Community Context in Cultural Competence: Moving towards Community Cultural Competence

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Acknowledgements

This work was supported by the Ministry of Science and Innovation of the Spanish Government, within the framework of the project entitled "Community Cultural Competence: Competent Professionals in Diverse Communities" [PP2015-4129].

Declaration of interest: None.

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Abstract

Addressing the complex needs of migrants and ethnic minorities is a challenge for host communities, where the cultural competence of service providers is considered an important asset for combating inequities and for encouraging well-being. However, efforts focused on promoting cultural competence have not been very effective in generating real changes to professional practice, organizations and/or communities. Current models of cultural competence are primarily centered on the personal capabilities of professionals and on organizational standards, overlooking their interdependence with community contexts. To address these challenges, this study introduces the community psychology approach and explores the concept of Community Cultural Competence (CCC) as a way of including the community context in cultural competence frameworks and using it to promote migrant and ethnic minority health equity. CCC is defined as a multilevel and multidimensional process of personal development that implies the acquisition of critical awareness, responsiveness to diversity, capacity to act within the organization, and capacity to act within the community. These competences strengthen the effectiveness and influence of providers across different levels or work environments—i.e., intrapersonal, interpersonal, organizational, and community. This paper describes a mixed-method study carried out in southern Spain in three different contexts (i.e., reception, transition and settlement contexts). Data collection involved a questionnaire administered to 525 community service providers. The results were shared in community forums attended by multiple agents, who put forth recommendations for interpreting the results and transferring them to local actions. Major theoretical contributions and suggestions for improving CCC are discussed.

Key words: Community Cultural Competence, equity, context, service provider, community psychology, mixed-method.

Introduction

Complex European migration flows have led to a call for responsive health systems (Pottie et al., 2017). This challenge has redirected attention to the cultural competence of health and social care staff, given its positive impact on migrant well-being (Paloma, García-Ramírez, & Camacho, 2014; Rechel, 2011). The concept became popular in the 1960s-1970s, within the framework of the African-American civil rights movement. It was originally developed in order to increase health professionals' capacity to reduce the cultural gap between them and users from different backgrounds. Cultural competence could be defined as the knowledge, attitudes and abilities that enable providers to work effectively in culturally diverse contexts (Campinha-Bacote, 2002; Sue, Arredondo, & McDavis, 1992).

Several authors have pointed out that the traditional conceptualization of cultural competence oversimplifies health users' needs, often ignoring the complexity of social reality and the impact behind the social determinants of health (Marmot, 2007; Ridley, Baker, & Hill, 2001; Weaver, 2008). Essentially, emphasis was placed on ensuring that professionals were trained up and that healthcare services were adapted to meet the medical needs of ethnic minorities in health-related contexts (e.g., medicine, nursing, counselling), yet disregarding a broad, inclusive approach which encompasses the social determinants of health. Ottersen et al. (2014) have argued that "we must acknowledge the need for a global cross-sectoral action and justice in our efforts to address health inequity". Thus, the present study extends the analysis of cultural competence to include community services as health services.

Community services is an umbrella term used to refer to any community-based resource aimed at securing the local population's well-being and health. This covers health education, the promotion of healthy environments, decent housing conditions, employment and access to a sufficient level of income, safety and protection, spiritual support and citizen engagement. Community services are at the forefront of the response to migrant and minority needs, irrespective of legal status, administrative situation, or length of stay (Permanand, Krasnik, Kluge, & McKee, 2016). Community service providers (hereinafter, *providers*) play a crucial,

active role in this response. We use this term to refer to those people who work either contractually or voluntarily in community service settings to improve the health of their users and communities—e.g., health and education staff, NGO volunteers, association leaders, and religious leaders.

In response to recent mixed migration flows, many 'developed' countries have increased restrictive policies against migrants and other ethnic minorities—with actions like cutting the entitlement for some groups—and have reduced financial support and resources for community services (Ingleby, 2012). This situation along with the effects of austerity policies introduced in many European countries, like Spain, places most migrants and ethnic minorities in a situation of extreme vulnerability. They tend to settle into socially segregated areas which hinder their incorporation into mainstream society—limiting their capacity to learn the language and actively participate in the community—and they often remain unemployed or work under very precarious and unhealthy conditions (Carr, 2010; Hernandez-Plaza, Garcia-Ramirez, Camacho, & Paloma, 2010).

According to the IOM (2016), mixed migration flows demand an in-depth analysis of their implications for host societies, which are impelled to adapt their policies, structures and services to diversity in the population, focusing on the reduction of inequities in health (Ingleby, 2012). Providers play a crucial role in addressing these issues by (a) highlighting and advocating for the rights of minorities; (b) empowering minorities and creating opportunities for their sociopolitical participation; (c) building networks and injecting social capital into communities; and (d) ensuring accountability for policy implementation (Bishop, Vicary, Browne, & Guard, 2009).

With this in mind, the study aim is to redefine the cultural competence of providers, prioritizing the role played by contextual factors in the analysis of cultural competence, which is key to achieving health equity and guaranteeing the rights of migrants and ethnic minorities (Balcazar, Suarez-Balcazar, Willis, & Alvarado, 2010; Rechel, 2011).

Theoretical Background: Beyond Cultural Competence

Despite the vast literature on cultural competence—see the reviews developed by Balcazar et al. (2009) and Alizadeh and Chavan (2016)—a commonly accepted definition has yet to be established. One of the most popular definitions was proposed by Campinha-Bacote (1999): "a process in which the provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family or community" (p. 203). This process enables people to understand and appreciate differences, to recognize and respect variations that occur within cultural groups, and to adjust their practices to the needs of people from various cultures.

Cultural competence has been primarily formed by two concepts: culture and competence. "Culture" is usually linked to ethnicity, nationality or country of origin, categorizing users according to their origin or color. This has been criticized by many authors because of its reductionist nature, which ignores not only the multiple dimensions and diversity of identities that are implicit in every culture, but also the contextual determinants associated with the country of origin (Balcazar et al., 2010; Owiti et al., 2014; Weaver, 2008). On the other hand, "competence" is understood as the trainable capability of providers and organizations, recommending a series of 'do's and don'ts' that define how we respond to migrants and ethnic minorities' needs (Abe, 2012).

