Cultural Diversity and Cultural Competency: New Issues for Elderly Care and Services

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ABSTRACT

The aging world society has to deal with a classical yet not only European problem: the increasing number of elderly people requiring daily care. Currently, the global trend of ageing is yielding only a small scale of culturally diverse care recipients. What has not been foreseen however, is how this cultural diversity will affect the care provided to older people in care nursing homes. The aim of this work is to show how healthcare professionals can use cultural competence to mitigate disparities that occur in nursing homes. Cultural competence means demonstrating knowledge and understanding of client's culture, health-related needs. The research questions are how does cultural diversity affect the provision of care? How does culturally defined health belief impact the delivery of care and how does culturally competent care affect adherence to treatment, care provision or the satisfaction of the client? The idea of this thesis was conceived while working in elderly homes. This thesis work is based on literature review with content analysis with the author interpreting the content of the articles. The research articles were found through the academic search elite EBSCO-host, and PUBMED. The results show that when healthcare professionals and clients come from different cultural background misunderstanding may occur but applying cultural competency in health care practice is very essential to mitigate disparities among cultures.

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ABSTRACT

Det åldrande världssamhället måste nu hantera en klassisk, men inte bara europeiska, problem: den ökande antal av åldringar som behöver vård dagligt. Närvarande, det global trend med åldring ger ut bara få vårdtagare av olika kulturbakgrunder. Syftet med dessa arbete är att visa hur vårdpersonal kan använda kulturell kompetens för att minska skillnader som förkommer på vårdhem. Med "kulturell kompetens" innebär författaren den kunskap att visa att man känner och förstår kundens kultur, hälsorelaterade behov och kulturellt specifik betydelse för hälsa och sjukdom. Frågorna i det här forskning är: Hur påverkar kulturell mångfald på vårds tillhandahållandet? Hur innebär de kulturellt definierade övertygelse om hälsa på vård och hur påverkar kulturellt kompetent vård på följsamhet till behandlingen, sjukvården eller kundstillfredställelse? Tanken med avhandling föddes medan författaren arbetade på äldreboenden. Den här forskningen bygger på litteraturgenomgång och författaren är den som här tolkat innehållet i de valda artiklar. Artiklarna som användas i forskning hittades genom Academic Search Elite EBSCO-värd och PUBMED. Resultaten visar att när vårdpersonal och kunder kommer från olika kulturella bakgrunder missförstånd kan uppstå, men den är mycket viktig att applicera kulturell kompetens i hälsovården för att minska skillnaderna i olika kulturer.

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TIIVISTELMÄ

Ikääntyvä maailmanyhteisö joutuu kohtaamaan klassisen, mutta ei yksinomaan eurooppalaisen ongelman: päivittäistä hoitoa tarvitsevien vanhusten kasvava lukumäärä. Tällä hetkellä maailmanlaajuinen ikääntymistrendi tuottaa vain pienen määrän eri kulttuuritaustoista tulevia hoidon saajia. Tämän työn tarkoituksena on osoittaa miten hoitoalan ammattilaiset voivat hyödyntää kulttuuripätevyyttä lieventääkseen hoitokodeissa tapahtuvaa eroavaisuutta. Kulttuuripätevyydellä kirjoittaja tarkoittaa sen osoittamista, että tuntee ja ymmärtää asiakkaan kulttuuria, terveydenhoitotarpeita sekä terveyden ja sairastamisen kulttuurikohtaisia merkityksiä. Tutkimus käsittelee kysymyksiä: Miten kulttuurillinen moninaisuus vaikuttaa hoidon järjestämiseen? Miten kulttuurisesti määräytyvä uskomus terveydestä vaikuttaa hoitoon, hoidon toteuttamiseen tai asiakastyytyväisyyteen? Tämän teesin ajatus heräsi vanhainkodeissa vietetyn työjakson aikana. Tämä teesi pohjautuu sisältöä tutkivaan kirjallisuuskatsaukseen, jossa kirjoittaja tulkitsi valittujen artikkeleiden sisällön. Tutkimuksessa käytetyt artikkelit löytyivät akateemisen hakueliitin EBSCO-hostin ja PUBMED:in avulla. Tulokset osoittavat, että silloin kun hoitoalan ammattilaiset ja asiakkaat tulevat erilaisista kulttuuritaustoista voi väärinkäsityksiä voi syntyä, mutta kulttuuripätevyyden soveltaminen hoidon annon aikana on erittäin oleellista, jotta eri kulttuureista tulevat asiakkaat saisivat yhtä hyvää.

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1. INTRODUCTION

As we have been repeatedly reminded by demographers, “population ageing” is an international problem. “Population ageing” occurs, when mortality reduces and fertility decreases. A careful analysis of the age structure of the Finnish population reveals this phenomenon arriving in Finland, too. The ageing process of a whole population is having negative impact on the workforce as more people are going on retirement and therefore causing shortage of labor. Additionally, the first generation immigrants into Europe including those living in Finland are also ageing and require care just like their Finnish counterpart.

In an effort to control this shortage, the Finnish government and healthcare organizations have resorted to the recruitment of healthcare professionals from abroad. The increase in the number of healthcare professionals emigrating yearly from Finland has not been helpful. It is expected that caring for this diverse ageing population in the nearest future will be increasingly troublesome. This assumption is based predominantly on the demographic development, that is, an increase in the number of older people and an increase in the number of foreign healthcare providers with different cultural beliefs and practices. Considering the differences, it is not wrong to expect misunderstandings.

This work aims to show how healthcare professionals can mitigate disparities that occur in culturally diverse nursing homes by applying cultural competency in care work. The author has chosen the use of cultural competency as an instrument that can help to mitigate misunderstandings between healthcare professionals and recipients of care. Despite the numerous writers or advocators of the use of cultural competency in healthcare, the author has chosen the model of cultural competency by Purnell (2009). He thinks that any healthcare provider who understands the cultural beliefs, practices, and values of his/her client is in a better position to interact and provide an acceptable care by the recipient. The author discusses Purnell’s model of cultural competence since the theoretical framework of this work is based on his model. Additionally, other definitions of the concept of cultural competency are discussed as well.

The author has chosen literature review with content analysis as his method of data analysis. By reviewing scientific articles from different countries that are experiencing same problems, the author was able to answer the research questions. The author started

by giving a vivid consideration of the meaning of culture. The author brought to light what influences culture and how each of us might be affected by it unconsciously. This work does not aim to enlist as many cultural practices and beliefs as possible but rather to show how implementation of a culturally competent care can help to offer quality services to our ageing population and therefore mitigate disparities common in culturally diverse nursing homes. Thus, the author did not enlist any behavioral pattern of a particular culture. The consequences of cultural diversity in other countries, however, are discussed to find recommendable solutions for professionals in any healthcare setting.

Are you a healthcare student, a provider of care in nursing homes or an international student who wishes to stay permanently in Finland? If your answer is "yes" to one of these questions, the author thinks this thesis work might be an important material for you. Not only will it help you to be an efficient worker but most importantly a well integrated resident into this society. A careful consideration of the suggestions will be worth applying. It is a timely tool.

1.1 Aim and Research Questions

As a means to combat healthcare provider's shortage, the Finnish government and healthcare organizations have resorted to the recruitment of foreign nurses as a means to subdue the growing shortage of health care and elderly care professionals. However, not much has been done towards tackling the problems that might occur due to cultural diversity. When left unsolved this might affect the workforce and provision of care to the elderly group living in care institutions. Furthermore, the first generation of immigrants into Europe including Finland is also ageing. (PRIAE, Research Briefing 2004). These ageing migrants also require care from the government.

Little is known about the influence of cultural diversity between professionals and care recipients in nursing homes. However, research has shown that a different cultural background of care professionals and clients might lead to disagreement due to differing cultural paradigm. In some situations, it even can affect the quality of care given (Leininger 1991; Galanti 2008; Purnell 2009). The author wants to use this forum to help healthcare organizations to understand that diversification requires them to pay

closer attention more than ever before to cross-cultural issues in order to meet the healthcare needs and maintain the high standard of care given to the ageing elderly. The author also offers practical strategies to managers and healthcare agencies to support overseas trained nurses in managing cultural diversity in care institutions. The author intends to propose a process that will facilitate cultural competence in Finnish care practice.

The driving force behind this study is therefore to emancipate people and make possible suggestions to this social problem and in that way empower and liberate people. This is in harmony with the objectives of any social research (Sarantakos, 1998). The aim of this thesis work therefore is to show how healthcare professionals can use cultural competency to mitigate disparities that occur in nursing homes.

Based on this fundamental viewpoint, the research questions of this thesis work are

1. How does cultural diversity affect the provision of care?
2. How does culturally defined health belief impact the delivery of care?
3. How does culturally competent care affect adherence to treatment, care provision or the satisfaction of the client?

2. THEORETICAL FRAME OF REFERENCE

A theoretical framework provides a context for examining a problem, that is, it provides the theoretical rationale for developing a hypothesis. It is also a frame of reference that is a base for observations, definitions of concepts, research designs, interpretations, and generalizations. It serves as a guide to systematically identifying logical, precisely defined relationships among variables (Wood & Haber, 1994).

The driving force behind any research conducted in social research is the philosophical framework behind it. This philosophy dictates not only general perception of reality and social relations but most importantly the methods and techniques (Sarantakos, 1998).

Purnell (2009) constructed a model for cultural competence that I have found useful to apply as a theoretical framework when administering care in a culturally diverse institution. His model seeks to go beyond understanding the culture of our clients. It comprises twelve actions from healthcare practitioners. The model is shown in figure 2. Table 1 shows the assumptions on which his model is based.

According to Purnell (2009), this framework or assumptions and the model itself are very essential in assessing the cultures of our clients. This model does not only provide a theoretical framework but also a practical guide on how to use cultural competency to administer care in a diverse cultural environment. As explanation to the above table, Purnel thinks that cultural competence is the adaptation of care in a manner that is agreeable with the culture of our client and therefore it is a conscious process. Consequently, he thinks that a culturally competent healthcare provider develops an awareness of his or her existence, thoughts, sensations, and environment without letting them have influence over our decisions or on those we are offering care to. Furthermore, despite the fact that cultures are similar or share some similarities, none is better than the other and therefore there is a need to adapt to standard intervention method in order to mitigate differences because every client that healthcare providers meet/face or care for is a cultural encounter.

