ARCADA

Cultural Competence in Provision of Care

A Literature Review

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Abstract:

The aim of the study was to explore and analyze through literature review, the importance of cultural competence in provision of care. In other words, it explores the unique ways of providing services in a way that is respectful of and responsive to the health and care beliefs, practices, cultural and linguistic needs of a diverse aged population. It includes an understanding of the determining role that culture plays in all of our lives and of the impact culture has on every care provision encounter. It is a combination of attitudes, knowledge base, acquired skills, and behaviors that helps care professionals learn more about the impact of culture on health and care provision decisions. The research question is therefore, how does cultural competence affect provision of care? Qualitative content analysis developed the work. Materials were from Academic search Elite (EBSCO), CINAHL and SAGE. Additional articles were identified through reference list. The findings found that if sociocultural differences between caregiver and recipient are not explored and communicated, client dissatisfaction, no adherence and poorer health and care outcomes may result. In conclusion the concept of cultural awareness, cultural sensitivity, cultural safety and cultural competence demonstrated satisfactory, compliance, knowledge base and reduced disparities

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Tiivistelmä:

Opinnäytteen tavoitteena oli tutkia ja analysoida kirjallisuusarvioiden kautta kulttuurisen pätevyyden tärkeyteen vanhuspalvelujen tarjoamiseen. Toisen sanoen se tutkii ainutlaatuisia tapoja palvelujen tarjoamiseen tavalla, joka on kunnioittava ja avoin monimuotoisen ikääntyneen väestön terveyteen ja hoitoon liittyviin uskomuksiin, käytäntöihin, kulttuurisiin sekä kielellisiin tarpeisiin. Tämä on yhdistelmä asenteita, tietopohjaa, hankittua taitoja sekä käytöstä mikä helpottaa ammattilaisia oppimaan enemmän kulttuurin vaikutuksista terveyden ja terveydenhoidon palvelujen kysymyksissä. Tutkimuskysymys on siksi, miten kulttuurinen pätevyys vaikuttaa hoidon tarjoamiseen? Tutkimus perustui laadullisen sisällön analyysiin. Aineistot ovat seuraavista tietokannoista Academic Search Elite (EBSCO), CINAHL ja SAGE. ADDITONAL artikkeleita on merkitty lähdeluetteloon. Tulokset osoittavat, että mikäli sosiokulttuurisia eroja hoidon tarjoajan ja saajan välillä ei tutkita ja niistä ei viestitä, saattaa tämä johtaa asiakkaan tyytymättömyyteen, hoito-ohjeiden noudattamatta jättämiseen ja huonompaan terveyteen sekä huonompiin terveyspalveluihin. Johtopäätöksenä tietoisuus kulttuurisen valveutuneisuuden, herkkyyden, ja turvallisuuden käsitteistä on lisännyt tyytyväisyyttä hoitoon, hoito-ohjeiden noudattamista ja tietopohjan sekä vähentäneet hoidon eroavuuksia.

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FOREWORD

The author of this work would gratefully like to thank the Finnish state and the Finnish people for offering free education and providing a peaceful environment for the Immigrants. Not forgetting Arcada administration as a whole that believed in the author and gave him a chance to learn and experience life.

Special thanks go to my loving wife Mary who kept reminding me that, it might be hard but when done it is a new page of opportunities in our life. This was a motivation of its kind that even brought reality closer.

To my kids Jane and Daniel, you played a big role in reminding me that besides writing this work I had other responsibilities, getting concerned of my long hours on the computer was a good alert especially for 1.5 year old Daniel who drew on the research papers.

Thank you all.

1 INTRODUCTION

The movement of people and increase in diversity around the world has brought the realization that, current models of healthcare and health education are not adequately responsive to the changing needs of populations around the globe Andrews (2010 p 54s). And as a consequence of these movements, the world has become a global village where people moving in and out of their national boarders in search of a better life, changing the world and it environment tremendously. Most Western countries are becoming increasingly multicultural due to migration of which Finland is not an exceptional.

According to Niessen, Jan & Yongmi Schibel (2002, P, 2) Europe's population is diminishing in size as well as becoming older. Ageing has shortened the employment period and the dependency ratio of persons in retirement ages is relative to those of working age. In reality those in employment need to support more people out of employment. There is therefore need to consider migration as an important ingredient and improve level of integration to respond to demographic trends.

The population of Finland is 5.1 million, and Finns comprise 94% of the general population. The ethnic minorities are Sami (7000) and Roma (10, 000). Foreigners mainly from Russia, Estonia and Sweden are estimated to be around 107, 000 (Statistics Finland 2009). Migrations from different countries are growing from year to year, for instance, in between 1973 and 2003, 22, 250 refugees immigrated to Finland (Statistics Finland 2009).

It is mainly during this period that Finnish people started facing cultural differences and they belief that these new cultures need to be understood which helps to provide transcultural health and social care (Papadopoloulos, 2006). The Finnish state is challenged to make appropriate provisions to health, social and welfare programs to accommodate the ethnic minorities, while health /care workers are challenged to adequately prepare to provide them with culturally competent health care and other social services.

The fact that demographic change is a reality and without doubt unavoidable Giger et al (2007 p 96).These changes in healthcare will dictate how provision of health and elderly care will be strategized and implemented. And as Finland becomes increasingly diverse, due to migration and the need for more workers in the country, care givers will meet, interact and care for clients from a variety of sociocultural backgrounds on a daily basis.

According to Xu (2004, P 435), culture values and beliefs plays a large role in shaping health and to an extent determine how a client/ patient respond to care. Cultural values cannot be ignored in a multicultural community, they are critical elements in care, and they affect behavior and action modes. The belief that culture has an important aspect on once live that include: behaviours and attitudes to illness, pain and other misfortunes may affect care (Papadopoulos. I, 1999 P, 1098). This can be a challenge for an elderly person who may have experienced a lifetime of change and just wants things to be "normal".

The fact that culture runs in our blood Xu (2004, p 433). The changes in health care setting can be a challenge to the native, care provider, recipient of care and their family. What is therefore important is the healthcare provider of a diverged community to understand the specific cultural beliefs and values of the client during cultural encounter so that reliable care plans and decisions about care are developed (Papadopoulos. I, 1999 P, 1098).

Ethnicity has been shown to have considerate importance in determining variations in the aging experience, defining of need and how the elderly make use of the services available to them Papadopoulos. I, (1999, P, 1097). Where a person comes from can help one to provide personalized and respectful care. On the other hand, stereotyping people based on their country of origin, race or on where they currently live can be dangerous. What is needed is consideration of cultural diversity and cultural custom knowledge to avoid misunderstanding and provide holistic care.