Many theoretical frameworks place the responsibility of providing culturally competent service provision upon professionals. Quite a few models have proposed that cultural competence comprises cognitive, affective/attitudinal, and behavioral components. The cognitive component—i.e., knowledge and critical awareness—refers to the way in which people perceive the world, themselves, and service users (Campinha-Bacote, 1999). The affective/attitudinal component refers to feelings and emotional tendencies toward migrants; it includes a sense of cultural humility, cultural sensitivity, and/or ethnocultural empathy (Arasaratnam, 2006; Papadopoulos & Lees, 2002). The behavioral component encompasses

communication skills, including the appropriate use of translators or making materials and instructions available in the recipient's preferred language (Kupka & Everett, 2007; Steenbarger, 1993); flexibility and adaptability to cross-cultural situations (Moffit & Wuest, 2002; Poole, 1998; Suh, 2004); and effective participation in intercultural encounters (Campinha-Bacotte, 2002; Kupka & Everett, 2007; Overall, 2009).

Subsequently, models and guidelines for implementing cultural competence at an organizational level have emerged. A good example is the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in U.S. Health and Health Care, whose principal standard is to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." (U.S. Department of Health and Human Services, 2013). However, these models have also been a source of criticism. They have not been able to override the "culturalist" concept of earlier models, nor have they delved into the social nature of the health inequities that ethnic minorities experience (Cattacin et al., 2013). This limitation becomes more evident as we struggle to see any models striving to incorporate and address the interdependence of professionals and their organizations with the community contexts in which the social reality of their services' users play out (Balcázar et al., 2009; Hernández et al., 2009; Abe, 2012).

The *community context* epitomizes the social reality faced by ethnic minorities, because it is the physical and sociocultural environment which paints a picture of their lives. It determines the rules governing civil coexistence, the chance to share their values and traditions, to rebuild their social networks and social capital, and the opportunities for inclusion in the labor market (Hernandez-Plaza et al., 2010). The community context is also a space that casts light on the public policies important to the lives of its citizens. Migrant persons and those belonging to minority groups with limited political rights are highly dependent on their

local settings, key determinants when it comes to accessing community-based services that look after and promote their health.

A few authors have highlighted the importance of the social context as a core component of cultural competence. According to Overall (2009), the environmental domain encompasses knowledge of the community's languages and dialects, local transportation, home mobility, safety issues, and the housing conditions of service users. Hernandez et al. (2009) also view the community context domain as a central dimension of cultural competence, emphasizing the role that ethnic and racial differences play in service delivery. Although these models contribute significantly to the importance of the social context in cultural competence conceptualizations, more research is needed to address the dynamic interdependence between community contexts and other impactful components. These include access to political leaders, participation in community-based activities, establishing trust, and building familiarity with gatekeepers of migrants and ethnic minority groups. Furthermore, strong empirical support for the community context as a key dimension of cultural competence is warranted.

This study aims to build on this direction, proposing and testing the concept of Community Cultural Competence (CCC), considered not only a learning process for developing the capability of providers to reduce the cultural gap, but also as a way of gaining power to facilitate changes toward equity at intrapersonal, interpersonal, organizational, and community levels. This perspective could advance our understanding and transformation of professional practices, as well as those of the organizations, communities, and policies underpinning them (Council of Europe, 2011; Seeleman, Essink-Bot, Stronks, & Ingleby, 2015).

Community Cultural Competence

We define *Community Cultural Competence* (CCC) as a multilevel and multidimensional process through which providers acquire capacities and create opportunities that allow them to effectively operate across different work contexts (i.e., intrapersonal,

interpersonal, organizational, and community). CCC is multidimensional because it refers to several distinct but related dimensions treated as a single theoretical concept (Edwards, 2001), and it is multilevel because these dimensions operate across different levels/contexts (Snijders & Bosker, 2011). As Figure 1 illustrates, the CCC model is made up of four dimensions: critical awareness, responsiveness to diversity, capacity to act within the organization and capacity to act within the community.

Insert Figure 1 about here

On an intrapersonal level, *critical awareness* permits providers to gradually decode their own sociocultural background and that of their users, analyzing the differences and respecting them. Similarly, it encourages ethnocultural empathy (Rasoal, Eklund, & Hansen, 2011), which enables providers to maintain a willingness to challenge what they know about a user based on generalizations about his or her culture, and to better understand their circumstances. Critical awareness seeks to overcome the limitations of knowledge provision-based models which often stereotype users and misattribute cultural reasons to their problems, instead of acknowledging that they may be linked to social inequality (Napier et al., 2014). Critical awareness helps providers to gain a deep understanding of the health inequities that ethnic minorities experience, so that they can guide users on how to address them at their sociopolitical roots.

To be effective on an interpersonal level, providers must develop *responsiveness to diversity*. This includes cultural sensitivity and communication abilities (i.e., patterns for decoding verbal and nonverbal communication, managing different communication styles, and active listening), thus allowing them to adapt their professional practices to the reality of their users. These skills also enable them to collaborate with other community providers, mediators, and community gatekeepers. Through the development of skills, providers can build new

professional roles (e.g., counseling, mediation, advocacy) to protect their own well-being and to increase their influence with respect to their own professional practice, becoming more autonomous and effective (Spreitzer, 1997). Moreover, these skills can place providers and users in a mutually beneficial relationship that seeks to diminish power asymmetries.

Capacity to act within the organization is about acquiring the skills to successfully respond to one's daily work demands at an organizational level. It is crucial for providers to receive appropriate organizational support in terms of available information, resources and training in order to manage diversity. Greater capacity to act within the organization implies increased autonomy and opportunities to influence at organizational level and making organizations less biased toward immigrant consumers (Balcazar et al., 2009). It can empower not only providers, but also users and their communities (Maton, 2008).

Capacity to act within the community implies being embedded into the users' community. To this end, it is necessary for providers to become acquainted with the available community resources and gatekeepers. In addition, it involves developing a deeper knowledge and familiarity with the target community and capacity to mobilize resources in both the organizational and community contexts. From this perspective, providers should influence policies and practices to meet the needs posed by cultural diversity, playing an important role in empowering users to become multicultural citizens capable of transforming the contexts in which they live.