Table 1. Assumptions underlying Purnell’s Model of Cultural Competence

1. Information regarding cultural diversity is needed by all healthcare practitioners
2. The concept of global society, health, family and person should be shared by all healthcare professionals
3. Cultures are merely different and therefore no one is better than the other
4. All cultures are similar or share similarities
5. There are differences among, between and within cultures
6. Cultures undergo changes after a long period of time
7. The degree of variation between cultures is determined by primary and secondary characteristics of culture
8. If clients take part in their own care and have choice towards health-related goals, interventions, and plans, they are able to comply easily towards improved outcome
9. Interpretation of healthcare and response towards it is influenced by culture
10. Families and individuals are members of several subcultures
11. Each individual should be respected based on his/her unique cultural heritage
12. In order to be able to provide a culturally competent care, caregivers need cultural specific information of their client's culture
13. Improved and quality care can only be attained if caregivers are able to assess, plan, evaluate the manner of their client
14. Learning about cultures is a process and can only be attained through cultural encounters
15. Understanding cultures will help to minimize biases and prejudices
16. In order to be able to offer efficient care, healthcare must take into consideration the values, beliefs, lifeways, worldview of those they are serving as well as each client's acculturation method
17. Adaptation to a standard intervention is very essential to mitigate differences between cultures
18. By being culturally aware, a caregiver becomes self aware.
19. Using theory of culture, the culture of professions, organizations, and associations can be analyzed
20. Every client that caregivers meet/face is a cultural encounter.

Source: Purnell 2009

3. LITERATURE REVIEW

In this section, the author intends to show that there is existing knowledge on his topic of choice. He has cited from scholars who have contributed enormously to knowledge about cultural diversity and its remedy. The author has listed thematically all the elements that are necessary for better understanding of this thesis work in order to bring clarity to the research problems and broaden the knowledge base (Kumar 1999).

The goal of any health care system is to provide optimal care to the clients. Achieving optimal care may become a problem when the health care professionals and clients arise from different cultures. Thus the implementation of cultural competence and a patient centered approach to care might be one of the solutions to these problems. Such concepts will enable health care professionals to understand - why men coming from Middle East cannot allow a male nurse to examine their wives or why an Iranian patient will resort to holistic medicine as the only solution to health problems rather than resorting to Biomedicine. It will also help us to imagine what might happen when a Nigerian male nurse and a Philippine female nurse are caring for a Finnish woman or a Chinese female nurse is caring for a Somali client. It is not the aim of this thesis work to discuss the disparity occurring due to denial of rights to a certain race, ethnicity, or culture but rather to focus on the solution to cultural diversity when caring for the ageing population.

3.1 The trend of ageing

This trend of ageing, caring, and cultural diversity in healthcare is a worldwide affair. The demography profile of U.S projects that by 2050, the older adult population will increase by 230%. In the same respect, the projection shows that the population of the minority elders living in the U.S is expected to grow by 510% (Xakellis, 2004).

Population ageing is more advanced in Europe as compared to America (Saraceno, 2008). Finland has the world's fastest ageing population (Statistics Finland, 2007). With the increase in life expectancy and the baby boomers going on a massive retirement, the number of elderly people requiring care has increased. The reduction of fertility rate is

not helping matters. A consideration of the population age structure of Finland in 1917 and 2006 will prove this assertion right as shown in Figure 1 below.

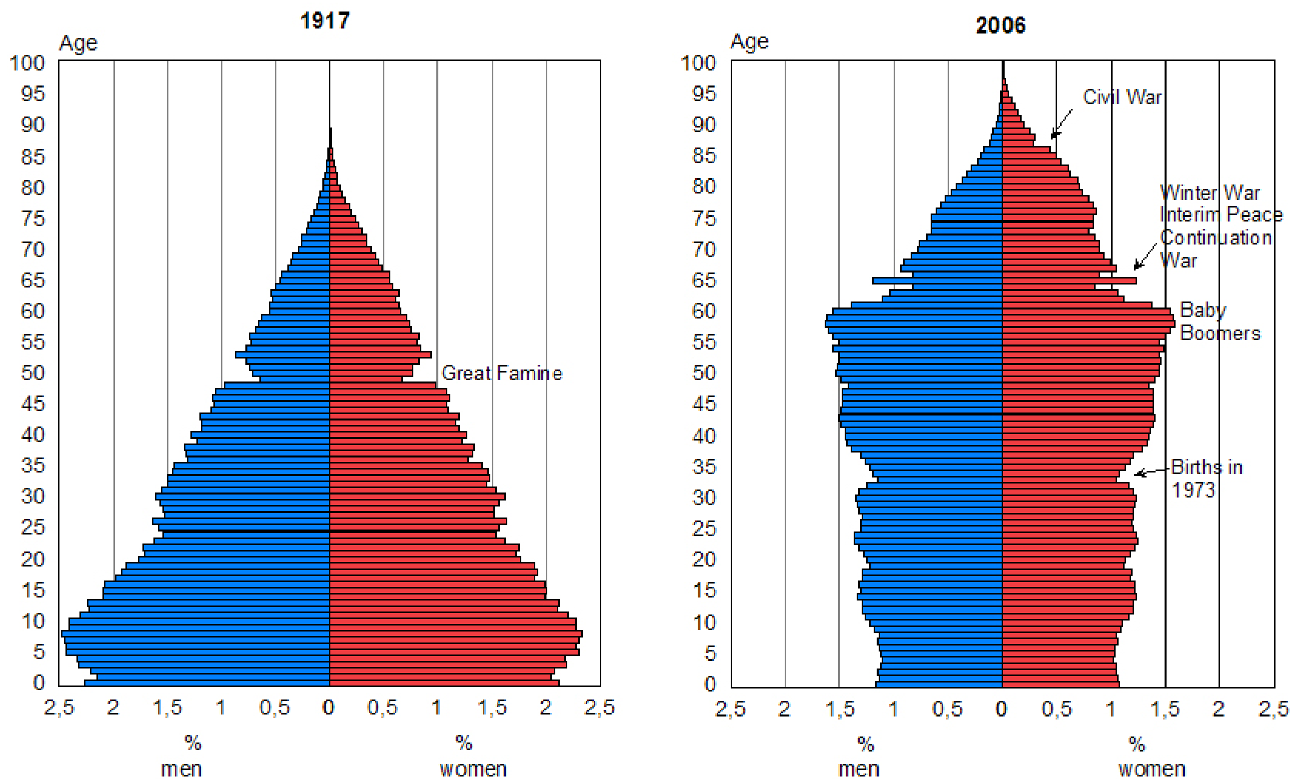

FIGURE 1. The population pyramid of Finland in 1917 and 2006

Source: Statistics Finland, 2007

The population pyramids show the age structure of Finland in 1917 and 2006. The 1917 population pyramid shows Finland as a country with high fertility rate, where children aged between 0-14 constituted 35% of the population whereas today's children between the ages of 0-14 make up only 17%. The statistical life expectancies of men and women were 43 years and 49 years. Today, the life expectancy of Finns is 76 years and 83 years respectively. Furthermore, one in every 10 children born during the era of independence died whereas the infant mortality rate is 0.5 percent today; one of the world's lowest (Statistics Finland, 2007).

3.2 The meaning of culture

The relevance of cultural meaning as a world view is very essential to understanding health, illness, and care of humans (Leininger, 1991). In other words: health, wellness, illness, old age and youth to a group of people are determined by their culture. Therefore, culture shapes the health behaviors and defines the roles and expectations of clients and that of health care providers (Capell et al., 2007). The issue of cultural diversity is difficult to understand and appreciate without a proper understanding of the meaning of "culture".

Culture which is considered to be the opposite of nature is derived from the Latin word "colere" which means "cultivating, inhabiting, worshipping, and protecting" (Eagleton, 2000). The word culture is so broad that anthropologists and philosophers have not been able to come to an agreement. However, according to Taylor, a 19th century anthropologist, culture is defined as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Taylor, 1871). Herskovits, another anthropologist who lived in the 20th century defined it as "the man-made part of the environment" (Herskovits, 1955).

The only weakness to these definitions is that according to Goodenough (1961), anthropologists referred to culture only as an observable phenomenon of things and events. Thus they failed to refer to it as an organized system of knowledge and beliefs where people formulate acts and choose between alternatives, experience, and perceive things. The quotation below by Lewis (1999) helps us to understand the influence of culture on our behaviour.

"We think our minds are free, but, like captured American pilots in Vietnam and North Korea, we have been thoroughly brainwashed. Collective programming in our culture, begun in the cradle and reinforced in kindergarten, school and workplace, convinces us that we are normal, others eccentric" (Lewis, 1999).

According to Hoftede (2005), culture is "the collective programming of the mind that distinguishes the members of one group or category of people from another". It is "the totality of socially transmitted behavioral pattern, beliefs, values, customs, lifeways, arts, and all other products of human work and thought characteristics of a people that

guide their worldview and decision-making" (Purnell, 2009). This helps us to understand that culture is very much unconscious in our minds. The meaning of culture becomes clearer to us when we go through the quotation below:

"For a German and a Finn, the truth is the truth. In Japan and Britain it is all right if it doesn't rock the boat. In China there is no absolute truth. In Italy, it is negotiable" (Lewis 1999).

The above quote helps us to understand that when people from different cultures meet, for example, when people from linear-active culture work with people from multi-active culture irritation ensures.

3.2.1 Primary and secondary characteristics of culture

According to Purnell (2009), there are primary and secondary characteristics of culture. Factors that influence and shape people's worldview and that makes them to identify themselves to a particular group are known as primary and secondary characteristics of culture. The primary characteristics are those traits that cannot be changed and when changed are always left with stigmas. They include such things as nationality, race, color, gender, and religious affiliation.

The secondary characteristics of culture are those attributes that can easily be changed without stigmas. They include occupation, marital status, and political beliefs, urban versus rural residence, reason for migration which could be sojourner, immigrant, or illegal immigrants (Purnell, 2009). Anthropologists have tried to categorize humans into groups. Richard D. Lewis's classification will be used in this work. Lewis classified human behavior into three cultural categories namely; linear-active, multi-active, and reactive cultures.

Linear-Active Cultures

- Value facts and figures
- Respect highly organized planners
- Think linearly
- Use a straightforward, direct communication style
- Take task-oriented approaches
- Prefer rationalism and science over religion
- Typical example cultures include mainstream Americans and Western Europeans.

Multi-Active Cultures

- Value emotions, close relationships, compassion, warmth, and feelings
- Act more impulsively than people from linear-active or reactive cultures
- Prefer face-to-face interaction
- Use direct and animated communication style
- Feel uncomfortable with science
- Typical examples cultures include African Americans, Africans, Arabs, Jews, and Latinos

Reactive Cultures

- Value subtle communication: listen first, then respond
- Honor harmony, humility, and agreement
- Use indirect communication style
- Tolerate silence and find it meaningful
- Typical example cultures include Asian Americans, Pacific Islanders, and Native Americans.