According to Capell, Veenstra, and Dean (2007, p, 30).There is need to address the healthcare needs of a culturally diverse people and service delivery because when people meet from different cultural back ground, trying to understand and be understood cause frustrations due to language barrier and cultural differences and in turn may affect key information, assessment and care planning documentation Tuohy. D et al, (2008, P, 166).

Despite the fact that cultural competence is crucial to reducing health disparities and improving healthcare, Duffy (2001, p 488) belief that currently care/ nursing is going through a cultural crisis due to peoples movement around the world (see Tuohy. D et al, 2008, P, 164).And there are challenges in delivering culturally competent care. Although cultural competence will not eliminate all health disparities in care, it will play an influential role in improving client's satisfaction and their interaction with their caregivers.

1.1 Motivation of choice of topic

The author was motivated by past experience, He was a victim of communication barrier, it happened to him while he was undergoing his first practical training on activities of daily living in one elderly home in Helsinki. In the institution communication was either Finnish or Swedish language and since the author had been in Finland for a year by then his Finnish communication skills was inadequate. The author could only speak very few words and understand very little.

The author's daily activities at the practical training included: walking around with the clients, assessing the client, report writing and discussing each day event with the client. The aim was to improve the author communication skills for better service delivery to the elderly. The client was a 75 year old woman, loved singing, social and very cooperative. She had been having Alzheimer since she was working and due to deteriorating of her memory she could not live alone anymore. She needed help and assistance in activities of daily living. Due to her increase in weight, the author, s supervisor and the author had a goal to client weight control, one morning at around 10 am the author, s supervisor and the author planned for a walk. The author and the client had to make a 30 min walk around the institution then come back before lunch.

Before they left the elderly home, the client asked three questions:
Kuka tämä on? Meaning who the author was.
Mihin olemme menossa? asking where they were going.
Mistä hän on kotoisin? asking where the author came from.
According to author, s supervisor translation, she told the client that the author was a student, he was from Kenya and that they were going for a walk.

After preparation the author and the client took off and started walking. A few minute later at round 10:12am while on their way the client stated some words and they were as follows: mihin minossa? The author felt that, he had heard so of the words from the previous conversation with the supervisor and so the author told the client Kenya.

The client sat down on the path way and started shouting en mene Keniaan, en mene Keniaan. The author was very shocked, confused not knowing what to do. He tried to help her stand because he thought the client was in pain but to no avail. The author immediately called for help from the institution and in few minutes a group of three nurses including the author's supervisor came to rescue.

When the client saw the nurses at a distance, she started shouting kiitos, kiitos tule auttaa minua. The author supervisor spoke with the client and after a short conversation the client stood up and joined the others going back to the institution. None of the three nurses asked the author any question they knew so well that the author did not speak nor understand Finnish and they had the fear to speak English.

On arrival at the elderly home, the author's supervisor told the author that there was nothing to worry and that it was just a misunderstanding between the client and the author. All went well but at report time the nurses had a laughing time narrating to each other the morning time drama. And to the author it was a learning experience not to ever comment or answer anything that one do not understand or know the meaning.

1. 2. Aim and Research Question.

It is through this introduction that this study aims to explore and analyze through literature review, the importance of cultural competence in provision of care. In other words, it explores the unique ways of providing services in a way that is respectful of and responsive to the health and care beliefs, practices, cultural and linguistic needs of a diverse aged population.

It includes an understanding of the determining role that culture plays in all of our lives and of the impact culture has on every care provision encounter. It is a combination of attitudes, knowledge base, acquired skills, and behaviors that helps care professionals learn more about the impact of culture on health and care provision decisions. The purpose is to describe and obtain and understanding of elderly care experiences in health and care provision and the role cultural competence play in these experiences.

A central basic assumption of the study is that when sociocultural differences between caregiver and recipient are not explored and communicated, client dissatisfaction, no adherence and poorer health and care outcomes may result. The research question is therefore:

Research Question

1. How does cultural competence affect provision of care?

The research question will help the author to explore the importance of cultural competence in provision of care through Papadopoulos (2006) and Campinha-Bacote 2008 model for developing cultural competence.

1.3 Concept Definitions

Cultural awareness: The care giver becomes sensitive to values, beliefs, lifestyle, and practices of the patient/client, and explores his/her own values, biases and prejudices. Unless the care giver goes through this process in a conscious, deliberate, and reflective manner, there is always the risk of one imposing his/her own cultural values during the encounter (Campinha-Bacote 2008).

Cultural knowledge: The process in which the care giver finds out more about other cultures and the different worldviews held by people from other cultures. Understanding of the values, beliefs, practices, and problem-solving strategies of culturally/ethnically diverse groups enables one to gain confidence in his/her encounters with them. It is the process that provides the primary and experiential exposure to cross-cultural interactions with people who are culturally/ethnically diverse from oneself (Campinha-Bacote 2008).

Cultural sensitivity: As a process, it is concerned with carrying out a cultural assessment. Based on the cultural knowledge gained, the care provider is able to conduct a cultural assessment in partnership with the client. According to Papadopoulos (2006), it is a process where care givers view their clients as partners in negotiating the appropriate care, and treat them as unique individuals with unique needs. Cultural sensitivity involves acceptance, trust, respect and facilitation (see Andrews 2010, p 118s).

Cultural competence: According to Papadopoulos (2006)Cultural competence requires synthesis and application of previously gained awareness, knowledge and sensitivity It involves understanding others cultural beliefs and behaviors, the ability to communicate effectively, the ability to conduct a cultural assessment, and the ability to challenge racism, discrimination and ethnocentricity (see Andrews 2010, p 118s).

2. Background

The concept of cultural competence has become a priority due to the changing demographics and economics of a growing multicultural world Campinha-Bacote (2002 p 181). Most occupations example business and rehabilitation involve a direct contact between professionals and individuals from different cultural backgrounds F. E. Balcazar et al (2009, p 1154).According to (Capell, Veenstra, & dean 2007, p 30) Leininger claimed to be the first to have described the term cultural competence. Papadopoulos (2006) defined cultural competence as ability by health care providers and health care organizations to understand and respond effectively to cultural and linguistic needs of client (see Andrews, 2010.p, 118s); a complex combination of knowledge attributes and skill (Andrews 2003, see Shen p 321) emphasized the importance of space, self-awareness, respect and communication. It is a process but not an event (Campinha-Bacote 2002, p, 181).