Consequently, providers not only gain the capacity to be effective, but they also adopt a reflective and ethical stance which facilitates their empowerment in their work. As they develop CCC, they become agents who can defend equity and well-being in their operational contexts. Hence, by boosting their CCC, providers increase their positive impact on the work contexts in which they act: their own professional practices, their organizations and their communities.

Objectives and study design

In order to provide empirical evidence to support this proposal, we developed an explanatory sequential mixed-method design, which involves a two-phase research approach (Creswell, 2014). During the second phase, the qualitative data gave feedback, expanded and helped to provide more insight into the quantitative data collected in the first phase.

First, the quantitative phase—based on questionnaires—had two objectives. On the one hand, to determine if the CCC of providers is a multilevel and multidimensional construct comprising critical awareness, responsiveness to diversity, capacity to act within the organization, and capacity to act within the community; and on the other hand, to explore whether the providers' CCC has a positive impact on their work contexts. Specifically, we hypothesize that (a) critical awareness and responsiveness to diversity will have a positive impact on providers' professional practices at an individual level; (b) capacity to act within the organization will make their work more effective at an organizational level; and (c) capacity to act within the community will make their work more effective at a community level.

Second, the qualitative phase—based on community forums—was carried out in order to understand quantitative data implications at a local level and to develop action guidelines that facilitate their transfer to local initiatives. Both studies are presented below, detailing the methods and results. Lastly, we discuss the findings and draw some final conclusions.

Quantitative phase

Method

Settings and Participants

The study was carried out in Andalusia, Southern Spain, where foreigners represented 7.6% of the registered population (Observatorio Permanente Andaluz de las Migraciones, 2015). We used a Geographic Information System (through the ArcGis software, version 9.2) to identify and map out communities of Andalusia that represent diverse contexts. This system is capable of capturing significant visual information about the distribution of the different communities, taking into consideration some specific criteria (Luke, 2005). In this case, we

included: (1) the existence of a high proportion of migrants; (2) settings which characterized different phases of the migration process (i.e., reception, transition and settlement contexts); (3) settings which represent the different types of geographic enclaves (i.e., urban, rural, and border areas); and (4) the presence of contextual vulnerability indicators (i.e., poverty, unemployment, poor living conditions, and geographic exclusion).

In particular, we selected Algeciras as the reception border context, the area of Moguer and Palos de la Frontera (Huelva) as the transition rural context, and the district of Macarena in the city of Seville as the settlement urban context. In each context, 15 organizations that offered different community services were identified (i.e., education, health, community-based organizations and NGOs, socio-occupational services, law enforcement, and faith-based services) with the help of cultural brokers and community leaders as well as observations in situ. A total of 41 organizations agreed to participate (4 refused), with which collaboration agreements were established.

Finally, within those organizations, we requested the involvement of the providers and 525 voluntarily agreed to participate. Half of the sample was female (52.2%) and up to 67.1% of the people in the sample were 31-50 years old, 22.4% were aged over 50, and 11.5% were less than 30 years old. They worked in their current organization for an average of 12.9 years (SD 10.29; range: less than 1 year to 54 years). Participants belonged to law enforcement (n=163), education (n=123), community-based organizations and NGOs (n=86), healthcare (n=75), socio-occupational services (n=58), and faith-based services (n=20). In terms of educational attainment, 1.4% had no education, 8.5% had a primary education, 39.8% had a high-school education, and 60.3 % had a higher education.

Instruments

To measure CCC, we designed an ad hoc instrument, following the recommendations made by Clark and Watson (1995). First, literature findings were analyzed to determine the dimensions of CCC. Second, we identified and developed items to measure each dimension.

Several items were adapted from the *Cultural Competence Assessment Instrument* (CCAI; Suarez-Balcazar, et al., 2011). Third, a panel of experts—from academia and the community—reviewed the original questionnaire and selected the most culturally appropriate and conceptually relevant items. This panel helped us to acquire external consensus about the operational definition underlying the test is congruent with prevailing notions of the domain, which could be interpreted as validity based on test content evidence (AERA, APA & NCME (2014). Fourth, we conducted a pilot study at two organizations from a rural area and two from an urban area. Consequently, some items were modified and others were eliminated, resulting in a 14-item instrument assessed on a 5-point Likert-type scale ranging from 1 ("strongly disagree") to 5 ("strongly agree").

To measure the *influence on the work contexts*, we also designed an ad hoc instrument based on the Scale of Psychological Empowerment in the Workplace developed by Spreitzer (1995) in its Spanish adaptation (Albar, Garcia-Ramirez, Lopez & Garrido, 2012). The items measure different levels (individual, organizational, and community) and are rated on a 5-point Likert-type scale. The alpha coefficient of the designed instrument was $\alpha = .83$.

Items used in the questionnaire are presented in Table 1. The questionnaire also included socio-demographic and occupational questions that asked participants to indicate their gender, range of age, educational attainment, and their experience within the organization.

Insert Table 1 about here

Data collection and analysis

Data collection was carried out from March 2014 to June 2015. Community agents—representatives from providers and users—were invited to join the research team during the entire research process in order to (a) ensure the cultural validity of the model and the

methodological process; (b) identify and select organizations in each enclave; and (c) facilitate the recruitment of participants and data collection.

The questionnaires were completed individually—after participants signed an informed consent—and anonymously, without any incidents. Each participant could choose the time and place where the questionnaire was to be completed (i.e., at the organization, at home).

Quantitative data analyses were conducted using the statistical package *SPSS* version 15.0 and *Mplus7*. Quantitative data analyses were guided by the *Standards for Educational and Psychological Testing* (AERA, APA & NCME, 2014). Evidence validity based on the internal structure of CCC was obtained through a confirmatory factor analysis. The relationship between CCC and the perceived influence of the contexts of work was obtained by running a structural equation model. These types of analyses are often used to assess unobservable latent constructs through one or more observed variables (items), allowing multiple indicators of latent constructs and reliability and validity estimation (Bollen & Long, 1993). Results were interpreted using the 2-index strategy proposed by Hu and Bentler (1999): (1) the RMSA (*Root Mean Square Error of Approximation*), appropriate when equal or inferior to 0.08; and (2) the CFI (*Comparative Fit Index*), appropriate when equal to or higher than 0.90. Additionally, we interpreted the $\chi 2$ test to evaluate the overall model fit. It is appropriate when statistically significant ($p<0.05$) and when the $\chi 2/df$ is inferior to 3 (Hu & Bentler, 1999).

