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DEVELOPMENT OF THE XENOPHOBIA IN HEALTHCARE DELIVERY (XHCD) SCALE

Sağlık hizmeti sunumunda zenofobi (XHCD) ölçeğinin geliştirilmesi

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Abstract

The aim of this study is to develop the "Xenophobia in Healthcare Delivery Scale" and evaluate its validity and reliability in our society. It is a methodological scale development study carried out between September and December 2023. In scale development studies, it is recommended that the sample size be 10-20 times the number of questions in the scale. Since the scale planned to be developed consists of 18 questions, it was decided that the sample would consist of 360 participants working in a tertiary hospital. The data were evaluated with SPSS and AMOS package programs. As validity analysis; Content Validity Index was applied for content validity, and Exploratory Factor Analysis and Confirmatory Factor Analysis were applied for construct validity. As reliability analyses; Internal consistency analysis (Cronbach's Alpha Coefficient), test-retest reliability and item analysis based on lower-upper groups were applied. The study was completed with 101 male (27.7%) and 264 female (72.3%) participants with an average age of 31.5±7.5 (min=21, max=59). As a result of exploratory factor analysis, the Kaiser-Meyer-Olkin coefficient was found to be 0.91 and the Bartlett test result was also found to be significant (X^2=2470.8 and p<0.001). Confirmatory factor analysis values were found to be X^2/df= 2.94, GFI= 0.901, AGFI= 0.866, CFI= 0.912, RMSEA= 0.073. Within the scope of the reliability analysis of the XHCD Scale, Cronbach's alpha value was found to be 0.88. As a result, it has been proven that the scale can be used as a valid and reliable scale in Turkish society and culture.

Keywords: Xenophobia, healthcare delivery, scale development, immigrants.

Özet

Bu çalışmanın amacı “Sağlık hizmeti sunumunda zenofobi ölçeği”nin geliştirilmesi ve toplumumuzdaki geçerlilik ve güvenirliğinin değerlendirilmesidir. Eylül-Aralık 2023 tarihleri arasında gerçekleştirilen metodolojik bir ölçek geliştirme çalışmasıdır. Ölçek geliştirme çalışmalarında örneklem büyüklüğünün ölçekteki soru sayısının 10-20 katı olması önerilmektedir. Geliştirilmesi planlanan ölçek 18 sorudan oluştuğundan, örneklemin üçüncü basamak bir hastanede çalışan 360 katılımcıdan oluşması kararlaştırıldı. Veriler SPSS ve AMOS paket programları ile değerlendirildi. Geçerlilik analizi olarak; kapsam (içerik) geçerliliği için Kapsam Geçerlik Oranı ve yapı geçerliliği için Açıklayıcı Faktör Analizi ve Doğrulayıcı Faktör Analizi uygulandı. Güvenirlik analizleri olarak; iç tutarlık analizi (Cronbach’s Alpha Katsayısı), test yeniden test güvenirliği ve alt-üst gruplara dayalı madde analizi uygulandı. Çalışma yaş ortalaması 31,5±7,5 (min=21, max=59) olan 101 erkek (%27,7) ve 264 kadın (%72,3) katılımcı ile tamamlandı. Açıklayıcı faktör analizi sonucu Kaiser-Meyer-Olkin katsayısı 0,91 bulundu ve Bartlett testi sonucu da anlamlı saptandı (X^2=2470,8 ve p<0,001). Doğrulayıcı faktör analizi değerleri; X^2/sd= 2,94, GFI= 0,901, AGFI= 0,866, CFI= 0,912, RMSEA= 0,073 olarak bulundu. XHCD Ölçeğinin güvenirlik analizleri kapsamında Cronbach alfa değeri 0,88 olarak bulundu. Sonuç olarak, ölçeğin Türk toplum ve kültüründe geçerli ve güvenilir bir ölçek olarak kullanılabileceği kanıtlanmıştır.

Anahtar kelimeler: Zenofobi, sağlık hizmeti sunumu, ölçek geliştirme, göçmenler.

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Introduction

Xenophobia, known as the fear or hostility of strangers; It derives from the Greek words "phobia" meaning "fear" and "xenos" meaning "stranger" and "guest". It basically expresses the fear and hostility towards things that are foreign to us (1, 2). Racism, xenophobia, and discrimination are important determinants of health and equity, and public health practitioners have a responsibility to question and address these issues. Understanding and combating discrimination and its underlying ideologies is crucial to promoting public health and social equity. Healthcare providers should not ignore these facts (3, 4).