Campinha-Bacote (2003) also de-emphasized the idea of an end point in reaching cultural competence. She defined cultural competence as a process in which one continuously strives to achieve the availability to effectively work within the cultural context of a client, individual, family or community(see Capell, Veenstra, & dean 2007,p 30).

Research on cultural competence in Finland has mainly focused on ethnic minority and their interactions with Finnish health care workers, discrimination against culturally diverse residents living in Finland, language barrier, non-Finnish speaking clients, and minorities experiences from customer/employ point of view.(Clake, 2005,Markkanen, & Tammisto 2005).

Although Finland is according to National Minorities of Finland (2004) considered as one of the most culturally homogeneous countries in Europe, the concept of cultural competence in health care is becoming a priority due to globalization, migration and trends in ageing, caring and cultural diversity.

According to Niessen, & Schibel (2002) population ageing is more advanced in Europe. Finland has the world´s fastest ageing population (Statistics Finland, 2007). With increase in life expectancy and the baby boomers going on a massive retirement, the number of elderly people in need of care will increase rapidly. See Figure 1

According to Honkatukia (2006), due to ageing of the population, the labor force is decreasing, causing shortage of labor in health and care field and on the other hand create a demand for the same services. The number of people speaking foreign language has also increased mostly in Helsinki (Statistics Finland 2009).see figure 2

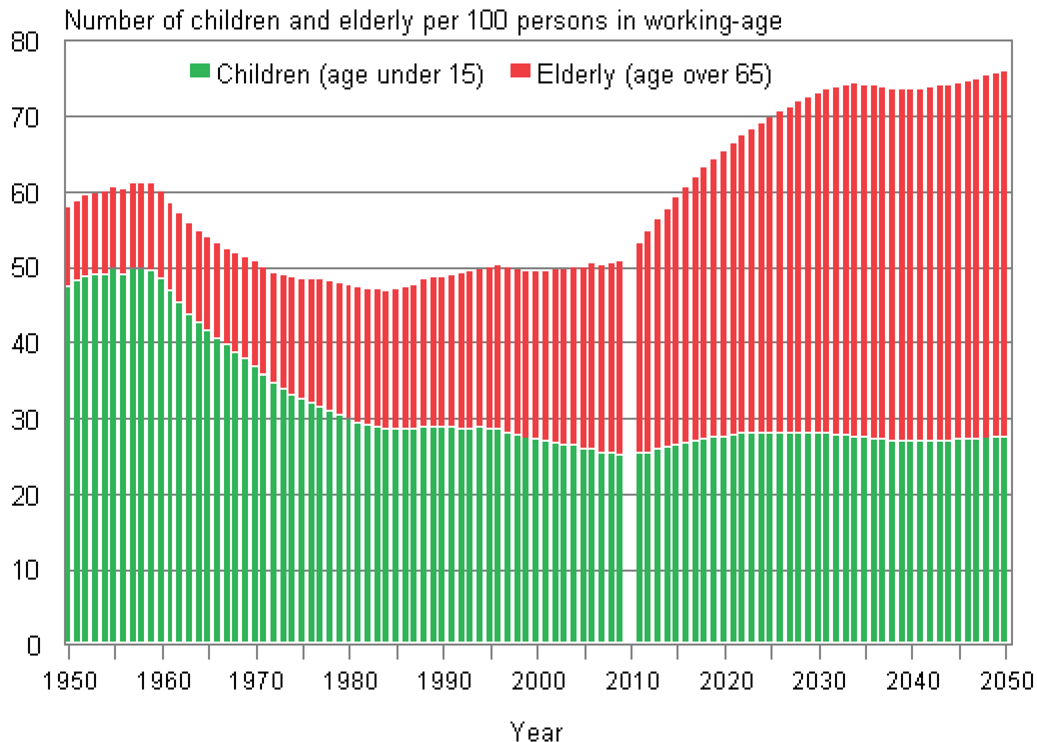
As the goal of any health and care system is to provide optimal care to all clients, Finland is one of the countries that face challenges in providing culturally competent elderly care, and thus the implementation of cultural competence and a client centered approach to care might be one of the solutions to these challenges.

2.1 Migration a solution of Labour in Finland.

Before the 1990s Finland had not attracted many Immigrants because baby boomers had ensured supply of labor. The number of immigrants grew rapidly then after and it have been continuous to date. With baby boomers going to retirement and a low fertility rate there is need to welcome and recruit immigrants to fill the gap between 15-65 years. (Statistic Finland 2007)

The diagram below illustrates the current situation and projection for the future in Finnish population.

Demographic Dependency Ratio in 1950-2009 and Projection for 2010-2050



Source: Population Structure 2009, Statistics Finland

Figure 1

The diagram below shows how the number of pensioners is growing at a very fast rate and the number of children between the ages of 0-14 is also high than the employed and thus resulting to a reduced labor force, decline in economy, no enough taxpayers to sustain rapidly rising pension expenditure and also increase need for health care and other services.