Source: Yehieli &Grey. 2005

Understanding and accepting these differences in cultural behaviors will help providers of care to offer a better care. However, accepting individual differences is very essential. Categorizing every person from the same ethnic group as having same cultural behavior will be wrong because people’s values and worldviews vary (Galanti, 2002; Yehieli & Grey, 2005; Purnell, 2009).

3.2.2 Subcultures

In any cultural setting, there are groups of people who do not share attributes shared by the culture at large. In the study of anthropology, these groups are called subcultures. There are many factors determining a subculture such as ethnicity (African American, Gypsy, Asians), occupation (nurses, physiotherapists, gerontologists, doctors), activity (gangs, politicians), or sexual orientation (lesbians, homosexuals). When one subculture is stronger or popular than the other, it is called "dominant culture". Those cultures with less power are then referred to as "minority cultures" and often feel discriminated against (Galanti, 2008). Nevertheless it is important to note that subcultures have their values, worldview, language, and norms. For example, the gypsies have values which are very important to them but these values are not shared by the Finns and vice-versa.

3.2.3 Discrimination and Prejudice

Prejudice is defined as "the holding of a negative attitude about members of a different social group such as a racial or ethnic group" (Fennell, 2005). One encyclopedia defines it as "an opinion formed without taking the time or care to judge fairly. As humans, we are prone to be prejudicial to a considerable degree and undoubtedly, everyone has been misjudged by someone at some point in our lives. Furthermore, owing to globalization, strained inter-ethnic relations, prejudice and discrimination are important issues which can lead to lower quality of services provided by health care providers and nurses. The long history of slavery in America coupled with institutionalized racism has made many African Americans to have distrust on the health care system (Galanti, 2008; Markova & Broome, 2007). The prejudice that exists between Finland and Estonia, Finland and Russia is well documented (Markkanen & Tammisto, 2005).

3.2.4 Value Worldview and acculturation

In order to understand people, we should understand their values. Values are things that people think are very important to them. Just as a value is important to an individual so also is value to a certain culture. Some people value money, freedom, independence, health, while others value fitness, physical appearance, and privacy and so on and so

forth. Whereas some subcultures in the United States value money, other subcultures in Finland value honesty and privacy. In Japan, some value honor (Galanti, 2008).

Another essential concept to help understand people's "strange" behavior is to understand their worldview. Problems can result due to the disparity between the worldview of the health care provider and that of the client. People's worldview is made up of their basic assumption or belief about the nature of reality. This foundation therefore becomes the basis of all their actions and interpretations to events and these views will definitely have influence over his/her healthcare behaviors (Galanti, 2008).

However, despite the fact that we all have different worldviews, our culture, religion, and friends can influence our worldview. Our culture can influence us to change the way we think just as our religion or friend can do. For a person who is devoutly religious, the belief in the existence of a creator will certainly be his/her worldview and everything is shaped around this belief (Galanti, 2008).

When one cultural group adopts the beliefs and behaviors of another group, it is called acculturation. Although acculturation is usually in one direction; immigrants adopting hosts country's' beliefs and patterns of behavior, it could also be the other way round, that is, the host country adopting the immigrant's cultures and beliefs. Through acculturation, immigrants integrate easily into their new places of residence. Language is a variable of acculturation (Castro et al., 2009). In the United States, acculturation to Latinos meant learning and blending mainstream cultural values, beliefs, and attitudes with those which originated from Spanish speaking cultures (Rodriguez, 1998). The acculturation level of an individual is influenced by age. The young find it easy to acculturate compared to the elderly (Shadi, 2009).

3.2.5 Stereotype versus Generalization

A discussion on these two subjects is very important in the better understanding of culture and the consequences of cultural diversity. People often mistake these two words for another or use them interchangeably. However, these words have different meanings and their differences do not lie in their content but rather lies in their usage. A practical example is for instance, if I meet a Somali client and say in my mind "she must have a large family", in that case I am stereotyping her. But if I think that Somalis

have large families and then ask her "how many children do you have", in that case, I am making a generalization. Stereotype is defined as "the use of social categories (such as race and gender) to acquire, organize (and infer), and process information about an individual" (Fennell, 2005).

3.2.6 Ethnocentrism and Cultural Relativism

In anthropological studies, these two concepts are very essential in the study of culture. However, in healthcare, these two concepts will help to understand cultural values and appreciate the differences in culture. The belief that one's own way of doing things is the best and only reasonable way is known as ethnocentrism. An ethnocentric individual belief in that all other ways of doing things are abnormal, senseless, and ridiculous. This view is not consensus with a cultural relativist who beliefs that other ways of doing things are valid but merely different (Galanti, 2008). At some point in our lives we all are ethnocentric. Right now some of us are still ethnocentric. However, in order to be balanced individuals, we should strive to be culturally relativists.

3.3 International Migration

During the last years, international migration has been major concern in Europe. With the political and economic changes in European Union Member States, migration has moved from America to Europe. European countries have now moved from suppliers of migrants into countries of immigration (Saraceno, 2008). Globalization and increase in information and communication technologies have facilitated transnational network and international mobility more than ever before. Despite restrictive measures to combat immigration to Europe, the population ageing is making this policy unreachable. Consequently, there has been a great surge in the number of migration to Europe which has reached peak level since World War 2 (Saraceno, 2008).

In North America and Europe where international migration is rampant, patients, physicians, and healthcare professionals are likely to come from non-western cultural background with Finland not building an exception in the nearest future (Galanti, 2008). In Canada, 18.4% of the total populations were foreign born making it the highest in 70

years. Formerly, immigrants to North America came from Europe; however, the trend is changing today. A study showed that in the 1990s, 58% were from Asia, 11% from Caribbean, Central and South America, 8% from Africa but surprisingly only 19% from Europe. The same study showed that in 2005, 22% of the physicians graduated outside Canada (Rosenberg et al., 2007). The same is a common phenomenon in Finland especially when we consider the statistics in table 2 below.

Table 2. Healthcare professionals in Finland who had qualified abroad on 30th May 2005

Occupation	Finnish national	Foreign national	Total
Doctors	579	1029	1608
Dentists	209	128	337
Nurses	111	139	250
Midwives	5	4	9
Public health nurses	5	3	8
Medical laboratory tech.	3	2	5
Physiotherapists	12	19	31
Dental hygienists	6	0	6
Radiographers	1	3	4
Paediatric nurses	0	0	0
Practical nurses	39	20	59
Dental assistants	10	4	14
Practical mental nurses	17	7	24

Total	997	1358	2355

Source: TEO 2004

Table 2 shows the number of professionals who gained their qualifications abroad but now working in the Finnish healthcare sector. It brings to light the fact that more foreigners had qualifications from abroad compared to the number of Finns who also have foreign qualifications. As this statistics was taken five years ago, it is reasonable to believe that the number has increased since then.

3.4 Cultural Diversity and cultural perception of health

Cultural diversity is a resultant effect of international migration. Due to lack of definition, numerous terms are used to describe different aspects of what we understand when referring to cultural diversity, such as multiculturalism, cultural pluralism, interculturalism, cultural fusion etc. Out of the general lack of understanding of culture and its role in people's lives, images of racial groups (black, white, and brown) or various ethnic groups (Hispanics, African, Asian Americans) come to mind when we think of cultural diversity. With the world becoming a global village, more than ever before, cultural diversity is unavoidable even in homogenous societies. Cultural diversity has been influenced by the need for adaptation to a new environment, natural disasters, political instability in developing countries, and the search for greener pastures. As a result of these, the UNESCO Universal Declaration on cultural diversity was adopted on the 2nd November 2001 in Paris. The theme was "The cultural wealth of the world is its diversity in dialogue" (UNESCO 2002). Article 3 of the constitution, while acknowledging cultural diversity as an essential factor in development, says "cultural diversity widens the range of options open to everyone; it is one of the roots of development, understood not simply in terms of economic growth, but also as a means to achieve a more satisfactory intellectual, emotional, moral, spiritual existence" (UNESCO 2002).

The way health is conceptualized is influenced by culture. Consequently, culture has powerful influence on health and illness (Purnell, 2009). Different perception of health is a component of cultural diversity. "Culture and language influence individual

expression of mental distress, psychiatric diagnosis, treatment, and the delivery of mental health care" (Rai, 2002). Furthermore, "age influences an individual's adjustment to a new culture" (McConathat, Stoller, & Oboudiat, 2001).

Patients and providers of care may differ in their evaluation of clinical condition of a patient due to language and/or culture. So for example, elderly terminally ill immigrants from Morocco and Turkey experienced several difficulties in using the Dutch professional home care. The reasons for such disparities were lack of understanding of the illness and the cause of death. Other reasons include the values and norms in the families concerned. However, when these patients receive care, communication problems hampered the care given to them (Graaff & Francke, 2009).

In the U.S, there is a higher level of discrepancy in assessment of clinical condition in black patients than in whites leading to discrimination of minority patients. The causes and contributing factors to these disparities are complex and multiple ranging: from socio-economic status, medical conditions, educational level, health insurance and cultural perception of health. Furthermore, the article says that older minority adults are still likely to receive less health services than their white counterparts (Xakellis, et al., 2004). Despite the cultural differences among healthcare practitioners, Leininger (1991) advice that nurses should gain knowledge on cultural values, beliefs, and practices of their clients in order to provide meaningful and congruent care to people in the world.

Holistic Medicine Theory (Holistic Approach) and Biomedicine

Iranian immigrants, who migrated to U.S after they had turned 50, had a different mental health concept which was quite different from the American concept. Holistic medicine is practiced in Iran. Holistic medicine suggests that a person should be evaluated in whole (holistic approach) including physical, emotional, mental, and spiritual wellbeing of the patient (Shadi, 2009). The theory of holistic medicine also suggests that the patient should have the right to contribute to the decision of medical choice.

Biomedicine, which is the dominant Western model of health and illness, suggests the detection and elimination of illness and disease without taking into consideration the social and emotional factors that affect the health of the individual. It focuses on

physical procedures which are predetermined and pays less attention to client/provider communication (Shadi, 2009). Although about 80% of the world's population is of non-Western origin, the approaches of health adopted are defined by Western society (Salovaara, 2000).

3.4.1 Cultural competency: An abstract or reality

Since the health care needs of minority groups are not met due to cultural differences, healthcare experts and policy makers suggest that the needs of such group can only be adequately addressed through the provision of a culturally competent care (Bowen, 2008; Chilgren, 2008, Purnell, 2009).