Results

The nature of CCC as a multidimensional and multilevel construct

In order to better understand the nature of the construct, descriptive statistics, reliability and correlations of the CCC dimensions are presented in Table 2. The four dimensions obtained high or medium mean scores; responsiveness to diversity had the highest average, and those dimensions related to the capacity to act within contexts obtained lower scores. Moreover, all dimensions were correlated to each other ($p<.001$) and reliability calculations revealed high internal consistency for all dimensions (Alpha Cronbach >.70).

Insert Table 2 about here

To determine the degree to which the theoretical model fits the data, a confirmatory factor analysis (CFA) was developed. The results support our hypothesis by which CCC is a first-order model comprising four interconnected dimensions: (a) critical awareness; (b) responsiveness to diversity; (c) capacity to act within the organization; and (d) capacity to act within the community. Figure 2 shows the dimensions of CCC and their correlations, which were statistically significant ($p<.05$). The figure also illustrates the factorial structure of this model, where standardized weights are detailed for each item in each dimension. All of them are higher than .50 and statistically significant ($p<.001$). Indices of fit are presented on the bottom part of Figure 2. It should be noted that we assumed correlation between two items from responsiveness to diversity (HH1 and HH2) due to a high error covariance. The results show a stronger relationship between critical awareness and responsiveness to diversity on the one hand, and between capacity to act within the organization and capacity to act within the community on the other. Adopting a multilevel perspective, there are stronger relationships between the more proximal dimensions at the levels.

Insert Figure 2 about here

The relationship between providers' CCC and their influence on the work contexts

For the second objective, a structural equation model was conducted to test the impact of the providers' CCC dimensions on their influence on the work contexts. Figure 3 illustrates the model and fit index. The results show that some CCC dimensions have a positive and significant impact: providers' responsiveness to diversity positively influenced their own practice, and the capacity to act within the community had a positive impact on both

organizational and community influence. It seems that the dimensions which had an influence on the work contexts were those that emerge when providers have a direct relationship with users (responsiveness to diversity) or with the community (capacity to act within the community). These results partially support our hypothesis, and highlight the importance of the community-level dimensions.

Insert Figure 3 about here

Qualitative phase

Method

Contexts and Participants

The results of the quantitative study were shared at three community forums held across all three contexts where the studies took place, in order to facilitate their interpretation, dissemination and applicability to the local communities (Becker, Harris, McLaughlin, & Nielsen, 2003). A total of 36 community agents participated, 12 in the transition rural context (Huelva), 17 in the settlement urban context (Seville), and 7 in the reception border context (Algeciras). Their roles covered providers, autochthonous and migrant users, political leaders and researchers. They were mainly women (24/36) and their age ranged from 20 to 65 years.

Data collection and analysis

The community forums followed the same structure in all contexts, following a four-step process, adapted by Becker et al. (2003): (1) welcome and explanation of the common goal; (2) presentation of the CCC concept and the main local results; (3) small groups discussions about the results and development of guidelines for improving the providers' CCC at a local level; and (4) a common joint selection of the best guidelines and the conclusions. The detailed procedure is presented in the Table 3.

Insert Table 3 about here

The information collected during the community forums was summarized by the researchers in order to achieve a unique compendium of recommendations, but they always maintained the participants' structure and words.

Community forums' recommendations for amplifying the impact of CCC and transferring results to local actions

The summary of the main suggestions and guidelines for action is presented in Table 4—indicating the popularity of the guidelines. In general, community agents highlighted the need to develop critical awareness and to improve cultural humility and flexibility among providers. They pointed out the importance of cultural competence trainings, aimed at identifying the rights and realities of migrant populations, and also to remove their own prejudices and reflect upon structural and institutional racism. At an organizational level, they denounced the shortage of resources and the need to adapt services to the real situation faced by migrants and providers. They asked for more organizational support, such as training courses and extra services (e.g., cultural mediators). Finally, at a community level, they proposed to improve the coordination and community embedding of providers, and to also increase the participation of migrants within their local organizations and the development of their own socio-political agenda. Additionally, the participants recognized the privileged position of the community-based organizations (i.e., NGOs, cultural and citizen associations) regarding the task of identification migrant and ethnic minorities' needs and addressing them.

Insert Table 4 about here

Discussion

This article redefines cultural competence of community service providers as a multilevel and multidimensional construct, which includes their organizational and community interdependence. Adopting a community psychology approach and a mixed-method design, we offer empirical support for *community cultural competence* (CCC), comprising four interconnected dimensions: (a) critical awareness; (b) responsiveness to diversity; (c) capacity to act within the organization; and (d) capacity to act within the community. These results support the nature of cultural competence as a first-order construct, shedding light on their internal structure (Suarez-Balcazar et al., 2014; Abe, 2012). According to Edwards (2001), clarifying the nature of multidimensional constructs is a critical step towards greater theoretical and empirical precision.

Moreover, this study shows that some dimensions of providers' CCC have a positive impact on their influence on the work contexts. At an individual level, responsiveness to diversity can have a positive impact on the providers' own practice. This coincides with the results obtained in studies on psychological empowerment in workplaces, which showed that improving work skills makes professionals develop greater control of their work, self-determination, and self-efficacy (Laschinger & Leiter, 2006). They also acquire a more positive assessment of their daily work and the impact they can generate in the local community (Conger & Kanungo, 1988).

Nevertheless, contrary to what we hypothesized, the structural equation model did not show providers' critical awareness as having an impact on their practice. This could be explained by drawing on a traditional critique of cultural competence training based on cognitive elements, which maintains that cognitive changes are not usually transferred to behavioral changes (Beach et al., 2005; Weaver, 2008), especially when the contexts of work do not offer support for it (Cattacin et al., 2013). Community forums shed light on this issue. The participants considered critical awareness an indispensable element of CCC, but

underlined the importance of receiving support from organizations and communities to develop and implement it in their practice. Otherwise, critical awareness could act as a risk factor, leading to burnout among professionals.