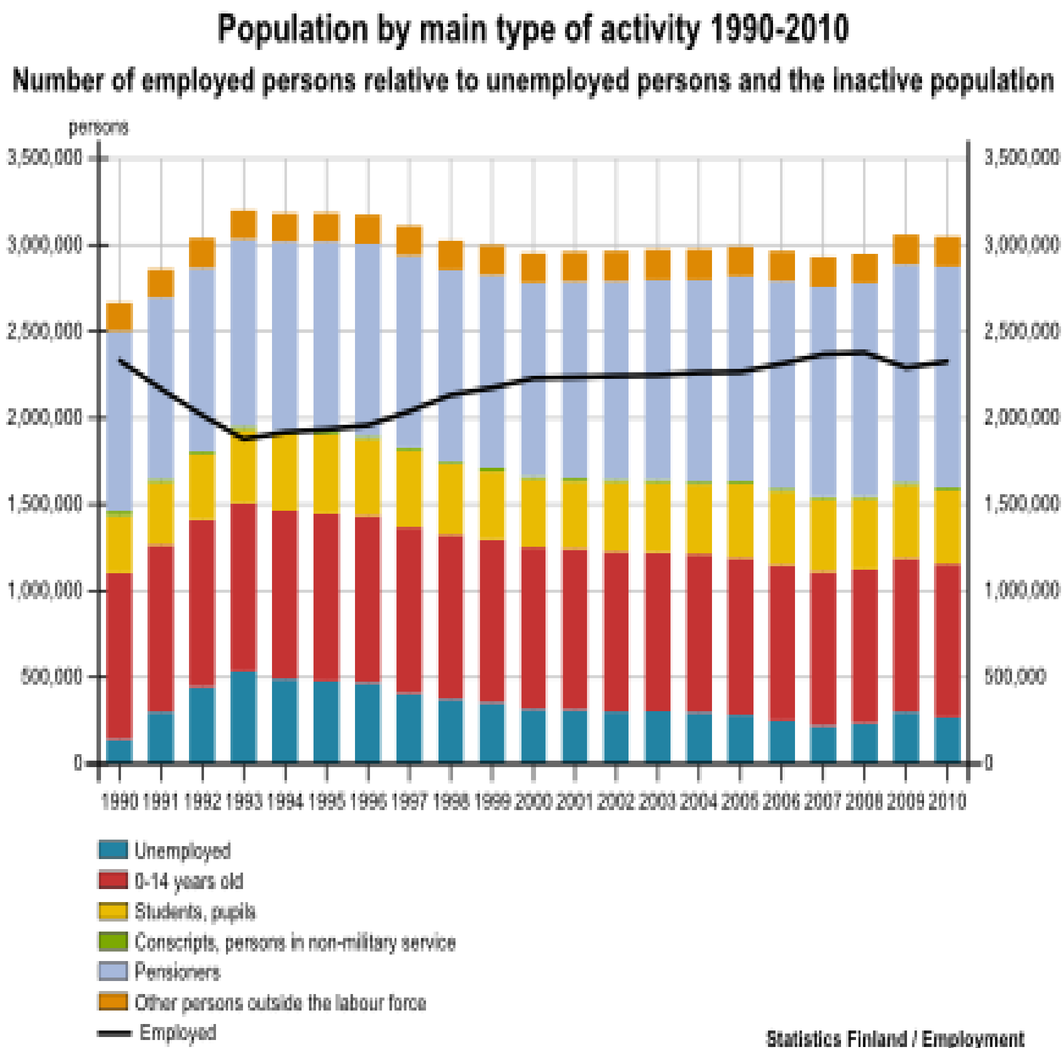


Figure 2

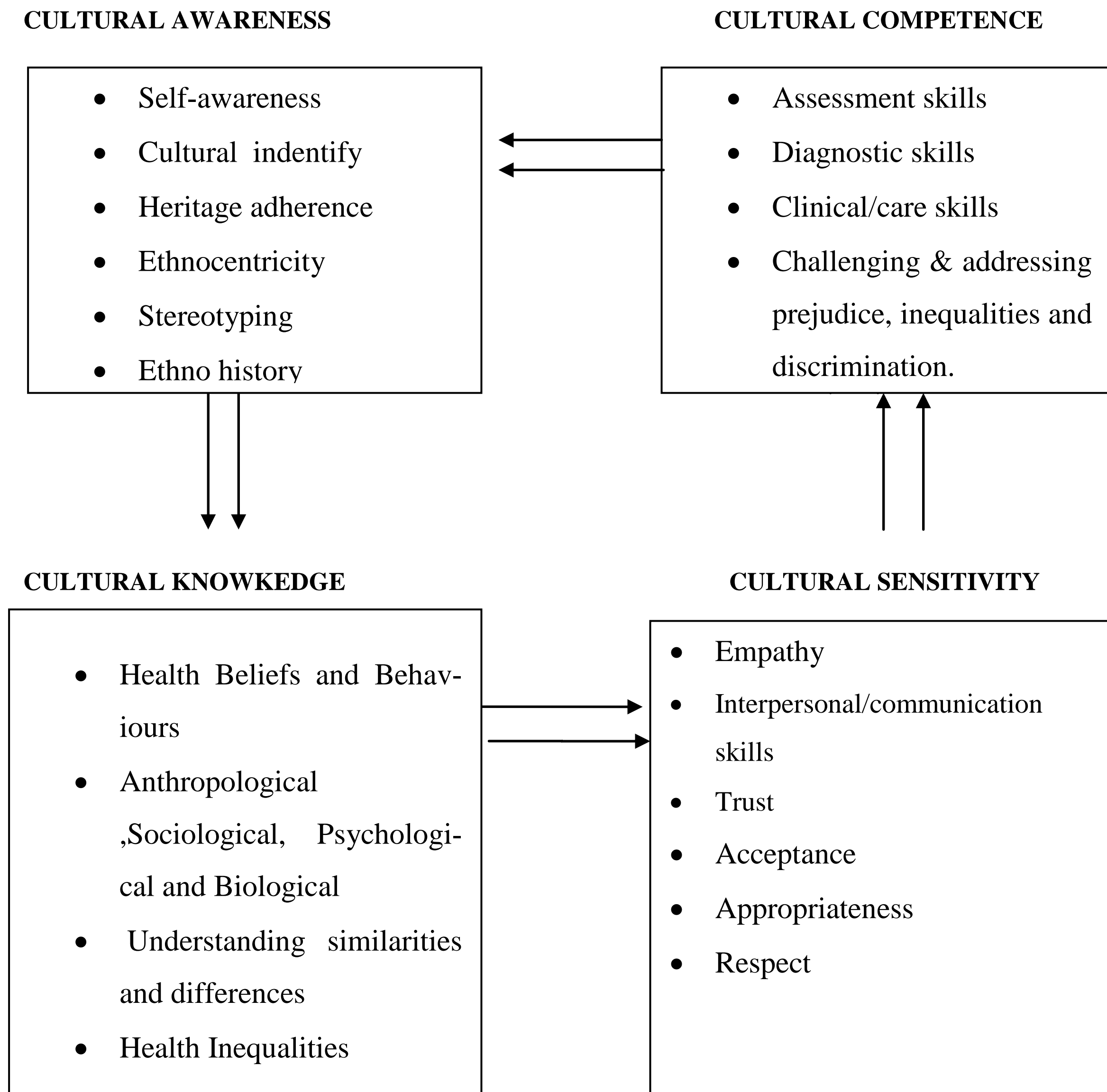
3. Theoretical Framework

A theoretical framework is a type of manuscript that relates concepts, empirical research and relevant theories to advance and systematize knowledge about related concepts or issue (See, Rocco, Plakhotnik 2009 p 128).