The term "cultural competence" related to healthcare was first explained by Leininger (1978). Despite efforts to define this concept, there is no consensus on a universally accepted definition. However, the definitions of some writers are truly appealing. Leininger (1991) defines it as "the process that occurs when culture care values, expressions, or patterns are known and used appropriately and meaningfully by the nurse with individuals or groups". "The process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client" (Campinha-Bacote, 1999),"the ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client system functioning within the appropriate cultural context" (Galambos, 2003). Bhui et al., (2007) defined it as "including a set of skills or processes that enable mental health professionals to provide services that are culturally appropriate for the diverse populations that they serve". According to these definitions, cultural competence does not require nurses to familiarize themselves with every culturally specific belief and behavior; rather it demands that nurses should endeavor to respect the diversity of cultural health beliefs that influence the health priorities of individuals and communities that they serve (Xakellis et al. 2004).

However Purnell (2009) argues that despite the fact that cultural awareness, cultural sensitivity, and cultural competence are used interchangeably, they are all different concepts. He says that cultural awareness means appreciation of extrinsic signs of diversity, whereas cultural sensitivity has more to do with personal attributes and not

saying things that might be offensive to someone who comes from a different cultural background. In the same book, Purnell pointed out twelve meanings to the concept of cultural competence. The meaning is quoted in its entirety in table 3.

Table 3. The twelve meanings to the concept of cultural competence after Purnell, 2009

1. Developing an awareness of one's own existence, sensations, thoughts, and environments without letting them have an undue influence on those from other backgrounds.
2. Demonstrating knowledge and understanding of the client's culture, health-related needs, and culturally specific meanings of health and illness.
3. Continuing to learn cultures of clients to whom one provides care.
4. Recognizing that the primary and secondary characteristics of culture determine the degree to which clients adhere to the beliefs, values, and practices of their dominant culture.
5. Accepting and respecting cultural differences in a manner that facilitates the client's and family's abilities to make decisions to meet their needs and beliefs.
6. Not assuming that the health-care provider's beliefs and values are the same as the client's.
7. Resisting judgmental attitudes such as "different is not as good."
8. Being open to cultural encounters.
9. Being comfortable with cultural encounters.
10. Adapting care to be congruent with the client's culture.
11. Engaging in cultural competence is a conscious process and not necessarily a linear one.
12. Accepting responsibility for one's own education in cultural competence by attending conferences, reading professional literature, and observing cultural practices.

Source: Purnell 2009

The table 3 above mentions Purnell's twelve meanings to the concept of cultural competence. This shows that the concept can mean many things to healthcare practitioners. Developing awareness of existence without letting it have undue influence over our decisions and manner of administering care to those from other cultural background. It also mentions that our awareness should help us learn, understand and

appreciate the cultures of our clients. Furthermore, despite the similarities, healthcare providers should never assume that their beliefs are similar to those of their clients. Therefore, by being open to cultural encounter means that we are being culturally competent in the delivery of care. Adapting care not to suit only our cultural interest but that of our clients. Finally, since attainment of cultural competent care is a process, this requires healthcare professionals to attend conferences, read current professional literatures because the knowledge in science is always growing.

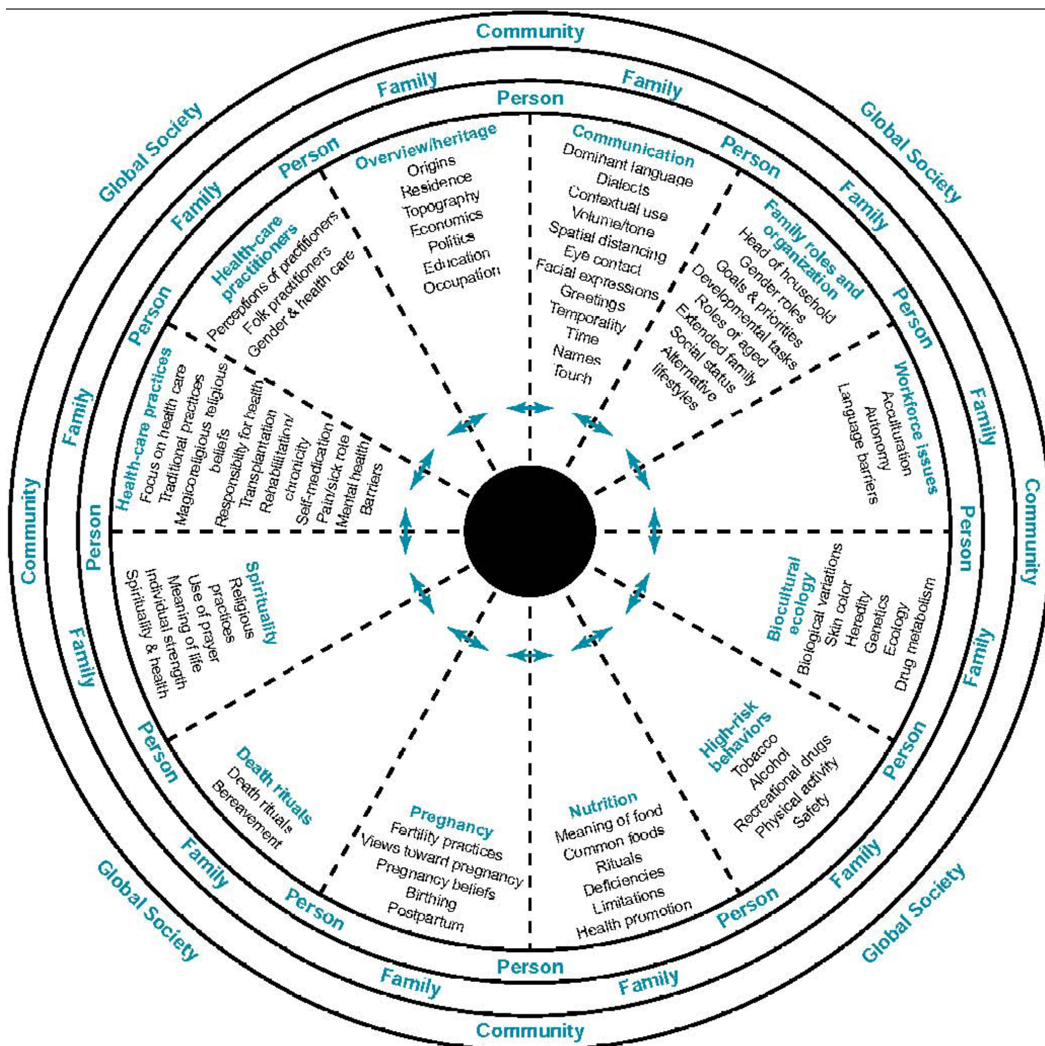

Figure 2. The Purnell Model for Cultural Competence

Source : Purnell 2009

Unconsciously Incompetent- Consciously Incompetent- Consciously Competent- Unconsciously competent (The process of cultural competence)

According to Purnell (2009), cultural competence is a process and not an endpoint. As explained in figure 2 above, one progresses from a stage where one is unaware of his/her lack of knowledge (unconscious incompetence), to a stage that one is aware of lacking knowledge about another culture (conscious incompetence). The third stage is what he called conscious competence. At this stage, the healthcare provider is learning about the culture of his/her client and verifying generalizations made about the clients culture and then provide interventions. The fourth stage is what he called unconsciously competent level. At this level, the healthcare provider is automatically providing culturally accepted care to clients of diverse cultures. According to him, the last stage is very difficult to accomplish owing to individual differences that exist within cultural groups.

Purnell's model of cultural competency is represented in series of circles with an outlying rim which signifies global society (Figure 2). The second rim signifies community, the third and fourth rims signify family and the person respectively. The inner part of the circle is divided into 12 pie-shaped wedges which portray cultural domains or constructs and their associated notions representing cultural domains and their concepts. At the center of the model is black circle which is empty and this signifies unknown phenomena about the cultural group. After the dark circle is a saw-toothed line and represents the nonlinear concept of cultural consciousness. This represents health care providers or health care organizations depending on their stage of attaining to cultural competence. The cultural domains and their ideas provide the organizing framework. Each of those domains includes ideas that health care professionals need to address when assessing patients in various settings. In addition to this, health care professionals can use these ideas to better understand not only the cultural beliefs of their clients but as well as the attitudes, values, practices, and behaviors of themselves. According to the author, these 12 domains are not separate but connected to each other and therefore supplement each other. These domains or constructs include; Overview and heritage, communications, family roles and organization, workforce issues, bio-cultural ecology, high-risk health behaviors, nutrition, pregnancy, and the childbearing family, death rituals, spirituality, health-care practices, and health-care practitioners (Purnell, 2009).

It is pertinent to note that since these concepts are defined from a broad perspective, they do not reflect any particular national, cultural or ethnic beliefs and values. Furthermore, some cultures do not have translatable words for these concepts. In such a situation, the healthcare providers may need to adapt these concepts according to the culture of the care recipients.

3.5 Domains of Purnell's model of cultural competence

Purnell's domain of cultural competence includes suggested questions to ask and observations to make when assessing clients from a cultural perspective. These questions and observations are like guiding tools that helps healthcare professionals ask culturally related questions to clients from diverse culture.

Overview and Heritage: This concept includes such things related to the country of origin and the present situation of health, economics and political condition of such a person. Educational level of the migrant and the reasons for migration and occupation are inclusive in this domain.

Communication: This domain includes the language, dialect and ability to make use of the language by the individual. Nonverbal communication patterns such as the meaning of touch, body language, what is acceptable greeting, the issue of space, worldview, the meaning of time, and formality when calling names are important elements in this domain.

Family Roles and Organization: This domain includes ideas which are related to the household, the goals and priorities of a family, expectations of children and adolescents as they grow, gender roles, the role of the aged, as well as the role of extended families and the social status of a family in a particular community. View of single parenting, nontraditional sexual orientations such as lesbianism and homosexuality and view of childless marriages and divorce are inclusive here.

Workforce Issues: This includes the healthcare practices of the country of origin, autonomy and willingness to acculturate and assimilate in new country of residence. It also includes their view towards gender perception and communication style of the family.

Biocultural Ecology: This domain includes the physiological, physical, and biological differences among ethnic groups such as skin color which can never be hidden, genetic, hereditary diseases and the physiological variations that influence human body metabolizes drugs. The causal factors of disease and illness falls into three categories: lifestyle, environment, and genetics. Lifestyle includes such practices and behaviors which can be easily controlled such as smoking, the kind of food or diet and stress. Environmental causes include such things as our external environment which cannot be controlled by us such as air we breathe and the water pollution. It also includes matters that we have little or no control such as the presence of mosquitoes which give malaria, exposure to pesticides and chemicals, and having access to healthcare. Genetically induced causes include diseases caused by gene.

