumun kültürel geçmişine göre belirleyebilirim.					
KD	17-Farklı kültürlerden olan grupların inançlarını anlamak için genellikle çok çaba gösteririm.					
KD	18-Farklı kültürel geçmişi olan birey-aile-topluma bakım verirken, genellikle onların kültürel normlarına uygun davranırım.					
KD	19-Farklı kültürel geçmişi olan birey-aile-toplumla iletişim kurabilirim.					
KD	20-Birey-aile-toplumun sağlık inanç/davranışları ile sağlık hizmetlerindeki bakım uygulamaları arasındaki farklılıkları onlarla konuşurum.					

KBc: Kültürel Beceri, KB: Kültürel Bilgi, KD: Kültürel Duyarlılık