At an organizational level, the quantitative results also indicated that the capacity to act within the organization had no impact on providers' influence in their organizations. Information provided during the forums could help us understand these results. Participants noted that organizations do not empower their professionals; some participants even complained that organizations—and the policies that guide them—contribute to alienating them, maintaining the status quo and the inequities that affect migrants. However, some participants indicated that organizations sometimes influence the well-being of providers, which could have a positive impact on their performance. These results are consistent with several studies that have shown how the capacity to act within organizations serve as a protective factor against burnout, anxiety or depression-related symptoms (Bennett, Lowe, Matthews, Dourali, & Tattersall, 2001). Future research should explore these relationships, which may have a mediating effect on the relationship between the capacity to act within organizations and the providers' organizational influence.

Finally, the capacity to act within the community had a positive impact on providers' influence on both the organization and the community. These results, which were also supported by the forum discussions, underline the importance of working closely with gatekeepers so as to generate more impact on the local contexts (Suarez-Balcazar & Tayler-Ritzler, 2014; Vera & Speight, 2003). Becoming embedded in the community offers providers increased knowledge about the real needs and strengths of the community, and about other resources and possible collaborations they can pursue in order to increase the impact of their actions. By enhancing their capacity to act within the community, providers can exert a greater influence on community leaders, as well as on current and potential users.

This study has covered different types of community services, which is an innovation in research on cultural competence. It has allowed us to address cultural competence from a social determinants approach, encompassing healthcare, education, socio-occupational services, law enforcement forces, community-based organizations, and faith-based services. During the community forums, participants highlighted the privileged position of the community-based organizations, such as NGOs and citizen associations, into addressing the social determinants of health. Community-based organizations act as a bridge between the population and other entities, helping to enhance community engagement, especially for excluded populations (Wilson, Lavis, & Guta, 2012). In this case, the existence of migrant organizations is an indicator of empowerment (Paloma, García-Ramírez, De la Mata, & AMAL, 2010), because they seek to address their own needs, preserving their culture of origin or religion and/or promoting their social participation.

Applications and transferences

This study generates some guidelines for designing actions that take into account the community context at different levels and guides cultural competence towards promoting equity, as previously recommended by several authors (e.g., Ivey & Collins, 2003; Nassar-McMillan, 2014; Vera & Speight, 2003). One of the most obvious applications of this model is the development of training programs for providers. We propose that CCC training should be based on capacity-building principles (Suarez-Balcazar & Taylor-Ritzler, 2014). It should focus on reinforcing the strengths and assets of an organization, its professionals and the community where they are located, taking into account their social, historical, economic and political contexts. These training programs can utilize a contextually based approach which promotes empowerment, while enhancing competencies that are absent or low.

However, although this CCC model is focused on providers, its nature can allow researchers to anticipate which organizational characteristics should change in order to promote CCC among staff. This issue was discussed at length during the community forums,

establishing that providers with high CCC levels will be able to bring about change to their organizational structures to achieve: (a) a multicultural mission; (b) greater user accessibility; (c) increased user participation and empowerment; (d) the adaptation of services to the reality of users and providers; and (e) the promotion of changes focused on equity. These findings are in line with studies on equity standards for health and social care for migrants and ethnic minorities (Cattacin et al., 2013; U.S. Department of Health and Human Services, 2013). They also reinforce the proposal put forward by Maton (2008), presenting organizations as *empowering community settings*. These settings can act as bridges between users and communities, protecting their well-being and empowering them (Paloma et al., 2010). Consequently, there should be a balance between providers' empowerment and their organizations in order to take advantage of the best characteristics that can have a positive impact on the service users and their communities.

Research limitations and directions for future research

There are several limitations that should be considered when examining the findings from this study. First, the sampling was not random. However, we followed a strategy based on several steps with an aim to recruit a diverse sample of service providers. Therefore, although the sample was not statistically representative, it can be considered representative of the diversity of contexts in which providers offer services in Andalusia. Furthermore, the target population of providers from the Spanish region of Andalusia may not be representative of other populations (Hughes, Seidman, & Williams 1993). This is a region that boasts a unique cultural history and which attracts a large number of migrants every year because of its location in the southern region of Spain and its proximity to North Africa. Consequently, many service providers have been exposed to migrants (mainly, Africans) for many years, particularly in rural and border areas. This situation could be quite different from other countries and regions, although current migration patterns around most developed countries have increased significantly during the last few years due to war and/or climate change.

Second, there are limitations associated with the self-administered instrument (Gozu et al., 2007; Shen, 2015), as the respondents may have shown some bias, such as the tendency to overestimate their own cultural competence capacities at baseline. In addition, social desirability control measures (Huang, Liao, & Chang, 1998) were not collected. This decision was taken intentionally during the development phase of the questionnaire, along with community agents, aimed at reducing the number of items and time required to complete the survey.

Third, the quantitative survey only included providers at front line level; however policy-makers, managers and other top organizational positions were not included. Although one of our objectives was to prove if competent providers could have a real influence in transforming organizational equity-cultural standards, that limited the scope of our results and thus future researches should include them. This will allow understanding what kind of leaders could promote a better engagement of providers in transforming organizations and also what kind of strategies are more suitable to promote providers as a link between communities and organizations.

Lastly but not least, another limitation of this study—shared by the majority of research on cultural competence—is that objective indicators were not included to measure the real impact of CCC. However, the perception of influence on the work contexts was included in the analysis, which, given the limited scope of a cross-sectional study to capture community complexities and organizational changes, may be a suitable approach for exploring the impact of CCC at this level. As suggested by many authors (Alizadeh & Chavan, 2016; Beach et al., 2005; Renzaho et al., 2013), future research should include objective variables related to organizational changes (i.e., increased efficiency in the operation of services, increased satisfaction toward services, etc.) and communities (i.e., increased health, equity, and empowerment). These measures could reinforce the perspective of people-in-context (Trickett,

2009), and could allow researchers to make multilevel analyses that provide a more complete and realistic understanding of the impact behind interventions (Snijders & Bosker, 2011).