3.1. Papadopoulos 2006 and Campinha-Bacote 2008 Model of Cultural Competence

The main focus of the two models is changing the behaviours of the professional practitioners and their interactions with people from different cultural background (F. E. Balcazar et al 2009, p 1154).The models have four main concepts that include: cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. The models emphasis on individual as well as organization desire to serve, (Campinha-Bacote 2008, p 142), and the ability to recognize and challenge racism, discrimination and ethnocentricity (Papadopoulos &. Lees, 2002, p, 262). According to Narayan (2001) Cultural assessment is also needed in every client, because it is an effective way to obtain relevant information about a client perspective on care (see Maier-Lorentz 2008, p 40).

CAMPINHA-BACOTE&PAPADOPOLOUS MODEL FOR DEVELOPING CULTURAL COMPETENCE.



Source: Andrews 2010: Journal of Transcultural Nursing 2010 21: 53S,

Figure 3

3.1. Terms in the Model

Self Awareness-Papadopoulos (2006) defines self awareness as a personal awareness about person own cultural background and cultural identity that help a person to understand the importance of his/her cultural heritage and that of others, and makes them appreciate the dangers of ethnocentricity (see Andrews 2010, p, 117).

Heritage adherence-Spector, (2009, pp. 9-18) defines as the ability to provide care considering personal Culture ethnicity and religion. Caregivers should be able to consider as a priority the life style of the client and adhere to them in order to preserve integrity. (See Andrews 2010, p, 113).

Stereotyping- Is having a simplified and standardized conception, image, opinion, or belief about a person or group. A health care provider who fails to recognize individuality within a group is jumping to conclusions and therefore stereotyping (Giger et al 2007).

Ethno history- Andrews (2010, p, 95) define ethno history as the sequence of facts, events, or developments over time as known or witnessed by the people under study.

Health Beliefs and Behaviours- According to (Spector, 2000) these are Cultural influences on one's health beliefs and practices, including perceptions of health and illness, disease prevention methods, treatments for illness, and utilization of healthcare services (see Andrews 2010,p133).

Understanding similarities and differences- It is the ability to understand differences and similarities between healthcare professionals and clients, appreciating and respecting those difference in order to create a peaceful working environment and win acceptance Andrews (2010, p, 96).

Health Inequalities- health care inequalities occur when persons of different races, ethnic groups, and cultures do not receive equal health care, and illness occurs disproportionately from one group to the other (Giger et al 2007).

Assessment skills-The ability to evaluate the need of a client depending on his/her cultural back ground and offer care that is culturally safe. Assessment help in developing individual care plan. It involves nutritional, medical, pain, and psychocial assessment Narayan (2001, p, 45).

Empathy-It is the ability to fit in someone's shoe, feel that person and be ready to help him/her for the better. An empathetic care provider is sensitive to how it feels to be an outsider in a different culture and is able to relate with the client's perspective (Narayan 2001, p 41).

Respect- The willingness to show appreciation or regard. Respect is shown when the caregiver is able to appreciate and respond effectively to care in a culturally safe way. A give who have respect avoid cultural mistakes, ask before acting while dealing with people of different culture (Foronda 2008, p, 209).

Culture: It is a learned, patterned behavioral response acquired overtime that includes implicit vs. explicit beliefs, attitudes, values, customs, norms, taboos, arts, and life ways accepted by a community of individuals. Culture is primarily learned and transmitted in the family and other social organizations, is shared by the majority of the group, includes an individualized world view, guides a decision making, and facilitates worth and self-esteem (Giger et al,2007).

Cultural skill: It is experienced when communication or use of language-both verbal and non verbal-is used in a way that reflects sensitivity and appreciation for the diversity of another. It is conveyed when words, phrases, categorizations, etc are intentionally avoided, especially when referring to any individual who may interpret them as impolite or offensive (Giger et al 2007). Cultural skill is expressed through behaviors that are considered polite and respectful by the other. Such behaviors may be expressed in the choice of words, use of distance, negotiating with established cultural norms of others, etc.

Diversity: It is an all-inclusive concept, and includes differences in race, color, ethnicity, national origin, and immigration status (refugee, immigrant), religion, age, gender, sexual orientation, ability/disability, political beliefs, social and economic status, education, occupation, spirituality, marital and parental status, urban vs. rural residence, enclave identity, and other attributes of groups of people in society (Giger et al 2007; Purnell & Paulanka, 2008).

Ethnocentrism: is a universal tendency to believe that one's own worldview is superior to another's. It is often experienced in the health care, in particular when the health care provider's own culture or ethnic group is considered superior to another (Giger et al 2007).

Cultural care- Spector (2000) defines cultural care as a professional healthcare that is sensitive, appropriate and competent. Follows cultural guidelines and information and also facilitate communication to culturally diverse clients (See Shen 2004, p321).

4. Methodology

In a broad sense, methodology refers to the practices and techniques used to gather, process, manipulate, and interpret information that can then be used to test ideas and theories about social life.

4.1 Literature review

As a literature review, this study is largely based on secondary sources, and as such; text books, journals, internet sources, magazines, newspapers, articles as well as other publications related to research on cultural competence and elderly care constitute the main source of information. The articles were mainly from United Kingdom, New Zealand, Asia, Canada and the United State of America.

Although it is obvious that this method has the main advantage of providing ready information, nevertheless, it has a number of draw backs. One of them is that some of the information may be old or even outdated, and thus one may unknowingly share some of the shortcomings of the original materials. This also makes it impossible to obtain fresh information and fresh insights coming from primary sources such as interviews, questionnaires, and observational methods among others.

4.2. Content analysis.

Qualitative content analysis-Is “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p.1278), (Holistic, 1968, p.608) further define the method as “any technique for making inferences by systematically and objectively identifying special characteristics of messages”. Because of its focus on human communication, content analysis offers practical applicability, promise, and relevance for research involving the practice and education of nurses and other helping professionals, allows researchers to understand social reality in a subjective but scientific manner and help in generating concepts or variables from theory or previous studies that is useful for qualitative research, especially at the inception of data analysis (Berg, 2001).

The author chooses to use a deductive approach strategy since the general aim of the research was to test previous theories. To the student qualitative content analysis are useful in generating students' understanding of changes in their values and beliefs about others and about themselves as they gain exposure and direct experience with diversity and promote affirmation and disconfirmation of highly personal and subjective assumptions about people and events.

4.3 Data collection.

Is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate the result. After the study was approved by Arcada administrative Board and a supervisor assigned, research question and a goal at hand, what followed was to search for the answers for the study. With a strategy to obtain materials related to cultural competence and it importance in provision of elderly care and having in mind that qualitative content analysis is best for literature review of human experience in health care, a review of previous research related to cultural competence was conducted from different data bases.