Forms of discrimination may vary: in some societies it is based on race or ethnicity; in others it may be based on colour, caste, religious beliefs, nativism or immigration status. Racism and xenophobia are about division, control and ultimately power (5). Crush and Tawodzera define medical xenophobia as “the negative attitudes of healthcare professionals and workers towards refugees and immigrants while doing their jobs.” A xenophobic healthcare professional classifies patients based on their language, appearance, or national origin and treats them accordingly, contrary to ethical principles and professional deontology. For this reason, xenophobia remains a widespread and growing concern (6).

According to the United Nations High Commissioner for Refugees (UNHCR), by the end of 2023, the number of people forcibly displaced due to reasons such as conflict, violence and persecution will reach record levels globally; Türkiye continues to be the country hosting the largest number of refugees in the world. In addition to approximately 3.6 million registered Syrian refugees in Turkey, there are also approximately 320,000 people of other nationalities (7). For this reason, the issue of xenophobia is of particular importance for Türkiye.

When the literature is examined, scales developed to measure the xenophobic attitudes of individuals are encountered. However, these scales are related to the general xenophobia status of individuals or society, and there is no scale developed to measure xenophobia in health service delivery. Due to the increasing immigrant population in Türkiye in recent years, it is natural for interaction with immigrants to increase in the delivery of health services. It is thought that the health services delivered to immigrants may be affected by the attitudes and behaviors of health professionals towards immigrants. Measuring xenophobia in health care delivery will contribute to due diligence and awareness.

The aim of this study is to develop the "Xenophobia in Healthcare Delivery Scale" and evaluate its validity and reliability.

Material and Method

The study is a methodological scale development study carried out between September and December 2023. The population of the study consists of employees working at Kütahya Health Sciences University Evliya Çelebi Training and Research Hospital. In scale development studies, it is recommended that the sample size be 10-20 times the number of questions in the scale (8, 9). Since the scale planned to be developed consists of 18 questions, it was decided that the sample would consist of 360 participants. Hospital employees were stratified according to their professions and 55 physicians, 55 medical secretaries and 250 midwives/nurses were planned to be included in the sample. Necessary permissions were obtained for the study (Kütahya Health Sciences University Non-invasive Clinical Research Ethics Committee, ethics committee decision dated 06.09.2023 and numbered 2023/10-11).

The data was collected with a survey form prepared by the researchers using the literature. The survey form consists of questions containing sociodemographic characteristics (age, gender, education level, profession, unit worked, year of work) and the 18-item "Xenophobia in Healthcare Delivery (XHCD) Scale" questions developed by the researchers, aiming to evaluate xenophobia in healthcare delivery (3, 4, 10, 11). The 5-point Likert type scale was rated as "1- I strongly disagree, 2- I disagree, 3- I am

undecided, 4- I agree, 5- I strongly agree". Items 6, 10, 12, 15, 17 and 18 are reverse scored. It is assumed that as the score from the scale increases, xenophobic attitude increases.

The data of the study were evaluated through the SPSS 25.0 and AMOS package programs. Descriptive statistics were presented as mean, standard deviation, median, minimum, maximum for numerical values, and as numbers and percentages for categorical and/or nominal variables. As validity analysis; Content Validity Index (CVI) was applied for content validity, and Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) were applied for construct validity. As reliability analyses; internal consistency analysis (Cronbach's Alpha Coefficient), test-retest reliability and item analysis based on sub-upper groups were applied. Situations where $p<0.05$ were accepted for statistical significance level.

Results

The study was completed with 101 male (27.7%) and 264 female (72.3%) participants with an average age of 31.5±7.5 (min=21, max=59). The mean score of the XHCD Scale was 54.5±10.2 (min=18, max=80). “The concerns and risks” factor mean score was 45.4±8.9 (min=13, max=60) and “the equality and rights” factor mean score was 9.1±3 (min=4, max=20). No statistically significant relationship was found between the average score of the scale and the variables of age (p=0.103), gender (p=0.759), education level (p=0.054) and professional experience (p=0.275). The relationship between professional group and scale scores was statistically significant, and the average scale score was lower in physicians than in the midwife/nurse group (p=0.007) (Table 1).