Conclusions

This study reviews the multidimensional and multilevel nature of the cultural competence construct, exploring interdependence between providers, their organizations, and the communities they serve. Our study contributes to breaking down the close link between culture and cultural competence, adopting an equity-driven approach based on the social determinants of health. From this perspective, the conditions of inequity that afflict migrant groups and ethnic minorities call for a focus on competence across all domains that determine the health of these populations, addressing it from different community services—going beyond healthcare services (Society for Community Research and Action, 2016; Sorensen et al., 2019). This perspective is particularly relevant when it comes to tackling the challenges that new and complex migration flows pose, not to mention the humanitarian crises which are breaking out at border areas and in transition and settlement contexts. As Knipper (2016) enounced: “States are obliged to ‘respect, protect and fulfil’ the ‘highest attainable standard of health’ based on the assumption that health depends on determinants beyond the control of the individual (e.g. social, economic, and political)”. Many professionals and organizations are trying to do the best they can, despite the difficulties and frustration they are experiencing because of a lack of resources to cope with the growing demand and because of policies in place that violate the rights of minority groups—e.g., blocking or restricting access to services that rightfully belong to them. To address such inequalities, the inclusion of the community context in the cultural competence equation allows us to frame it as a question of social justice.

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Table 1.
Descriptive Statistics of the items used in the questionnaire

Items used to measure CCC			
Dimensions	Items	Mean	SD
Critical awareness	CC1. I think it's important for a provider like me to know how to differentiate between the sociocultural groups that exist in the neighborhood.	3.98	0.92
	CC2. We as providers must be effective at promoting services for all people, regardless of their sociopolitical status, ethnicity or background.	4.23	0.81
	CC3. I show my appreciation for their cultural norms when I interact with people of another ethnic origin or sociocultural background.	4.06	0.82
	CC4. I am sensitive to valuing and respecting the differences between my cultural environment and that of immigrant users or those belonging to ethnic minorities.	4.14	0.74
Responsiveness to diversity	HH1. I am competent working with immigrants or persons belonging to ethnic minorities.	4.19	0.70
	HH2. I am effective when communicating with immigrants or persons belonging to ethnic minorities.	4.06	0.79
	HH3. My cultural sensitivity comes across in the way I work.	4.03	0.79
	HH4. I can adapt my work to the needs of immigrants or persons belonging to ethnic minorities.	4.05	0.80
Capacity to act within the organization	CAO1. My organization provides me with adequate training to work competently with immigrants or persons belonging to ethnic minorities.	3.26	1.19
	CAO2. In my organization I have access to interpreters when the user speaks a language I don't understand well.	2.92	1.44
	CAO3. In my organization I have up-to-date information (demographic, cultural, and epidemiological) about the population I work with.	2.67	1.25
Capacity to act within the community	CAC1. I have access to political leaders from whom I can request the necessary resources to develop community-based programs.	2.05	1.11
	CAC2. I participate in the community-based activities held in the neighborhood where I work (parties, gatherings, etc.).	2.60	1.24
	CAC3. I know most people who work to improve the neighborhood where I work (professionals, community leaders, gatekeepers).	2.69	1.21
Items used to measure Influence on the work contexts			
Dimensions	Items	Mean	SD
Individual influence	EI1. The work I do is important to me.	4.60	.61
	EI2. I have the specialized skills necessary to carry out my work.	4.37	.62
	EI3. I can decide for myself how to do my job.	3.99	.92
Organizational influence	EO1. The work I do is important to the running of my organization.	4.19	.80
	EO2. I have enough influence over what goes on in my organization.	3.26	1.06
	EO3. My work helps to transform my organization.	3.48	1.01
Community influence	EC1. My work is important to the running of this neighborhood.	3.81	.97
	EC2. I have influence over what goes on in this neighborhood.	2.87	1.09
	EC3. My work helps to transform this neighborhood.	3.21	1.07

1

Table 2.
Descriptive Statistics, Reliability and Correlations Among Community Cultural Competence Dimensions

Factors	Mean (SD)	# ítems	Alpha Cronbach	Correlations			
				CA	RD	CAO	CAC
Critical Awareness (CA)	4.132 (0.610)	4	.715	1	.469**	.182**	.144**
Responsiveness to diversity (RD)	4.076 (0.682)	4	.849		1	.364**	.182**
Capacity to act within the organization (CAO)	2.976 (1.072)	3	.741			1	.400**
Capacity to act within the community (CAC)	2.442 (0.973)	3	.742				1

**p< .001.

Table 3.
Four-step process of the community forums

Step 1	Participants were welcomed and informed about the objectives of the community forum (giving verbal consent): (1) to offer feedback on the CCC concept; (2) to help the researchers gain a better understanding of the local CCC diagnosis; and (3) to propose guidelines aimed at improving the providers' CCC on a local level.
Step 2	The CCC concept and the main local results were presented by the researchers using simplified graphics and tables.
Step 3	In small groups, participants combined this information with their own personal knowledge to reflect upon and discuss the results in order to propose guidelines for improving the providers' CCC at a local level. Researchers used some structured sets of questions in order to guide the group discussions. By each dimension of the CCC model, two questions were introduced. For instance, below are those relating to critical awareness: (a) What would you highlight from the results presented regarding critical awareness in your working community?, and (b) What lines of action do you think could be developed to improve critical awareness (keep in mind that these actions can take place at different levels: i.e., individual, organizational and community)?
Step 4	The groups shared their guidelines and were given an opportunity to explain why some actions are needed and how to implement them. Afterwards, the participants agreed upon 3-5 suggestions for each CCC dimension and conclusions were made.