The data bases that were used in developing the study included, Academic Search Elite (EBSCO), CINAHL and SAGE. Additional articles were identified through reference list of the articles that the researcher went through. This gave more knowledge and awareness about the study. Example, after reading the article, Cultural competence models in nursing, A selected Annotated Bibliography written by Zuwang Shen 2004 an article by Campinha –Bacote 2002 was found to be of interest, searched for in Sage and after going through the author decided to add it in reference list.

Though a long journey with different limitations, difficult in decision making of the best chooses of material to use, the study was able to access sixteen research articles that developed the study. A visit to Nelli then under degree programmes clicked on healthcare. Then selected sage journals online (sage premier) from the database list.

Then under search and browse journals by discipline clicked on advanced search wrote cultural competence and nursing full text, transcultural nursing and diversity full text, sage journals available to me, date range January 2000 through December 2011, format results: display standard format showing 10 results per page, sorted by relevance gave a result of 260 research articles of which seventeen were selected but only seven were used.

A visit to Cinahl with the term Homecare service Tx all text, Multicultural Tx all text or transcultural nursing Text all text, using smart text searching, Applying related words, Also searching within the full text of the articles, Limiting the result: linked full text, Abstract available, English language, research article, reference available, Published date from January 2000-December 2011, peer reviewed, Publication type journal article. A total of 37 articles were found where by 8 were selected and 2 used in this work.

In Academic Search Elite (Ebsco) the search word were Cultural competence Tx all text and Multicultural Tx all text and Transcultural nursing Tx all text, smart text searching, Apply related words, Also search within the full text of the articles, full text, Published between January 2000-December 2011,scholarly (peer reviewed) journals, document type: article, Language: English, image quick view. A total of 91 academic articles were found 10 selected and only 5 were used.

This is an Illustration of how the articles were gathered from different sources.

Database	**Keyword**	**Year range**	**results**	**Selected articles**	**Article used**
SAGE (EBSCO)	Cultural competence and nursing, transcultural nursing and diversity.	2000-2011	260	17	7
CINAHL (EBSCO)	Homecare service, Muticultural or transcultural nursing.	2000-2011	37	8	2
ACADEMIC SEARCH ELITE (EBSCO)	Cultural competence and Multicultural and transcultural nursing.	2000-2011	91	10	5
REFERENCE LIST					2

Table 1

4.3.1 Excluding and including criteria.

This was a very important section of the work; it acted as a plat form of vetting materials to use in building up the study. For eligibility an article had to be related to cultural competence and moreover show how professional care provider benefited in different experience while dealing with people from different background. Written in English language, easy to read and understand, published between the year 2000-2011, Reverences available, Abstract available, free and not more than 10 pages.

This is an Illustration of inclusion and exclusion criteria of the articles.

INCLUDING	EXCLUDING
-Articles had to be in English Language.	-Articles written in any other language rather than English.
-Free and available to researcher.	-Articles that had to be paid for and signed in.
-Related to cultural competence in delivery of care.	-Article that did not show any importance or benefit to culturally diverse population.
-Published between January2000-December 2011.	-Articles published before year 2000.
Be scientific that include, references, abstract	-Articles that did not have abstract or references.
-Essay to read and understand	-Not eye visible and difficult to understand.

Table 2

4.4 Validity and Reliability.

According to Patton (2001) validity and reliability are two factors which any qualitative researcher should be concerned about while designing a study, analyzing results and judging the quality of the study. Scientist believe that any kind of assessment, whether traditional or authentic must be developed in a way that gives the assessor accurate information about the performance of the individual.

Separating the two concepts for better understanding, reliability refers to the degree of consistency between two measures of the same thing (Mehrens and Lehman, 1987).It describes repeatability and affirms consistency of a test; While Validity is the degree to which they accomplish the purpose for which they are being used (Worthen et al., 1993). Validity is a key assurance of accuracy of an assessment.

Having the two factors as fundamental cornerstone of the study the researcher made sure that the research was consistent, stable and measured what it claimed to measure by comprehending, analysis, synthesizing and evaluating the articles used in this work. Going through a scientific process of data collection from qualified and reliable databases that were relevant to the study is a task that cannot be undermined for it brought the development of the study.

Another driving force for keeping a check on validity and reliability was the fact that the research was about human or venerable elderly clients who depend on others on daily bases. And therefore accuracy of the work was a necessity so as to avoid biasness, improve relationship between the provider of care and the client and bring a sense of reliability to the caregiver.

4.5 Ethical Consideration.

The aim of any research project is to facilitate learning through a better understanding of research and how it influences practice. It is therefore the responsibility of the researcher to avoid potential harm in the research by ensuring that mechanisms are laid down to avoid it and behaving in accordance with appropriate ethical standards. This protects the study and the institution from criticism or court action.

There are many ways in which clients/participants of research could be harmed either by physical, psychological, emotional or social harm. But with well laid strategy and taking other people into consideration, showing respect and striving to be fair and treating others equally, understanding cultural differences and collaborating with people from other cultures, be able to understand the effects of globalization and its opportunities in live a study with very minimal /no negative criticism can be developed.

Having in mind that ethics define the principle of right and wrong conduct in a society/profession, having read Arcada ethical rules and guideline and knowing it well that ethics do not change value but rather is an awareness of potential ethical issues that might come up in a project, this study was able to maintain good scientific practice by analyzing different scientific material through scientific processes.

5. RESULTS

Importance of cultural competence in care

In accordance with Campinha-Bacote and Papadopoulos model for developing cultural competence, the importance of cultural competence in provision of care is analyzed and presented as cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. It is therefore a moral and ethical obligation of every care giver to provide quality care to all clients/patients regardless of their age, gender, race, sex or cultural background in a polite and respective manner reflecting on these attributes of cultural competence to be culturally competent.

5.1 Importance of Cultural Awareness in Care.

Cultural awareness is the starting point or the first stage in developing cultural competence. As an attribute of cultural competence, it is important to healthcare providers in personal exploration and self examination. When healthcare providers go through the process of cultural awareness they are able to recognize personal biases and prejudice (Campinha-Bacote 2002, P 182). It is then after being aware of the influence of one's own culture that a foundation of appreciation and understanding other people values and beliefs is formed a base in identifying cultural differences and similarities (Rosenjack Burchum 2002, p 7).