Validity Analysis Results

Content Validity Index

The created Turkish form was presented to 10 experts (3 academician, 2 physicians, 3 research assistant, 2 medical personnel) for content validity. Experts were asked to evaluate the appropriateness and understandability of each scale item. The content validity index of each question was calculated according to the appropriate or item should be reviewed options (12). A pilot study was conducted in a group of 10 people to pre-test the scale questions, which were found to be 80% appropriate. All participants stated that the test was clear, understandable and trouble-free.

Table 1: Relationship between participants' sociodemographic characteristics and XHCD scale score.

Sociodemographic variables	Number (Percentage)	Mean ±SD	Median (Min-Max)	Statistical Analysis
Gender				
Male	101 (27.7)	55.0±11.8	54 (29-80)	0.759[a]
Female	264 (72.3)	54.3±9.6	54 (18-76)	
Age group				
21-30	212 (58.1)	55.1±10.3	55 (18-80)	
31-40	100 (27.4)	54.1±10	54 (24-80)	0.103[b]
41-50	46 (12.6)	53.3±10.1	53 (32-80)	
51 and over	7 (1.9)	47.1±8.7	51 (33-57)	
Education level				
High school and below	34 (9.3)	58.1 ±12.2	56.5 (33-80)	0.054[b]
Licence	294 (80.6)	54.4 ±10	54 (18-80)	
Master's degree and above	37 (10.1)	51.7 ±9.4	53 (34-70)	
Profession				
Physician	56 (15.3)	50.2 ±10.5	52 (24-69)	0.007[b]
Midwife/Nurse	265 (72.6)	55.4 ±9.8	55 (18-80)	
Medical secretary	44 (12.1)	54.3 ±11.3	53.5 (32-80)	
Professional experience (n=359)				0.275[b]
10 years and below	258 (71.9)	55 ±10.4	55 (18-80)	

11-20 years	73 (20.3)	53.9 ±8.8	53 (29-80)
Over 20 years	28 (7.8)	52.5 ±11.1	52 (32-78)

[a]Mann-Whitney U test, [b]Kruskal-Wallis test

Explanatory Factor Analysis

Explanatory factor analysis was performed on the first form of the scale, which consisted of 18 items. The Kaiser-Meyer-Olkin (KMO) coefficient was found to be 0.91 and the Bartlett test result was also found to be significant (X^2=2470.8 and p<0.001). The analysis was repeated by removing Items 12 and Item 18 with item loadings below 0.20 in the common variance table. In the final structure obtained, it was seen that the scale consisted of two factors. It was found that the first factor alone explained 38.27% of the variance and the total variance explained was 50.49%. When the Scree Plot was examined, it was concluded that the scale items were better defined in 2 factors, since the graph took a horizontal slope after the 2nd factor. In the final version of the scale, it was seen that the factor values of all items were above 0.40 in the "Factor Matrix" table. After the “Promax axis rotation technique”, it was determined that the first factor consisted of twelve items (1, 2, 3, 4, 5, 7, 8, 9, 11, 13, 14, 16) and the second factor consisted of four items (6, 10, 15, 17). The first factor was named “Concerns and Risks” and the second factor was named “Equality and Rights”. The score to be obtained from the scale will be between 12 and 60 for the "Concerns and Risks" sub-dimension, between 4 and 20 for the "Equality and Rights" sub-dimension, and between 16 and 80 for the entire scale (Figure 1-2) (Table 2).

Table 2: XHCD scale factor loadings.

Item	Concerns and Risks	Equality and Rights	Explained Variance
I9	0.815		
I8	0.801		
I7	0.776		
I4	0.753		
I13	0.698		
I5	0.693		
I16	0.683		
I2	0.655		38.27
I11	0.625		12.215
I14	0.614		
I1	0.613		
I3	0.523		
I15		0.760	
I10		0.758	
I6		0.743	
I17		0.422	