High-Risk Health Behaviors: This domain includes the use of substance and misuse of tobacco and alcohol. Inadequate exercise and increased intake of calorie, failure to use seat belts, helmets, driving safely; and not taking preventive measures from contracting sexually transmitted diseases including HIV/AIDS.

Nutrition: This concept includes the meaning of food and what emphasis is laid on food. What type of food is eaten? Is emphasis laid on nutritional food and is food used as a means to promote and restore health and the prevention of illness and disease?

Pregnancy and Childbearing Practices: This includes what is culturally acceptable as fertility practices; views towards pregnancy, birthing, and the postpartum period.

Death Rituals: Includes the society's view on death and euthanasia, burial practices, and the attitudes towards bereavement. It is important to understand that death rituals are difficult to change and that change in this regard is very slow.

Spirituality: This includes religious beliefs which have connotations to faith; the use of prayer in the service of an Almighty God; practices that give joy of heart and meaning of life to individuals.

Healthcare practices: This includes the meaning of healthcare; is it traditional or magic religious, biomedicine or holistic approach; is an individual responsible for his or her own health; self medicating practices; views on rehabilitation, blood transfusion, transplantation, donation of organ, and mental health.

Health-Care Practitioners: This last domain includes the perception of traditional healers, biomedicine and other forms of healthcare approach and the gender of the person providing care (Purnell, 2009)

That notwithstanding, the use of cultural competency as a tool to mitigate disparities becomes more effective based on the method of implementation. Some argue that the implementation at the individual level is better to that at the organizational level (Bhui et al., 2007). Despite the incorporation of cultural competency as a means to deliver quality care, Gunaratnam (2007), argues that there is limited evidence to prove the influence of cultural competency on the delivery of care owing to the fact that there is no clear and acceptable definition of the concept and how it should be applied. She argues that some people narrow cultural competence to getting a better knowledge of cultural beliefs and practices of a particular group without paying attention on how culture has modified the way people perceive illness, or behave towards an illness or intervene towards it. She warns that despite the fact that cultural knowledge of a particular group can improve responsive care, it should not be treated at the detriment of personalized care. This view was supported by Rundle et al (2002). They argued that although healthcare professionals are encouraged to learn about the traditions of their clients, overgeneralization or stereotyping of all members of the same cultural group as alike will be wrong. Individual's behaviors can be influenced by race, education, age, gender, socio-economic status, immigration method and area of residence prior to migration and therefore individuals from the same culture may not believe in the same values. We all belong to numerous cultures such as generation, sex, ethnicity, religion, education, all of which have degree of influence on us (Galanti 2008).

Gunaratnam (2007) did not only question the abstract concept of cultural competency but also questioned the need to promote it by policy makers to the advantage of minority elders who have little time left to live. The notion of cultural competence in nursing practice was also criticized by a Chinese working group by Diana Lee (2004, p.4). According to Lee, conflicting values of what is essential in the provision of care is a hindrance to achieving well being for older persons who is cared for in a different cultural perspective.

Despite these odds, the Institute of Medicine in U.S recommends that the only solution to eradicate or reduce health care disparities in U.S is through cultural competency

(Xakellis, 2004). Cultural competent care can lead to negotiation, mutual exchange of information, increased compliance between patient and health care professionals. Consequently, healthcare organizations are giving preference to professionals with cultural competent training and ability to speak numerous languages. However, according to Galanti (2008) “cultural competency is a journey and not a destination”. Despite U.S. hundreds of years of being a culturally diverse nation, Galanti continued by saying “….if the United States are a melting pot, the cultural stew still has a lot of lumps.” The need for cultural competency in healthcare organizations is a worldwide issue. However, the implementation of cultural competency varies from place to place. A method that is successful in the United States and Canada may not be successful in Finland and vice-versa.

3.6 Patient Satisfaction

Patient satisfaction is referred to as the process by which patients attain or experience gratification, pleasure, and contentment which in turn motivate them to be obedient to medical operations (Vahey, 2000). There are so many reasons why the satisfaction of a patient is salient. First, patient satisfaction indicates good medical service delivery. Second, satisfaction will help such patient to be willing to comply when his/her cooperation is needed again, thus it serves as a predictor of the future behavior of a patient (Castro et al., 2009). Effective communication between the health care provider and clients is very essential in patient’s satisfaction (Markova & Broome, 2007, Berglund &Ericsson, 2003).

3.7 Relevant Realities in Finnish Society

According to a government survey conducted in 2004, the labor market in Finland is becoming more international than ever before. Consequently, the number of foreign workers in Finland has increased and the healthcare sector is no exception (Markkanen & Tammisto, 2005). By the time of this survey, statistics show that the Finnish population can still be considered a homogenous society. However, five years later, the result has been great changes in the Finnish demography. During 2008, more than

29,100 persons have migrated to Finland: this is the first time since Finland's independency where migration more contributed to the increase of the population than natural growth (Statistics Finland, 2009). The same source also shows that 13,657 persons emigrated from Finland increasing the problem of labor shortage. The number of persons however, who emigrate from Finland, has been quite stable during the last ten years.

And yet, there is another historical effect: the "whole generation of baby boomers" is currently reaching the age of retirement. This will at once increase the number of elderly people requiring care, which will subsequently affect the workforce. In order to combat this ordeal, the Finnish government as well as private healthcare organizations has resorted to the recruitment of nurses from abroad. These foreign nurses mostly came from Philippines and China. Besides those, there are also some students from Africa, Asia, Europe, and America who have studied in the field of healthcare and are successfully working. There are, however, some other efforts: Finnish health care professionals who are based abroad shall be attracted to return home in order to bring new ideas and curb the shortage of labor in healthcare sector (Markkanen &Tammisto, 2005).

Besides the "baby boomers" there is also the first generation of immigrants reaching the age of retirement increasing the amount of professional care during the next years (PRIAE Research Briefing, 2004). In addition, a report shows that more than 200 people above 65 years gained Finnish citizenship last year. This number will certainly increase in a few years to come. Table 4 shows the number of naturalized foreigners and foreigners by age structure during 2008.

Table 4. Naturalized foreigners and foreigners by age structure in Finland (2008)

Age group	Naturalized	Naturalized foreigners in %	Foreigners	Foreigners %
Total	6,682	100.0	143,256	100.0
0 – 9	1,203	18.0	14,289	10.0

10 – 19	1,200	18.0	13,664	9.5
20 – 29	930	13.9	32,079	22.4
30 – 39	1,419	21.2	35,728	24.9
40 – 49	1,064	15.9	23,513	16.4
50 – 59	511	7.6	13,210	9.2
60 – 69	222	3.3	5,453	3.8
70 – 79	96	1.4	3,492	2.4
80 -	37	0.6	1,828	1.3

Source: Statistics Finland

The table 4 above shows that 6,682 persons got Finnish citizenship in the year 2008. Of interest is the fact that 13,210 persons were above 50 years and of these numbers, 511 were granted citizenship. Between the ages of 60 – 69, out of the 5,453 persons living in Finland, 222 were granted citizenship. The table also shows that the number of foreign elderly people above 70 years who require citizenship is on the increase. The above statistics suggests: if the number of elderly immigrants granted citizenship increases, then it is reasonable that the number of them requiring care will also increase. This means that there is a need for health professionals with the ability to care for such a diverse elderly group. This will be a challenge not only to the health care providers but to the government as well.

According to (Statistics Finland, 2009), the highest citizenship was granted to Russians with a total number of 2200. The second was Somalia with 800. Vietnam, United States, China, and Bosnia and Herzegovina sharing the same number of persons granted citizenship. This is a small representation especially if you have to consider numerous nationalities that are not mentioned.

4 METHODOLOGY

There is a considerable amount of confusion regarding the use of this word. This is very clear with regard to perception as well as the types of methodologies involved in a research process. According to Sarantakos (1998), methodology is "identical to a research model employed by a researcher in a particular project, including basic knowledge related to the subject and research methods in question and the framework employed in a particular context." Therefore, the author of this thesis work has used this section to explain the model that he used in this work.

4.1 Content Analysis

Qualitative content analysis is "a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the context of their use" Krippendorf (2004).

This thesis work is based on content analysis on reviewed literatures. The author used qualitative research method because it is a design best suited to study the human experience of health and also because it focuses on human experience and the meanings given by these individuals, and this permits broader understanding and deeper insight into human behaviors which are in themselves complex (Wood & Haber,1994).

Scholars provided three important definitions to the concept of content analysis. First, it takes the content to be inherent in a text. Second, it takes content to be property of the source of the text and third, it takes content to come out in the process of a researcher analyzing a text relative to a particular context. Therefore, the author by using content analysis focused on the manifest and latent contents of articles chosen. Consequently, the author concentrated on texts which includes words, sentences, and paragraphs and also made conclusions which are beyond the text and language through critical analysis. The author did not look for categories but rather interpretated the chosen contents.

4.2 Data collection and analysis of materials

The collection of data in this thesis work started after formulation of questions on existing problems. Next, the author continued with literature review to see if there is already existing knowledge on the chosen topic. A goal was set on how to obtain relevant data that will help answer the research questions. Concepts were defined and the search for data began.

The first step was searching for sources in relation to the topic. Criteria taken into consideration in the search for articles were reliability, accessibility, and relevance to research topic, year of publication, research method, and country where research was done. A review of the literature was conducted to locate relevant articles published between 2000 and 2009 using databases such as EBSCO –host and PUBMED. The author started with the use of EBSCO-host which is an approved academic database recommended by Arcada University of Applied Sciences. Second, PUBMED an international medical database was used in finding updated and relevant articles. However, most of the articles came from EBSCO-host because getting access to most articles was free. Furthermore, the author used "Google-Scholar" to understand basic concepts where articles found could not explain. Basing article search from the theme of the thesis made things easier and made the literature review process smooth. The author started by searching for articles related to cultural diversity in Finland. However, this was done after establishing evidences to prove that Finnish population is truly ageing and that there is need for workers. The author went further to find out what could happen in such circumstances. The author realized that based on experiences of multicultural societies like U.S, Canada, Australia, and Britain, there is a need to implement cultural competency in health care organizations in order to mitigate misunderstanding that might occur due to cultural differences. The key words used in the search for articles included; cultural diversity, cultural competence, ageing, immigration, cultural perception and healthcare in Finland.