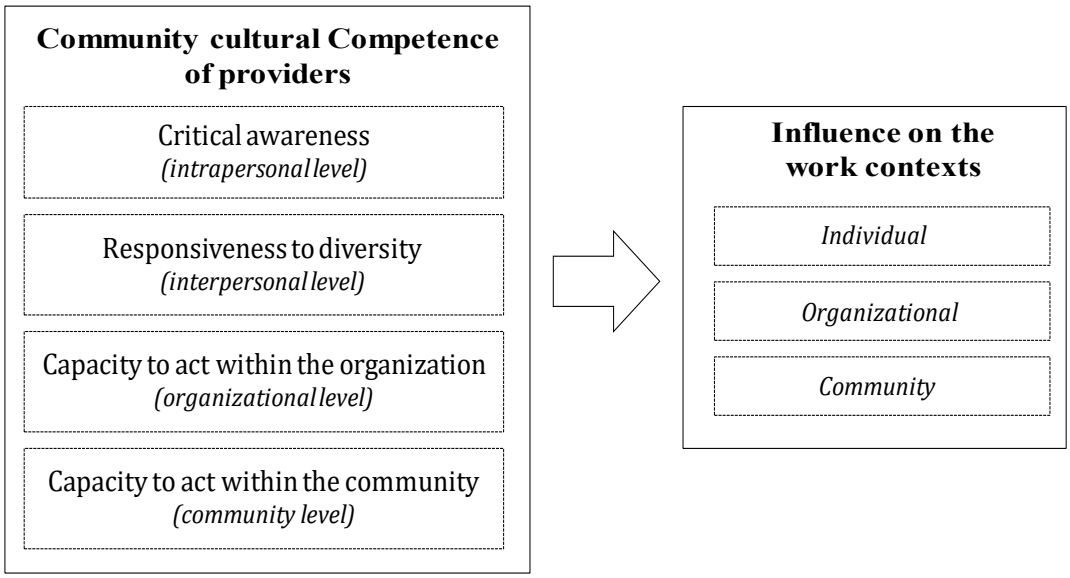
1

Table 4.
Recommendations for amplifying the impact of CCC and transferring results to local actions

Dimensions	Community Forum's Proposals
Critical Awareness	• Dismantle and challenge migrants and/or minorities' stereotypes (**) • Promote dialogue with the user and understanding of his/ her migration situation (**) • Encourage programs to develop critical awareness rather than cultural knowledge (*) • Remember that Spain has been and actually is a migratory nation (*) • Remind providers that they offer a community service and, thus, they should defend principles based on respect and tolerance (*) • Understand the sociopolitical crisis as an opportunity to reconsider issues that did not work in our socioeconomic model and offer more sustainable and responsive alternatives to address the citizens' needs • Promote awareness of the providers' role in generating structural changes • Make the leap from the organizations to the policies so as to foster equity
Responsiveness to diversity	• Collaborate with cultural mediators (**) • Enhance teamwork, not only interdisciplinary and cross-sectional, but also, with community agents (**) • Increase flexibility and adaptability among providers, particularly those who are civil servants (**)
Capacity to act within organization	• Increase the financial support to develop quality services (**) • Boost training programs in cultural competence and evaluate their impact (*) • Improve the working conditions so that the providers could demonstrate their skills (e.g., increase attention time per patient) (*) • Reduce accessibility barriers for migrants (e.g., hours of operation not consistent with habitual working hours, minimizing bureaucratic procedures) (*) • Sanction racist behaviors • Upgrade the incentive system • Foster organizational values which extend to multiculturalism • Increase the cultural diversity of the personnel • Strengthen service evaluations, revising the quality criteria in a participatory manner— with input from providers and users • Incorporate support to the community and the empowerment of the general public as an indirect objective in all organizations
Capacity to act within community	• Upgrade the planning of joint actions and coordination of networks (e.g., developing a common agenda for action) (**) • Improve health literacy in the migrant communities, mainly on their rights and proper use of resources (**) • Develop a guided map of the existing recourses in the community by sectors • Create new mobilization platforms and intersectional collaborations, as well as community-based coalitions • Increase recognition and trust for the providers from the community members • Promote the empowerment of the migrant communities, who are sometimes invisible or passive • Generate gatherings to share experiences and promote better practices

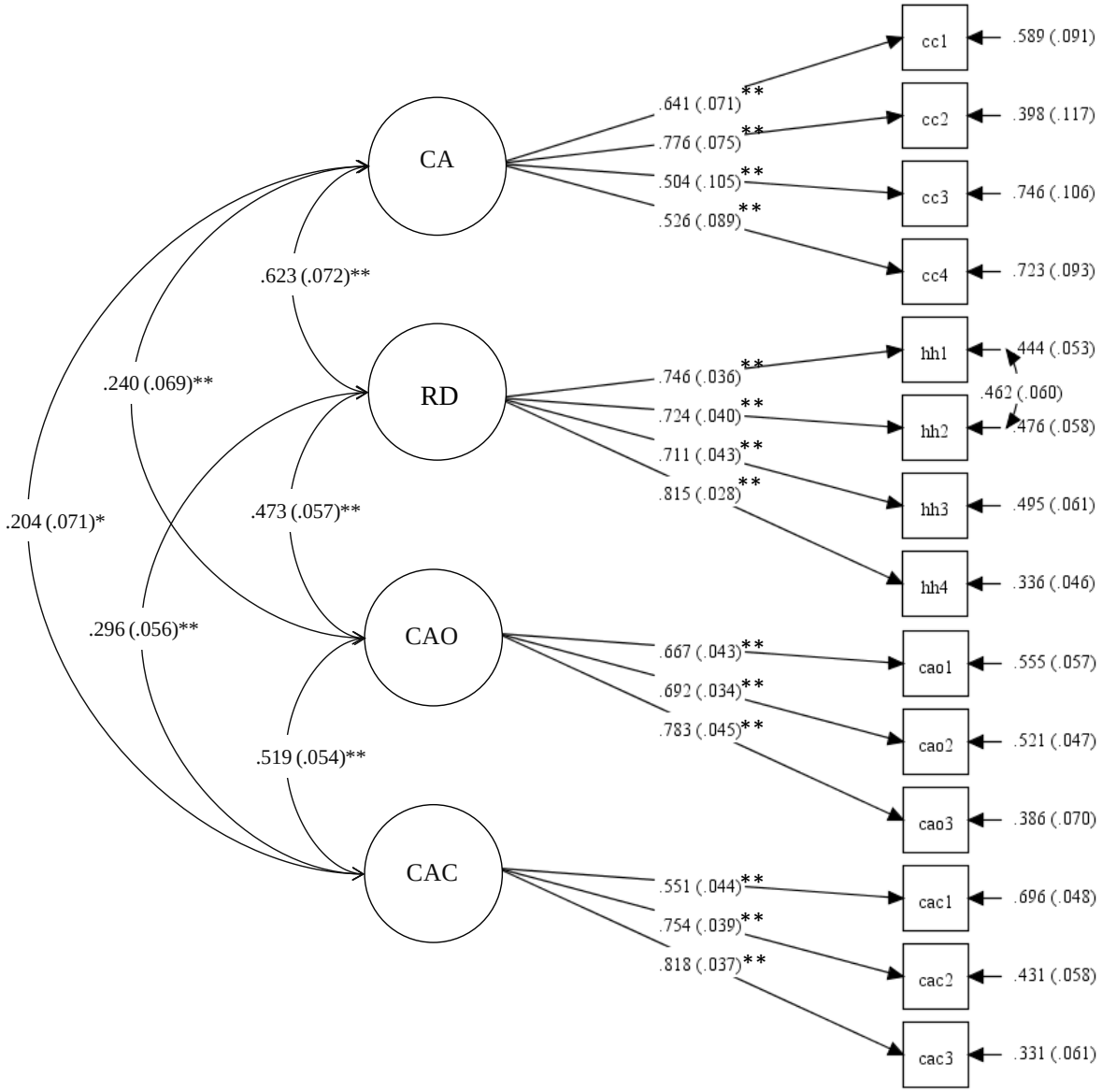
1 * Guidelines that were repeated in two forums
2 ** Guidelines that were repeated in all three forums.