According to Calvillo et al 2009,p 140 it is important for a health care provider to explore their personal and professional knowledge before addressing multicultural background that include clients and their families. These help the care provider to optimize interactions and cultural assessment of their clients. It also helps in avoiding cultural mistakes and engaging in cultural imposition. In emphasizing importance of cultural awareness Calvillo et al (2009, p 141) noted that a healthcare provider with cultural awareness and understanding of culture, promotes professional and decision making and is able to preserve integrity and respects of culturally diverse population.

According to Andrews (2003) it is important for a health care provider to learn how people of different cultural back ground communicate. Understanding communication cues example eye contact, touch, silence, and their meaning is necessary in attaining and maintains cultural competence. Silence for instance has different meaning depending to who the message is communicated. It shows respect to a speaker and careful think inking when asked a question (See Maier-Lorentz 2008, p 38). (Pacquiao, 2000) Added that, Although caregiver/provider of care cannot be competent in all cross-cultural encounters he/she should have the knowledge of the most common diseases and illnesses affecting the unique population to whom care is provided, Have an ability to interpret intentional communications and aware of cues and customs in cultural styles different from their own (see Calvillo et al 2009, p 141).

Another importance of cultural awareness is that it helps in understanding how personal, belief, altitude, and age, affect care. According to Helman (1990) a person culture has a lot of influence on one's beliefs, behaviours and attitudes to illness, and pain which is seen in outcome of care (see Papadopoulos 1999, p 1098). Those who belief they have control of life events, belief that they have some control of their healthcare and are compliant and most likely be positive about care (Maier-Lorentz 2008, p 39).

Additionally, cultural awareness help healthcare provider to realize the importance of space in dealing with culturally diverse clients. When caregivers realize that cultural encounter is either acceptance or rejection. They are able to monitor their altitude and that of their clients and have an over view of clients cultural norms. European from North American for instance feels most comfortable when not in close contact with any one (Maier-Lorentz 2008, p 39).

Despite the fact that we are all unique individuals who belong to the human race with similar basic human needs to be cared for and loved (Campinha-Bacote 2008 p143) lack of critical cultural awareness will lead to healthcare provider imposing their beliefs, values and patterns which result to cultural conflict, misunderstandings or misinterpretation, lack of trust and respect (F. E. Balcazar et al. 2009 p 1155), But with the desire that erupt like a volcano one will be encouraged to serve others.

5.2 Importance of Cultural Knowledge in Care.

According to Campinha-Bacote 2002, p 182, cultural knowledge is the process of seeking and obtaining a sound educational base about people of different culture. Papadopoulos (2006) noted that Cultural knowledge can be gain through interaction with patients/client and their family in a manner that preserves personal integrity and respects of the uniqueness and differences of individual patients/clients and families. It is at this point that one will understand health and social behavior from the client point of view (see Andrews 2010, p 117s).

Cultural knowledge is important in understanding history of discriminatory, treatment of population groups in society, analyzing the impact of health and social policy legislation on health, Understanding cultural premises influencing health and illness experiences of different groups and understanding factors that influence minorities and immigrant participation in a society (Calvillo et al 2009 p 140).In emphasizing importance of cultural knowledge(Anderson, 2004; Mackinaw, 2003 Indicate that, the more knowledge a caregiver has on diverse value' beliefs and practices of clients the better they can understand the client altitude about care (see Calvillo et al 2009 p 139).

According to literature review an in-depth understanding of cultural knowledge is important in understand specific as well as generally characteristics of a population. It assists in planning care that considers gender, ethnic, and racial disparities (Calvillo et al 2009 p141), for instance, Despite adding Asian menu in care, health providers were not able to provide culturally safe care .They treated everybody the same and did not understand why Asian people behaved in certain ways example shouting while in pain (Vydelingum 2005 p 26). It is therefore important to note that a person's culture/religion may affect the type of food that one take during illness. For instance observers of the Hindu religion do not eat beef because cows are considered sacred. Additionally it is very important not to give food to a Hindu client/patient with the left hand because it is seen as unclean. Temperature of food is also very important because it is helpful in different condition of the client.

Cultural knowledge is important in delivering of optimal care. The ability to understand and being understood guides the caregiver to dos and don'ts of a community. According to literature review, it was a challenge trying to understand client/caregiver who did not speak the same language. It caused frustration, and at time misunderstanding the clients (Tuohy et al.2008, p 166).According to Yahes & Dunn (1996) communication is the primary education to a foreign caregiver and if not adhered to leads to efficiency (see Cowan & Norman 2006, p 86).In emphasizing importance of cultural knowledge in care Moore& Scholes (2000) found it unethical for practicing caregiver to be unable to communicate appropriately with their clients (see Tuohy et al.2008, p 168).

Although a challenge in learning a foreign language and culture, the author found that language and cultural barriers as the main barriers to culturally competent care. They included: difficulties in communication, lack of educational preparation, time, lack of interpreters, Lack of diversity in healthcare's leadership and workforce, lack of awareness of cultural differences and lack of organizational support (Taylor and Alfred 2010, p 592).while showing the need of interpreters Brach and Fraser's (2000, stated that interpreter services result in improved communication between Healthcare Care Practitioner and client, which results in education designed to meet the needs of that group (see Taylor and Alfred 2010, p 594).

According to (Jones, Cason, & Bold 2004 & Dunn 2002), high level of cultural knowledge and skills about others, and the willingness to learn a foreign language build in confidence and form a relationship of trust in which to communicate and negotiate aspect of care (see Castro &Ruiz 2009, p 283).It is at this point of negotiation that the caregiver-client communication and collaboration can be improved, increase client's satisfaction and enhance compliance, thereby improving clinical outcomes and reduce healthcare disparities (Kripalani, Bussey-Jones, Katz, & Genao, 2006)(see Castro & Ruiz 2009 p 279).

The presence of cultural knowledge in care is important in accommodating family, relatives and friends in care. They play an important role in restoring and maintain the health of the clients, gives healthcare insight of client's support system (Spector 2000), (see Maier-Lorentz 2008, p 40),interpreting and act as cultural informants. Taking Asians for instance, the families cooperate, make suggestion about care and assist depending on the cooperation of the healthcare provider. If the provider is negative to cultural norms or not cooperating they can deny access to the client Xu (2004, p 434).