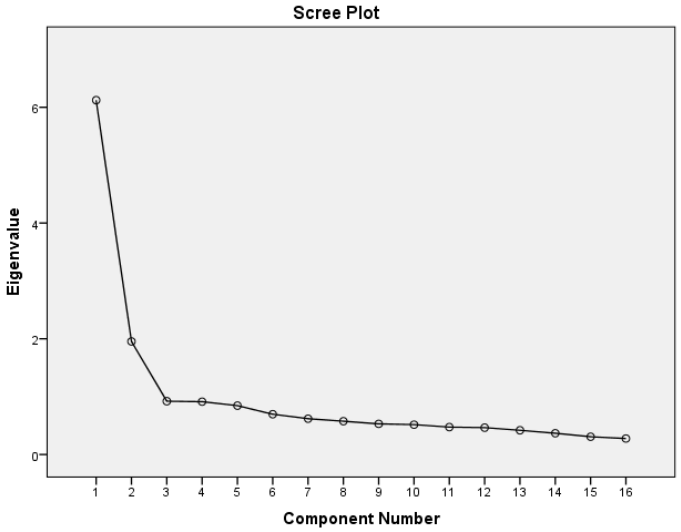

Figure 1: Scree plot.

Confirmatory Factor Analysis

Confirmatory factor analysis (CFA) was performed to determine whether the two-factor structure obtained by exploratory factor analysis was confirmed. For the CFA performed in this study, Chi-square value, Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI), Comparative Fit Index (CFI), Approximate Errors Root Mean Square Error of Approximation (RMSEA) fit indices were taken into consideration. The values were found as X^2/sd= 2.94, GFI= 0.901, AGFI= 0.866, CFI=0.912, RMSEA=0.073 (Table 3) (Figure 2).

Table 3: Fit index values for XHCD scale confirmatory factor analysis.

Acceptable Fit Indices	Calculated Fit Indices
X^2/sd<5	2.944
GFI>0.90	0.901
AGFI>0.85	0.866
CFI>0.90	0.912
RMSEA<0.08	0.073

X^2/sd: Chi-square value, GFI: Goodness of Fit Index, AGFI: Adjusted Goodness of Fit Index, CFI: Comparative Fit Index, RMSEA: Approximate Errors Root Mean Square Error of Approximation

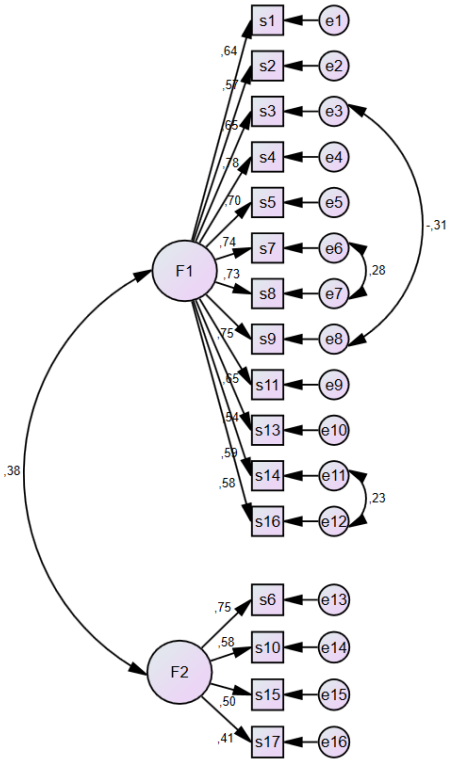

Figure 2: XHCD scale confirmatory factor analysis model.

Reliability Analysis

Within the scope of the reliability analysis of the XHCD Scale, Cronbach's alpha value was found to be 0.88. Average Variance Extracted (AVE) value was 0.41 and Composite Reliability (CR) value was 0.92. It was determined that the item-total correlation of the 16 questions in the scale varied between 0.21 and 0.70. When any of the items were removed, the Cronbach Alpha coefficient did not change significantly and was between 0.86-0.88. (Table 4).

Table 4: XHCD scale reliability analysis results.

	Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1	I would feel less safe providing health care to immigrants.	0.606	0.866
2	I have difficulty communicating when providing health care to immigrants.	0.512	0.871
3	If I had a choice, I would not want to provide healthcare to immigrants.	0.627	0.865
4	Our citizens' access to health services is negatively affected due to immigrants.	0.701	0.862
5	Violence in healthcare is increasing due to immigrants.	0.642	0.865
6	All patients, whether immigrants or not, should be treated equally.	0.398	0.875
7	Immigrants apply to outpatient clinics more per capita than our citizens, increasing the burden on health services.	0.679	0.863
8	Immigrants increase healthcare costs.	0.644	0.866
9	High birth rates among immigrants negatively affect the provision of health services.	0.631	0.866
10	In our country, benefiting equitably from health services is a right that comes from simply being human.	0.222	0.882

11	Health services to immigrants should be paid.	0.643	0.865
13	Due to immigrants, the spread of vaccine-preventable infectious diseases becomes easier.	0.440	0.873
14	Immigrants' access to health services should not be equal to our own citizens, but should be restricted when necessary.	0.569	0.868
15	Dissatisfaction with working conditions is no excuse for not treating immigrants well.	0.216	0.883
16	While our own citizens have difficulty getting a hospital appointment, it is not right for immigrants to have easy access to healthcare services.	0.529	0.870
17	Health personnel should be trained on how to approach immigrant patients.	0.347	0.879

Test Re-test Reliability

Two weeks after the data of the study were collected, 81 participants were contacted again and test-retest reliability was examined. An excellent positive correlation was detected between the test-retest scale total scores (r=0.925; p<0.001). When the relationship between test-retest and questions was evaluated, no statistically significant relationship was found between pre- and post-question scores (p>0.05) (Table 5).

Table 5: Relationship between question scores after test–retest.

n=81	Test		Retest		Statistical Analysis (Wilcoxon test) (Z and p value)	
	Mean± S.D.	Median (min-max)	Mean± S.D.	Median (min-max)		
Item 1	3.2 ±1.3	3 (1-5)	3.1 ±1.3	3 (1-5)	-0.778	0.437
Item 2	4.2 ±0.7	4 (1-5)	4.3 ±0.7	4 (2-5)	-0.924	0.356
Item 3	3.1 ±1.3	3 (1-5)	3.0 ±1.4	3 (1-5)	-0.944	0.345
Item 4	3.6 ±1.2	4 (1-5)	3.6 ±1.3	4 (1-5)	-0.019	0.985
Item 5	3.3 ±1.1	3 (1-5)	3.3 ±1.2	3 (1-5)	-0.200	0.841
Item 6	2.0 ±1.0	2 (1-5)	2.0 ±1.1	2 (1-5)	-0.243	0.808
Item 7	3.7 ±1.1	4 (1-5)	3.7 ±1.1	4 (1-5)	-0.069	0.945
Item 8	4.1 ±0.9	4 (2-5)	4.1 ±1.0	4 (1-5)	-0.850	0.395
Item 9	4.0 ±1.1	4 (1-5)	4.1 ±1.1	4 (1-5)	-1.198	0.231
Item 10	2.1 ±1.2	2 (1-5)	2.1 ±1.1	2 (1-5)	-0.085	0.932
Item 11	3.8 ±1.2	4 (1-5)	3.7 ±1.3	4 (1-5)	-1.802	0.072
Item 13	4.2 ±1.0	5 (1-5)	4.2 ±0.9	4 (1-5)	-0.155	0.877
Item 14	3.4 ±1.4	4 (1-5)	3.3 ±1.3	3 (1-5)	-0.342	0.732
Item 15	2.1 ±1.0	2 (1-5)	2.0 ±1.0	2 (1-5)	-1.250	0.211
Item 16	4.0 ±1.1	4 (1-5)	4.0 ±1.2	4 (1-5)	-0.412	0.681
Item 17	3.0 ±1.3	3 (1-5)	3.0 ±1.2	3 (1-5)	-0.635	0.526
Total	53.9 ±12.0	54 (24-80)	53.4 ±12.7	53 (25-80)	-0.679	0.497

Item Analysis Based on Upper-Lower Groups

Item Analysis Based on Lower and Upper Groups was performed for the 27% group with the highest score in total and the 27% group with the lowest score in total. A statistically significant difference was found in all items for the upper and lower groups (p<0.05) (Table 6).

Table 6: Relationship between lower and upper group items.