A grand total of 10 scientific journals were chosen in the review and analysis of this work. Articles were from Australia, Canada, UK, Sweden, Holland, U.S, and New Zealand. Some of the articles used qualitative research methodologies while others used quantitative. . Journals used included;

- The Journal of the American Academy of Nurse Practitioners
- The Journal of Health Services Research
- The Journal of the National Association of Social Workers
- The Journal of the America Geriatric Society
- The Journal of Theory Construction and Testing
- The Journal of Qualitative Health Research
- The Journal of Palliative Care
- The Journal of Family Practice

International Nursing Review Journal

The International Journal of Nursing Practice

4.3 Data processing

Table 5. Process of literature research

Key Words	No. of Hit	Literature Found	Relevant Material
Cultural Diversity	4	2930	10
Cultural competence	3	777	15

Source: author

Table 5 explains the author's processes of article search through EBSCO-host academic search elite. The author first went to the homepage of Arcada. Next the author went to Remote Access to Nelli, then Nelli Portal. The author then clicked on "Find Database" and then wrote "EBSCO" on the space below. The author then chose Academic Search Elite (EBSCO) FULL TEXT. The author went to Subject Terms and then to Advanced Search and back to Subject Terms again and then wrote Cultural diversity. The author got 2930 articles. The author double clicked on "CULTURAL PLURALISM" and got 132 articles. The key word used in the second search was Cultural Competence and the process as described in the first. A total of 777 articles came up. A double click on "CULTURAL COMPETENCE" produced relevant and meaningful 156 articles.

In the second search, the author restricted search to subject terms and fields. "Cultural diversity and competence" were used as keywords. The author selected "TX ALL Text" field in all three rows. A total of 2730 articles were found. Clicking on the subject terms on the left hand corner produces narrower results. For example, double clicking "MEDICAL CARE" produced 140 articles, 49 articles were found by double clicking "CULTURAL COMPETENCE". A double click on MULTICULTURALISM produced 231 articles.

After getting enough reading material, the author started reading and taking note of important and relevant concepts. The author used highlighters to indicate important texts (Lyon & Heasley, 2006). The author used green color highlighter to highlight ideas or concepts while the red highlighter was used for evidences. While reading, the author made notes on the front page to remind him of what the article says and what important concepts or evidences could be found on it. Books that could not be highlighted on, the author decided to make notes on a separate exercise book, taking note of ideas, title or article, and author. This process was very important because this enabled the author to remember all what each article says.

4.4 Validity and Reliability

The words "validity and reliability" are confusing and have been used interchangeably by students. Both are interrelated but not the same. If an instrument is valid it is expected to be reliable too but if an instrument is reliable, it does not imply that it should be valid (Sarantakos, 1998).

The word validity refers to the ability of a measurement instrument to measure accurately what it is supposed to measure while reliability is the extent to which that measurement tool can yield same result on repeated measurement (Wood & Haber, 1994). Reliability is concerned with the consistency, accuracy, precision, stability, equivalence, and homogeneity. Analyzing human behavior or measuring phenomena in a healthcare study is interesting as well as challenging. The author understood that the main principle underlying this concept is accuracy. When measurement tools do not validly and reliably reflect the concept, then the conclusions drawn will be invalid (Wood & Haber, 1994). Bearing this in mind, issues of reliability and validity became

central concern to the author. Additionally, the author understood that invalid measures will produce inaccurate generalizations not only to him and the institution that he represents but most importantly to the population being studied. The articles used in this study are retrieved from authentic databases and are scientific works by professionals.

4.5 Ethical Consideration and problems encountered

This thesis work was approved by the department of Social services and Health Care. Many researchers go into research with few limits and many options to choose from. The author of this work realized that he has freedom to choose from many options in order to answer his research questions. However, the author also knows that this freedom to choose in order to answer research questions despite their opportunities also have their adverse effects. The author lays emphasis on accuracy in data gathering and data processing, appropriate interpretation of the data and realizes that fabrication and falsification of data is misconduct and deserves punishment (Sarantakos, 1998). The author also read the Declaration of Helsinki 2004, which provides basic principles guiding all research. The author experienced some difficulties in the course of this study. First, finding literatures that were conducted in Finland was very difficult. The few ones found were in Finnish Language and due to my incompetency in Finnish Language they were of little importance. The second problem encountered was inability to understand and to apply content analysis as a method of research methodology. This was owing to the fact that most of the literatures reviewed used other methods in data analysis and the ones that discussed it said little on the concept making understanding difficult.

5. PRESENTATION OF CONTENT ANALYSIS

Table 6 below shows statements in literatures chosen, paraphrase and author's interpretation to the latent and manifest content of statements. The research questions determined what was important as statement in this content analysis. The results are later presented in table 7. The articles chosen are presented in appendix 2.

Table 6. Content analysis

I. "How does cultural diversity affect the provision of care?"

Statement in literature source	Paraphrase	Interpretatio
"Migrants for example tend to receive less end-of-life care in hospices or at home. Moreover, when they do receive care, the care is often hampered by communication problems." "Care at home seems to reach relatively few migrants" "It is likely that the care needs of terminally ill Turkish and Moroccan patients in the Netherlands will be substantial, and will differ somewhat from the needs of Dutch patients" Graaff, F.M., Francke, A.L. (2009) Barriers to home care for terminally ill Turkey and Moroccan migrants, perceived by GPs and nurses: a survey. BMC Palliative Care; 8:3	Cultural diversity is a barrier to the receiver of care. Immigrants living in terminally ill care homes receive less care as compared to their counterparts who are citizens of that country and due to lack of communication either as a result of migrant's inability to learn the local language or the care providers' inability to speak the language of the migrant, the care received is affected. It could be affected through poor data collection, incomplete assessment and diagnosis. Consequently,	Following this line of thought, since certain factors such as communication, cultural perception of care and other aspects of life vary between one nation and the other, it is therefore reasonable to believe that cultural diversity may hinder the provision of care negatively especially against the migrant group.

	care at home is obtained only by a small number of immigrants. The care needs of the immigrants also differ because the family members prefer their elderly to receive care at home and not in service homes.	
“Older Asian-American, Hispanic, and African-American residents of nursing homes are also less likely than whites to have sensory and communication aids, such as glasses and hearing aids” “Vietnamese American women have a 500% higher rate of cervical cancer than the general population......Researchers also report that minority adults often receive fewer healthcare services” Xakellis G, Brangman SA, Hinton WL, Jones VY, Masterman D, Pan CX, Rivero J, Wallhagen M & Yeo G (2004) Curricular Framework: Core Competencies in Multicultural Geriatric Care. American Geriatric Society 52:137-142.	African-Americans, Hispanic, and Asian-Americans who live in nursing homes do not have access to sensory and communication aids such as glasses and hearing aids like their Caucasian counterparts. Vietnamese American women have a much higher rate of cancer than the others. This disparity is due to less access to healthcare services according to researchers.	The main causes in disparities in healthcare may not be known but the effects correlates with limited access to health services. Higher rate of cancer and other disease may also be as a result of poorer health outcome, education level, medical condition, socioeconomic status as well as poor health insurance coverage.
“Research indicates that Native Americans, Asian Americans, African Americans, and Hispanic and Latino groups tend to underutilize health and mental health services”	Some minority groups like Native Americans, Asian Americans, Hispanic and African Americans make	Underutilizations of service by certain groups are determined by their

"Data from this survey revealed that 43% of African Americans and 28% of Latinos, in comparison with 5% of white people, believed that because of their cultural background, a health care provider treated them poorly" Galambos CM (2003) Moving cultural diversity toward cultural competence in health care. Health & Social Work; Vol.28 Issue 1, P3, 4P; (AN 9109958)	less use of health services compared to the majority group. This underutilization of healthcare service by minority groups is due to their cultural background.	cultural background and this may be related to cultural insensitivity, discrimination, and oppression. Therefore, one may be tempted to conclude that cultural diversity may affect the provision of care to the elderly.

2. "How does culturally defined health belief impact the delivery of care?"

Statement in Literature source	Paraphrase	Interpretation
"Although Iranian immigrants' mental health needs match or exceed those of the host society, Iranian immigrants are far less likely to seek or receive mental health services than the host population" "Although 80% of the world's population lives in non-Western societies, many of the modern approaches to health, particularly mental health, have been defined by Western society for its nonethnic population"	Iranian immigrants who migrated to U.S are reluctant to seek mental health care services. The biomedicine which is a dominant western model of health treatment defines the medical trend of services rendered to care recipients.	Because of differences in conceptualization of mental health between Iran and U.S, the Iranian immigrants were reluctant to seek mental health services. Whereas holistic medicine theory suggests that health should be considered holistically,

Shadi Sahami Martin (2009) Illness of the mind or illness of the spirit? Mental health related conceptualization and practices of older Iranian immigrants. Health & Social Work, Vol.34, No 2.		biomedicine suggests detecting and eliminating illness while ignoring the cultural and social factors. Consequently, lack of healthcare services by immigrants will definitely affect their health and well-being.
"Conflicting value systems of what is meaningful in health care provision sets up barriers to achieving well being for older persons when cared for in different cultural contexts" "The family finds Mrs. Kim upset when they visit her each evening as a male nurse has been attending her personal care. She is being addressed by her first name and placed in the same sitting room with men residents" "They notice an untouched food tray containing the meal that they brought in for her the previous evening" Chenowethm L, Jeon YH, Goff M, Burke C (2006) Cultural competency and nursing care: an Australian perspective. International Nursing Review 53: 34-40.	When cultural values differ between clients and care providers, the care recipients often are not well cared for. Mrs. Kim is upset because she is being attended by a male nurse and she expresses her distress by not eating.	Culturally defined health belief is impacting significantly on nursing care quality. Sometimes it may lead to poor quality outcomes both to the health consumer and family.
"An example of cultural beliefs in the Latino population is the use of a folk	The use of folk healer is a common healing	A great percentage of Latina population seek

healer (curanderismo) or the use of home remedies as primary healing practices before and instead of Western medicine" "Latina patients reported greater satisfaction with NPs of Latina origin who were certified, had received cultural competence training and could speak Spanish" Castro A & Ruiz E (2009) The effects of nurse practitioner cultural competence on Latina patient satisfaction. American Academy of Nurse Practitioners :.278-286.	practice among Latino people instead of western medicine. Latina patients prefer care from nurse practitioner who is also a Latino and who is certified or registered and has received training on cultural competence. Such a nurse would also know how to speak Spanish	healthcare initially from a folk healer before reporting to physician which may be due to mistrust of the healthcare system. They also prefer nurse practitioners who are Latina perhaps because of unconscious bias on the part of the western nurses or due to poor client-provider communication and lack of cultural competence and sensitivity on the part of other nurses.

3. "How does culturally competent care affect adherence to treatment, care provision or the satisfaction of the client?"