1 Figure 1. Community Cultural Competence Model and Predicted Relationship



2

Figure 2. Model of Community Cultural Competence



Fit Index:

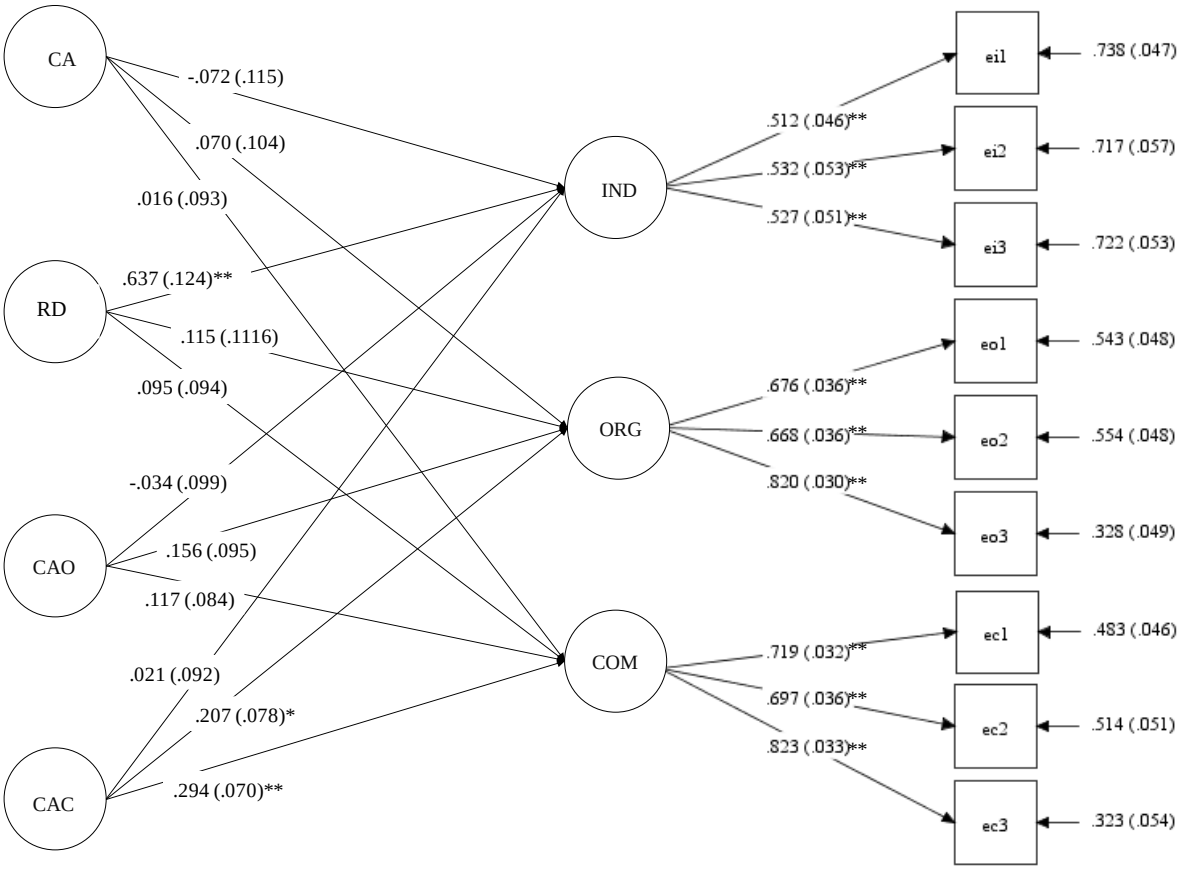
$\chi 2(70) = 242.31, p < .01$; CFI = .90; RMSEA = .07, 90%int=0.06-0.08

Note: CA=Critical awareness; RD= Responsiveness to diversity; CAO=Capacity to act within the organization; CAC=Capacity to act within the community.

* α<.05

**<.01

Figure 3. Structural equation model predicting the impact of the CCC dimensions on perceived influence on the work contexts



Fit Index:
$X2(80) = 536.36, p < .01$; CFI = .90; RMSEA = 0.06, 90%int =0.05-0.06

Note: CA=Critical awareness; RD= Responsiveness to diversity; CAO=Capacity to act within the organization; CAC=Capacity to act within the community; IND=Influence on the work contexts at individual level; ORG=Influence on the work contexts at organizational level; COM=Influence on the work contexts at community level,
* α<.05
**<.01