	Lower %27		Upper %27		Statistical Analysis (Mann Whitney U test) (Z and p value)	
	Mean± S.D.	Median (min-max)	Mean± S.D.	Median (min-max)		
Item 1	2.3 ±0.9	2 (1-5)	4.4 ±0.8	5 (2-5)	-10.835	<0.001
Item 2	3.6 ±0.9	4 (1-5)	4.8 ±0.4	5 (3-5)	-9.944	<0.001
Item 3	2.0 ±0.9	2 (1-5)	4.2 ±1.0	5 (2-5)	-10.684	<0.001
Item 4	2.6 ±1.0	3 (1-5)	4.8 ±0.4	5 (3-5)	-11.803	<0.001
Item 5	2.3 ±0.9	2 (1-4)	4.3 ±0.9	5 (1-5)	-10.619	<0.001
Item 6	1.5 ±0.7	1 (1-4)	2.6 ±1.3	3 (1-5)	-6.235	<0.001
Item 7	2.8 ±0.9	3 (1-4)	4.7 ±0.6	5 (2-5)	-11.490	<0.001
Item 8	3.3 ±1.0	4 (1-5)	4.8 ±0.4	5 (3-5)	-11.336	<0.001
Item 9	3.3 ±1.0	3 (1-5)	4.9 ±0.4	5 (3-5)	-10.992	<0.001
Item 10	1.8 ±1.0	2 (1-5)	2.3 ±1.3	2 (1-5)	-2.966	0.003
Item 11	2.8 ±1.0	3 (1-5)	4.8 ±0.5	5 (3-5)	-11.322	<0.001
Item 13	3.7 ±1.1	4 (1-5)	4.8 ±0.5	5 (3-5)	-8.396	<0.001
Item 14	2.5 ±1.1	2 (1-5)	4.5 ±0.9	5 (1-5)	-9.917	<0.001
Item 15	1.9 ±0.9	2 (1-5)	2.5 ±1.3	2 (1-5)	-2.791	0.005
Item 16	3.3 ±1.0	4 (1-5)	4.8 ±0.6	5 (1-5)	-10.039	<0.001
Item 17	2.5 ±1.0	2 (1-5)	3.9 ±1.4	4 (1-5)	-7.145	<0.001
Total	42.2 ±6.3	44 (18-49)	67.0 ±5.0	66.5 (61-80)	-12.105	<0.001

Discussion

In this study, the Xenophobia in Healthcare Delivery Scale was developed and its validity and reliability in our society was evaluated.

In the evaluation made for the content validity of the scale, it was reported that the expression form, content, suitability of the subject area and scope of the scale items were sufficient.

The factor analysis results used to determine construct validity were found to be appropriate and the scale showed a two-dimensional structureThese values show that the structure of the two-factor scale gives acceptable and valid results (13–16). Confirmatory factor analysis conducted in the light of these data confirmed the two-factor structure for the scale. In addition, it is claimed that if the CR value exceeds 0.7, validity will be accepted even if the AVE value remains below 0.5 (17,18). The high CR and AVE values also support that the scale validity has been achieved. In addition, it is quite acceptable that this structure explains 50.5% of the total variance (19).

Used to test the goodness of fit of the scale, RMSEA being less than 0.08, GFI, CFI and TLI values being over 0.90, AGFI being over 0.85 indicate that the fit is good (20, 21). The results of the study show that the goodness of fit values of the developed scale are above acceptable limits.

Reliability is defined as how accurately the measurement tool measures the feature it is intended to measure and its ability to provide consistent measurement results. Two basic criteria are required for the reliability of a measurement tool. The first one is explained as consistency between the answers obtained at the same time. For this purpose, the reliability coefficient Cronbach alpha is used, and it is desired that the Cronbach alpha value be above 0.60. The second criterion for reliability is consistency between the answers obtained at different times (8).

In the study, it was found that the scale Cronbach's alpha value was 0.879 and there was a very high correlation (r=0.925) in the test-retest score results and that there was no difference between the test-retest scores of each scale item. A statistically significant difference was found between the lower and upper groups.

In addition, it is reported that the item-total score correlation is important in order to show the relationship between the scores obtained from the test items and the total score of the test, and that this correlation is positive and high (above 0.20), indicating that the items exemplify similar behaviors and the

internal consistency of the test is high (22). The item-total score correlation coefficients of the scale ranged between 0.200 and 0.701. The absence of a negative result indicates that it is reliable.