Statement in Literature source	Paraphrase	Interpretation
White papers on healthcare policy concur that the needs of people from other cultures are not adequately addressed, and culturally competent care may address systematic healthcare disparities" "Cultural competence is fundamental to effective interpersonal interaction,	Healthcare publications suggest that the needs of people from other cultures are not properly taken care of and that giving culturally competent care to clients may help to address the differences	There is a need to design models of cultural competence to be used by healthcare professionals because of the effect of culture on healthcare. Culture determines

particularly in healthcare“ Capell J, Veenstra G, Dean E (2007) Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. Journal of Theory Construction and Testing; 11(1):30-37.	that result in that process. Cultural competence is very significant to effective interaction between client and care provider.	how people define health, wellness, illness, youth and old age.
“Research suggests that providing culturally competent care and ethnically relevant care improves overall health, increases patient care involvement, and reduces overall mortality“ Shadi Sahami Martin (2009) Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. Health & Social Work, Vol.34, No.2.	Researches in healthcare suggest that providing culturally competent care will improve the general health of the client, increase patient participation of care and most importantly reduce the number of deaths that occur	This will not only improve health but also go a long way to reduce the mortality.
“Cultural competency is now a core requirement for mental health professionals working with culturally diverse patient groups.....may improve the quality of mental health care for ethnic groups” Bhui K, Warfa N, Edonya P,	The study of cultural competence in healthcare is a very essential component in order to equip healthcare workers to be culturally competent because it may improve the quality of care	It is now almost mandatory to include cultural competence in the curriculum of studies of schools and healthcare providers in order to equip the care providers with

McKenzie K, Bhugra D (2007) Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research	especially for ethnic groups.	culturally competent skills. This will not only improve the quality of services rendered but also may improve mental health care of ethnic groups, and reduce the mortality rate.

Source: author

6. DISCUSSION: SUGGESTIONS AND LIMITATIONS OF THE STUDY

The demographic data showed that the Finnish population as well as other nations is ageing. Additionally, the number of elderly immigrants granted citizenship is on the increase. This means that the number of them requiring care will increase in the nearest future. This changing pattern of demography in the elderly population is a challenge to Finnish health care providers. There are three main concerns here; the Finnish elderly requiring care, the foreign immigrants requiring care, and the third concerns the nurses who are qualified abroad including those who studied in Finland but has been slow to acculturate. With this variation, how can the healthcare providers guarantee satisfactory care in order to mitigate disparities between clients and care providers? In this study, the author focused on the influence of cultural diversity in providing quality care as well as the use of cultural competency to mitigate disparities. The author by comparing results of previous studies concerning the use of cultural competent care to mitigate disparities found many similarities but also differences.

However, it is important to understand that the results of this thesis is not based on studies conducted in Finland. The author thinks that consideration of these facts would be of help to the Finnish healthcare system. This is inview of the fact that the Finnish population is also ageing as established in the demographic data and in future more healthcare providers may come from different cultural backgrounds. The author thinks that a questionnaire is needed to get the Finnish perspective of this subject. Therefore, the use of content analysis in this work is just to show that ageing is a worldwide problem and not just a problem only in Finland.

The author has identified Purnell’s model of cultural competency as most effective and practical method to implement. According to Purnell, healthcare providers who understand and respect the cultural values and beliefs of their clients stand a better chance or position to administer a good care. This means that great effort on the part of the healthcare provider is needed (Purnell, 2009). However, achieving culturally competent care is not the duty of providers alone. Culturally competent care is the responsibility of all in the healthcare sector and not just the providers (Markova & Broome, 2007).

According to the results, some factors such as communication pattern, cultural perception of care vary from one country to another. Inability of care providers to learn the client's language or inability of the clients to learn the language spoken in new areas of residence compounds the problem between both parties. This problem of language also makes it possible for some care recipients to underutilize services provided. In this situation, application of Purnell's model of cultural competence becomes a problem because when a care provider do not understand what a client wants, it becomes even more difficult to know what that person wants. However, it is very pertinent for care providers to learn about the cultural beliefs of their clients because this will help them provide better care (Purnell, 2009).

Failure to respect the cultural beliefs of clients may result to misunderstandings as exemplified in the care between Iranian immigrants who would prefer holistic medicine theory to biomedicine. Holistic medicine suggests that healthcare should be analyzed in whole, that is, mentally, spiritually, emotionally, cultually, socially, and physically whereas biomedicine suggests that illness should be detected and eliminated while ignoring the cultural, and social factors of the client. The former method is in harmony with cultural competence because it promotes respect for clients cultures and beliefs (Shadi, 2009). In some cultures, they prefer to consult their folk healers instead of going to the medical doctors. This is a serious problem because seeking medical advice from two different healthcare practitioners can be confusing and frustrating especially in situations where health means different things. Furthermore, when cultural values differ between clients and care providers, the care provided is always affected. It is reasonable to therefore say that culturally defined health belief is impacting significantly on nursing care quality.

In order to avoid the disparities that comes with cultural diversity, the implementation of culturally competent care is very relevant. Definitely, there will always be misundestandings but the application of this method of care may be of great help. It is essential to include cultural competency training in curriculum of studies in institutions of learning (Bhui et al. 2007).

The application of cultural competency as a care method has been criticized due to inability of writers to come to a consensus on a universally accepted definition (Capell et al., 2007). Additionally, according to (Bhui, Warfal, Edonyal, Mckenzie, Bhugra,

2007, Capell et al. 2007), the application and practical use, assessment and evaluation of cultural competency is problematic. This is so because there is a considerable confusion about what people understands to be cultural competence. Sometimes it is narrowly understood to mean getting a better knowledge about the cultural beliefs and practices of a particular cultural group. However, this limits the possibility of understanding how culture modifies the perception of illness, behavior, and interventions. Irrespective of the growing body of health and educational policies trying to favor cultural competency, there is still little agreement on the meaning of the concept (Bhui et al., 2007). This therefore shows that cultural competency is a cultural construct.

This is very true especially when we consider Purnell's meanings to cultural competency. Purnell (2009) gave twelve meanings to the concept of cultural competence. This illustrates the difficulty in reaching a compromise on the meaning of the concept. Despite obvious divergence in the definition of concept by writers, there were also considerable convergences. The common meaning of the concept which was different in most of the reviewed articles was that of developing awareness, sensations of other cultures in order to understand meanings of health and illness by client's culture. This means being open to cultural encounters and giving care the way it suits client. However, in addition to making the concept clearer, Purnell, (2009) included ideas which were not found in the chosen articles. For example, attending conferences, reading professional literatures, and observing cultural practices were factors which were not found in the articles but which are essential in order to apply cultural competence in care.

Gunaratnam (2007) links cultural competency to an abstract system. Making reference to Giddin's (1991), he says that abstract systems are interested in controlling knowledge and everyday routine. Secondly, abstract system excludes questions that are raised everyday by nature, criminality, sickness, and death in order to protect their ontological security. What he means to say is that there is no assessing or evaluating standard in the use of cultural competence.

The inability of writers to come to a compromise on the meaning of this concept raises so many questions. For example, who defines cultural competency when it is applied? Should it be defined by health care providers or by clients or family of clients? Let us assume that cultural competency should be defined by care recipients, how do you

apply cultural competent care in the end-of-life care of elders from minority groups? How does a ninety year old lady with dementia who needs 100% assistance define cultural competency? What does it mean to her? What does it mean to a care recipient at the end-of-life care? Additionally, the level of application also shows the weaknesses of this concept. Should it be applied and taught at an individual level or should it be applied at the organizational level. The irony in this line of thought is that the only measurement standard that claims to test cultural competency only measures at the organizational level and not at individual level (LaVeist et al., 2008). Additionally, should it have been better if those in charge of cross-cultural studies to establish a common or precise word that describe cultural competence due to inability to reach a consensus? Capell et al. (2007) thinks so.

When we consider the differences in individuals, we definitely have nothing but doubts in our minds. For example, a client from a country with a high degree of authoritarianism may conclude that it is best if the health care provider decides what is good for the client and will readily accept whatever suggestions given by health care providers. This might not be true with a client who comes from a country where individual rights and autonomy is highly valued. The former example applies to Nigeria and some other African countries while Finland is a good example of the latter. Therefore, it is necessary to staff your organization with some personnel who are members of the same ethnic group like the client to reduce the subtle cultural barriers that may arise (Yehieli & Grey, 2005).

Another blow to the concept of cultural competency concerns the second core component which is cultural knowledge. This component means that healthcare providers should learn the cultural behaviors of their clients. Assuming that a care provider has gained adequate knowledge about a particular cultural group, how does he/she apply it to individuals who share this culture bearing in mind the unique differences of every individual? Well, this might be a difficult or easy question to answer but Gunaratnam (2007), thinks that making assumptions about families based on text book ideas might be misleading because despite the fact that they are common behavioral similarities among people from the same culture, every individual lives out their faith differently. Therefore, instead of following what the text books say, it is pertinent sometimes to also turn to the client and ask what he or she wants instead of generalizing everybody (Galanti, 2008). Gunaratnam (2007) concludes by saying that

the concept of cultural competency functions as a “protective cocoon” or protective coverage or envelope which has no practicality. No matter how unreasonable this line of thought may sound, there is an element of truth in it.

Following this line of thought, the author of this work has proposed suggestions to providers of care and healthcare organizations. This is very important because application of a culturally competent care is also effective depending on which level or method it is implemented. In harmony with any social research, this study seeks to use suggestions as solutions to social problems, suggestions to emancipate and therefore empower and liberate people (Sarantakos, 1998). It is important to mention that the articles used were relevant to the understanding of this work. This is so because they gave opinions from the nurses and patients point of view making the ideas balanced and authentic.

As an intervention plan, the author has given suggestions to individuals who are professionals in care work, to the healthcare organizations whose primary responsibility is to deliver quality care. The third suggestion is directed to academic institutions that specialize in training healthcare professionals. The author divided the groups into cultural competence at individual level, cultural competence at organizational level, and finally cultural competence at the level of academic institutions.

6.1 Cultural Competence at Individual level

Following the findings from literatures reviewed, they suggest that a culturally competent individual is able to accept, acknowledge, and respect the cultural differences of others (Bhui et al., 2007). Such person has the knowledge and skill that will enable her/him to appreciate differences and similarities. Such person is able to put the ‘LEARN’ model of communication or interaction into practice: Listen, Elicit, Assess, Recommend and Negotiate (Bhui et al., 2007).

Following the developmental process mentioned earlier (acceptance, knowledge, and skill), the importance of education and training is emphasized.

- Providers should be familiar with verbal and nonverbal communication styles of their clients. This means understanding the meaning of eye and physical contact

to a particular cultural group, health beliefs and practices, and most importantly the worldviews and values of clients.