In the study, a statistically significant relationship was found between occupational group and scale scores. It was seen that this relationship originated between physicians and the midwife/nurse professional group. There is not enough information in the literature about this difference. It can be thought that possible reasons such as education, professional ethics, and scientific perspective cause this result.

Three items with high xenophobia scores were identified. These; "I have difficulty communicating when providing health care to immigrants", "The spread of infectious diseases increases due to immigrants" and "It increases health costs". The most important factor affecting understanding the patient and diagnosis and treatment is communication between the patient and the physician. The main factor in ensuring this communication is to use the same language. In addition, because immigrants come from different countries, they are considered likely to have incomplete vaccinations, have low health literacy, and uncontrolled admission to health services and increase infectious diseases due to cultural and ethnic differences. In the study conducted by Başaran and Saylıgil, similar opinions of physicians were reported regarding communication and health costs (11).

The expressions "All patients, whether immigrants or not, should be treated equally", "Equitably benefiting from health services in our country is a right that arises only from being human", "Dissatisfaction with working conditions cannot be an excuse for not treating immigrants well" were determined as expressions with low xenophobia scores. Considering the deontological approach of healthcare professionals to patients, they should treat all patients equally. In addition, differences in the provision of health services due to economic, political, ethnic and social reasons lead to inequality in health. To avoid this situation, health policies should be organized and presented in a way that is in favor of those who provide and receive health services. The environments in which people live are important for their health and well-being. For this reason, it is important to provide migration health services tailored to the needs of different groups. Migration health is affected by decision-making mechanisms at varying levels. It is crucial that the ethical challenges and xenophobic attitudes faced by decision makers are recognized and addressed. Adopting an ethical approach to migration health will benefit governments, policy makers, healthcare professionals and migrants (11, 23).

Conclusions

As a result, although it has been proven that the scale can be used as a valid and reliable scale in Turkish society and culture, it can be said that it would be beneficial to apply it in larger and different sample groups. Studies on measuring xenophobia in healthcare workers are very rare in our country. Increasing these studies will shed light on the policies to be followed regarding immigrant health. In addition, the use of a standard scale that determines this attitude will facilitate the evaluation of researchers and decision makers.

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Annex. XHCD scale final version.

	SAĞLIK HİZMETİ SUNUMUNDA ZENOFOBİ ÖLÇEĞİ	Hiç katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle katılıyorum
1	Göçmenlere sağlık hizmeti sunarken kendimi daha az güvende hissederim.					
2	Göçmenlere sağlık hizmeti sunarken iletişim kurmakta zorlanırım.					
3	Eğer tercih hakkım olsaydı göçmenlere sağlık hizmeti sunmak istemezdim.					
4	Göçmenler nedeniyle vatandaşlarımızın sağlık hizmetlerine erişimi olumsuz etkilenmektedir.					
5	Göçmenler nedeniyle sağlıkta şiddet artmaktadır.					
6	Göçmen olsun veya olmasın tüm hastalara eşit davranılmalıdır.					
7	Göçmenlerin, vatandaşlarımıza göre kişi başı poliklinik başvurusu daha fazladır ve sağlık hizmetlerinin yükünü artırmaktadır.					
8	Göçmenler sağlık maliyetlerini artırmaktadır.					
9	Göçmenlerdeki yüksek doğum oranları sağlık hizmetlerinin sunumunu olumsuz etkilemektedir.					
10	Ülkemizde sağlık hizmetlerinden hakkaniyetli bir şekilde faydalanmak, sadece insan olmaktan kaynaklanan bir haktır.					
11	Göçmenlere verilecek sağlık hizmetleri ücretli olmalıdır.					
12	Göçmenler nedeniyle aşı ile önlenebilir bulaşıcı hastalıkların yayılması kolaylaşmaktadır.					
13	Göçmelerin sağlık hizmetlerine erişimi, kendi vatandaşlarımız ile eşit olmamalı, gerekli durumlarda kısıtlanmalıdır.					
14	Çalışma koşullarından memnuniyetsizlik, göçmenlere iyi davranmamak için mazeret olamaz.					
15	Kendi vatandaşlarımız hastane randevusu bulmakta zorlanırken, göçmenlerin sağlık hizmetlerine kolay erişmesi doğru değildir.					
16	Göçmen hastalara nasıl yaklaşılması gerektiği konusunda sağlık personeline eğitim verilmelidir.					