- Avoid stereotyping and overgeneralization.
- Be able to explain major ethnic minorities' views on epidemiology of diseases, differences in response to medication, and measures to assess them.
- Common alternative medical practices that are valued in other places besides Western practices
- Major strategies to cope with disease or illness such as the use of prayer and being religious
- Understand the role of family in decision making
- Be able to understand the meanings of such terms as culture, minority, and acculturation
- Understand and be able to explain the concept of cultural competence
- Assess your individual level of cultural competency and make improvements
- Make improvements on your language deficiency where appropriate in order to be able to interpret meanings or explain things correctly to your client (Bhui et al., 2007).

6.2 Cultural Competence at the Organizational level

This means implementing or focusing implementation at the organizational level. In the U.S, cultural competency is considered an organizational asset that could affect quality of care and cost effective. As a result of this there is the creation of Cultural Competency Organizational Assessment called 360 or COA360. This is a measurement instrument designed to evaluate the cultural competency level of healthcare organizations (LaVeist et al., 2008). The only weakness to this measurement tool is that it is not able to measure individuals but only organizations. Therefore, healthcare organizations are suggested to do the following;

- Promote and support the attitudes of staffs to be able to get the right knowledge and skills necessary for a competent care
- Implement strategies to address cultural and linguistic appropriate services
- Develop educational programs for educating staffs

- Provide clients access to language interpretation. The language act (6.6.2003/423) states that Finnish and Swedish are national languages and therefore nationals of Finland should receive healthcare and nursing services in both languages as decreed in Public Health Act (66/1972) and Special Nursing Act (1062/1989). However, the Finnish constitution (731/1999) states that every person has an equal right in law. It continues by saying no person should be treated differently from another on the basis of religion, beliefs, origin, sex, age, and language. Take note of what paragraph 17 had to say "Finnish and Swedish are the official languages but guarantees the Sami and some other groups the right to maintain and develop their own culture and language".
- Recognize and accept the differences between client and organizational values
- Accept alternative medicine practices preferred by clients
- Design and implement services in harmony with clients needs
- Provide written and oral notices at key points of contact to clients and visitors
- Encourage staffs to demonstrate language abilities in the official languages
- Use accurate methods to collect and analyze data for minority ethnic groups and be concerned with their needs
- Keep on assessing the cultural and linguistic competence of an organization
- Develop procedures to address and handle cross-cultural ethical and legal conflicts
- Document and evaluate annual progress and make improvements where necessary (La Veist et al., 2008).

Academic Institutions: Agencies to further the course of cultural competence

In the U.S, schools have incorporated cultural competency studies into their curriculum of studies (Chilgren, 2008). The main reason is to help students to be prepared in providing competent and high quality care to the diverse ageing population. To address this need in Finland, Arcada University of Applied Sciences partnered with placement centers should create a curricular framework that will focus on equipping students to be culturally competent. Faculty leaders should develop academic programs that specialize

on training students on issues pertaining to cultural competence. The author of this thesis work suggests that introduction of courses aimed at understanding the core components of cultural competence should be integrated into curriculum of studies with each level focusing on one of the core components. It should be divided in such a way that by the end of a degree program in health and social care, students should be familiar with cultural practices and beliefs of major minority groups. Encourage and involve students in interactive case studies to illustrate the complexity of cultural diversity and possible methods to overcome challenges. Implement methods to teach the students by including elders from majority ethnic groups in Finland. The author thinks that the inclusion of elderly people from minority ethnic groups into the course "Senior citizens" might be a highly valued idea.

A potential limitation of this thesis work is the writer's status as a foreigner in Finland. The author's outsider perspective can also be viewed as an asset because it influenced his perception of this great idea which is an area of study lacking research.

Another limitation to this work is the method of research. A qualitative content analysis of literatures outside Finland might influence the result. Experiences in U.S, Canada, Australia, or New Zealand may not be applicable or helpful in Finland and vice-versa. Therefore, the author thinks that empirical studies in Finland would have been very necessary to get the Finnish perspective on this matter.

A further limitation to this work is the author's lack of knowledge on the diversity level in order parts of the country. This issue of cultural diversity may not be a common problem in other smaller cities in Finland and therefore cannot or should not be over emphasized. In order words, what the author is offering is just a snapshot of cultural diversity only in Helsinki region.

7. CONCLUSION

The aim of this study was to find out how healthcare providers can use cultural competence to mitigate disparities that occur in nursing homes. Due to the demographic change in world population, this study is very relevant. It must be admitted, however, that this subject is very new and requires further research. The study has been able to answer the research questions establishing beyond all reasonable doubt that in as much as cultural diversity can cause some misunderstandings, the use of cultural competency might not be a cure but will go a long way to mitigate or diminish problems. This means, healthcare providers should continue with education training or read about the ways in which cultures differ to develop awareness and respect for differences. Healthcare organizations should make adequate provisions to enable their employees to be able to meet the required standard of being competent individually and as an organization. As an institution for academic excellence, Arcada University of Applied Sciences should be able to equip students with knowledge on how to become culturally competent healthcare professionals.

The main ideas behind the use of cultural competency in healthcare organizations are geared towards social justice and equity (LaVeist et al. 2008). This is in harmony with the constitution of Finland. The Act on the Status and Rights of Patients (785/1992), states that a patient is entitled to receive good quality health care and nursing. This means care in harmony with patient's human dignity and beliefs.

The author believes that if healthcare professionals, healthcare agencies and Arcada University of Applied Sciences can heed his suggestions, not only will it improve the quality of care given to our diverse ageing population but most importantly satisfaction to them. Thus, together in one accord, let us all make it our grand objectives to put cultural competency in practice. Now is the time.

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APPENDIX 1:

MEANING OF TERMS AS USED IN THIS WORK

1ST generation immigrants: Persons born abroad of two non-Finnish parents who have migrated to Finland.

2nd generation immigrants: Persons born in Finland with two foreign-born parents

Persons with immigrant background: Persons adopted from abroad, foreign-born with one Finnish-born parent and Finnish-born with one foreign-born parent

Non-western immigrants: Immigrants from Eastern Europe, Asia, Africa, and South/Latin America

Western immigrants: Immigrants from Nordic countries, Western Europe, North America, and Oceania

Worker with immigrant background: People who have moved to Finland from abroad for a variety of reasons at different times, and also their descendants

Patient/client: A person who uses health care services

Healthcare: Measures taken by healthcare professionals or in healthcare units in order to assess the state of health of a person or to maintain the health of such a person

Healthcare professionals:Persons who carry out healthcare services and includes; gerontologists (geronoms), nurses, practical nurses, physiotherapists, doctors, occupational therapists etc.

Statistical discrimination: Imprecise indicators of a patient's clinical condition because of wrong diagnostic tests or when clinicians give a wrong diagnosis due to cultural or language differences.

APPENDIX 2

TABLE 7: Presentation of chosen articles, authors, aim and results

Articles chosen	Authors, year aims, analyses method, and results
1	The effects of nurse practitioner cultural competence on Latina patient satisfaction: Anabel Castro & Ester Ruiz (2009) Aim: To find out the relationship between patient satisfaction and the level of cultural competence in nurse practitioners among Latinas Analyses method: Descriptive analysis and correlations Results: NPs of Latina origin who received training in cultural competence, were certified and able to speak Spanish were preferred by Latina clients
2	Cultural competence in mental health care: a review of model evaluations: Kamaldeep Bhui, Nasir Warfa, Paticia Edonya, Kwame MaCkenzie and Dinesh Bhugra (2007) Aim: To find out if training in cultural competency improves the quality of mental health care for ethnic groups Analyses method: Qualitative content analysis Results: There is change in attitudes and skills of staffs after undergoing training and therefore significant satisfaction of clients

3	Cultural Competency and nursing care: an Australian perspective: L. Chenowethm, Y.-H. Jeon, M. Goff, C. Burke (2006) Aim: To propose a process that will help to promote cultural competence in the practice nursing in Australia Analyses method: Qualitative content analysis Results: Cultural diversity is having great impact on the quality of care offered in nursing homes. There is a need for culturally competent care
4	Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants: Shadi Sahami Martin (2009) Aim: To find out whether Iranian immigrants' concept of mental health have any influence on their mental health-related practices Analyses method: Qualitative phenomenological methodology Results: Iranian immigrants who migrated to U.S after 50 years of age were reluctant to seek mental health services from American practitioners.
5	Intercultural residential care in New Zealand: Liz Kiata and Ngaire Kerse (2004) Aim: To determine how culturally defined health can have effect on the care given to older people Analyses method: Exploratory field study Results: The use of cultural competence will improve misunderstanding because of the cultural differences between the care providers (Pacific Islanders) and care recipients (Pakeha).
6	Barriers to home care for terminally ill Turkish and Moroccan migrants perceived by GPs and nurses: a survey: Fuusje M de Graaf and Anneke L Francke (2009) Aim: To explore how GPs and home care nurses understand the home care

	for terminally ill migrants and their families from Turkey and Morocco living in the Netherland Analyses method: Descriptive statistics Result: Care professionals should understand needs of migrants and family members in order to render effective care
7	GPs' strategies in intercultural clinical encounters: Ellen Rosenberg, Laurence J Kirmayer, Spyridoula Xenocostas, Melissa Dominice Dao, & Christine Loignon (2007) Aim: To bring to light strategies employed by GPs on patients who come from different cultures Analyses method: Qualitative inductive study Result: Three successive strategies employed included insistence on patients' adaptation to local beliefs and practices, physician adaptation to patients assumed needs and finally negotiation between physician and patient
8	Curricular framework: core competencies in multi-cultural geriatric care: George Xakellis, Sharon A. Brangman, W. Ladson Hinton, Vida Y. Jones, Donna Mastermind, Cynthia X. Pan, Jorge Rivero, Margaret Wallhagen, Gwen Yeo (2004) Aim: To develop a curricular framework for cultural competence training to assist medical and other health professional schools at the University of California Analyses method: Qualitative content analysis Result: In order to offer quality care, there must be a good patient-provider relationship. Cultural competency does not require healthcare professionals to be familiar with every belief and practices of a particular culture
9	From competence to vulnerability: care, ethics, and elders from racialized

	minorities: Yasmin Gunaratnam (2007) Aim: To discuss the meaning of social policy initiatives aimed at providing competence to patients at the end of life. Analyses method: Qualitative content analysis Result: There is no relationship between acquiring cultural knowledge and offering quality care.
10	Cultural competence in healthcare: Critical analysis of the construct, it's assessment and implications: Jennifer Capell, Gerry Veenstra, Elizabeth Dean (2007) Aim: To review models and assessment tools which claimed that the use of cultural competence can minimize healthcare disparities Analyses method: Assessment and evaluation of existing tools Result: Applying culturally competent care may augment the outcome of patient's health including satisfaction of patient needs and also reduce disparities in healthcare.