5.3 Importance of Cultural Sensitivity in Care.

Cultural sensitivity is important in developing interpersonal relationship with the client. It involves acceptance, trust, respect, facilitation and negotiation. It emphasis on healthcare provider viewing clients as equal partners in care and avoiding using power in oppressive way Papadopoulos (2006) (see Andrews, p 118s).According to Rosenjack Burchum (2002, p 7) cultural sensitivity develops when one appreciate, respect and value cultural diversity. In emphasizing the importance of trust, respect and negotiation Leininger (1988) noted that it is important to encourage clients to preserve cultural practice that would assist them in achieving health goal. Categorize those cultural practices and include those that are not harmful into care and restructure those that are harmful into healthier ones through negotiation and by so doing the health provider will have build trust that would then be reflected in care outcome (see Narayan 2001, p ,46).

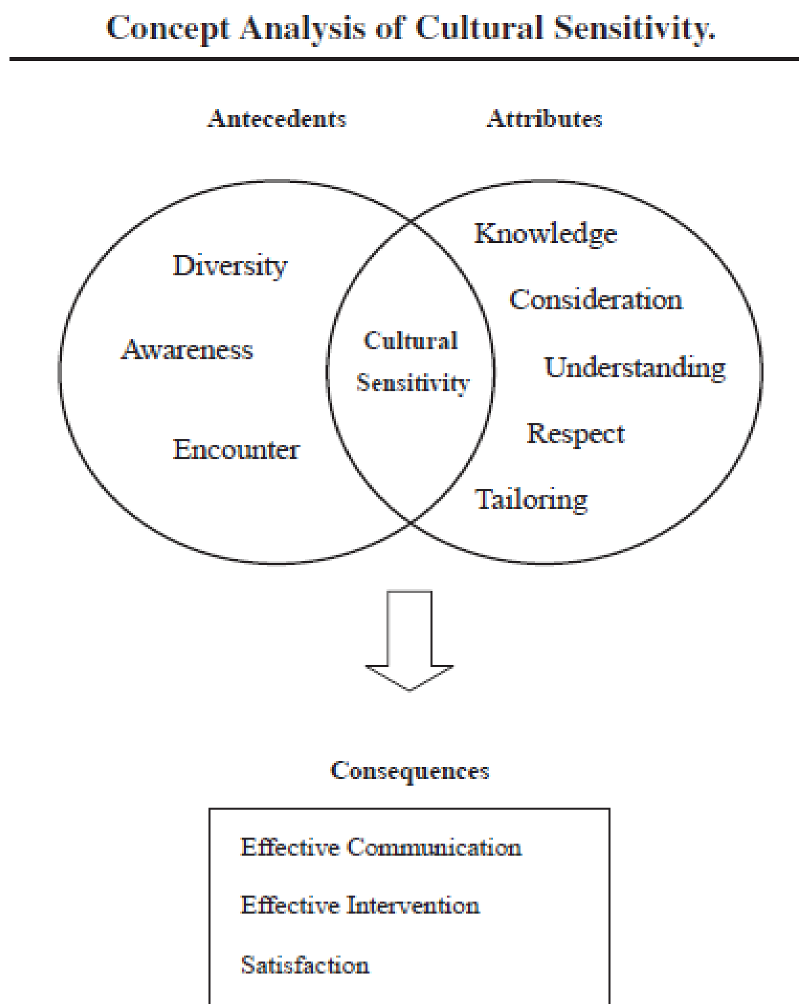
According to Rosenjack Burchum (2002, p, 10) after respecting and appreciating others, interaction develop and through a progress of cultural interaction one develop personal and professional relationship that guide them in care. Engebretson & Littleton notes that, interaction/negotiation is influenced by histories, beliefs, experiences, values and behaviors from client's and health professional's culture (see Mahoney 2006, p 232).In creating more awareness about cultural sensitivity (Godwin, 2001, para. 2) noted that, it is after developing both respect and acceptance that a social and cultural foundation is established for the creation of a unified society (see Foronda 2008, p 209). It is at this point that healthcare providers establish an equal partnership and develop a bond with all the aspects of people they takes care of, and thus provide optimal care.

After acceptance and creation of a unified society the partners in care create a comfort zone that is reflected in the way they communicate and relate to one another. Although there are differences even between people from the same culture with cultural sensitivity skills, the partners are able to accommodate each other including families and friends. In emphasizing on good interpersonal relationship (Raines & Morgan, 2000, p. 168) noted that, healthcare providers need to respect culturally grounded values, beliefs and practices of clients to ensure safe, quality care (see Foronda 2008, p, 208).

Knowledge of culturally safe care improves provider's understanding, consideration, decision making, judgment and a desire to want to care for others. According to Giger et al (2007,p 100) when offering care, words and phrases categorizations should be internationally avoided, especially when referring to those individual who might be interpreted as impolite or offensive. It is also important for healthcare provider to consider individual or group when expressing compassion to medically interview a client (Dowdy, 2000). Bender, (2000) added that, Healthcare professionals should take into consideration personal needs example diet and language of clients if they are to provide culturally sensitive care (see Foronda 2008, p, 2009).

According to Campinha-Bacote (1999) while expressing importance of culturally safe care she noted that, it does not really matter how much someone knows until they show how much they care. Culturally sensitive care is care that focuses on a win, win strategy; care that has the ability to walk in someone moccasins (See Narayan 2001, p 41) Campinha-Bacote (2003a) added that healthcare providers with knowledge of cultural safety are motivated by that knowledge to engage in becoming culturally competent without hidden agendas. They wear a servant's heart to symbolize love's (Chapman 2005: 10), (see Campinha-Bacote 2008, p 143).In emphasizing the importance of culturally safe care (Calvillo et al 2009 p139) noted that, Learning a foreign language promotes empathy for the experiences of others who are less proficient in the dominant language of the culture. It improves one's understanding of the difficulties inherent in linguistic differences and one's ability to interact with different groups in health care.
After implementing all the characters of a culturally sensitive healthcare provider the end result is that the clients get satisfied with care, there is effective communication and effective intervention.

The diagram below shows concept Analysis of cultural sensitivity their importance and effects in care



Source: Foronda / Cultural Sensitivity 209

Figure 4

5.4 Importance of Cultural Competence in Care.

Cultural competence equips and gives the healthcare provider the confidence to care for culturally diverse population without letting his/her personal beliefs have an undue influence in care. It include: knowledge, understanding, and skills (Giger et al, 2007, p 100). According Campinha-Bacote (2002), Cultural competence is important in developing healthcare provider's intellectual and awareness. It encourages the care providers to engage in the process of becoming culturally competent through interaction with people from different background (see Mahoney, Carson & Engebretson 2006, p 231).

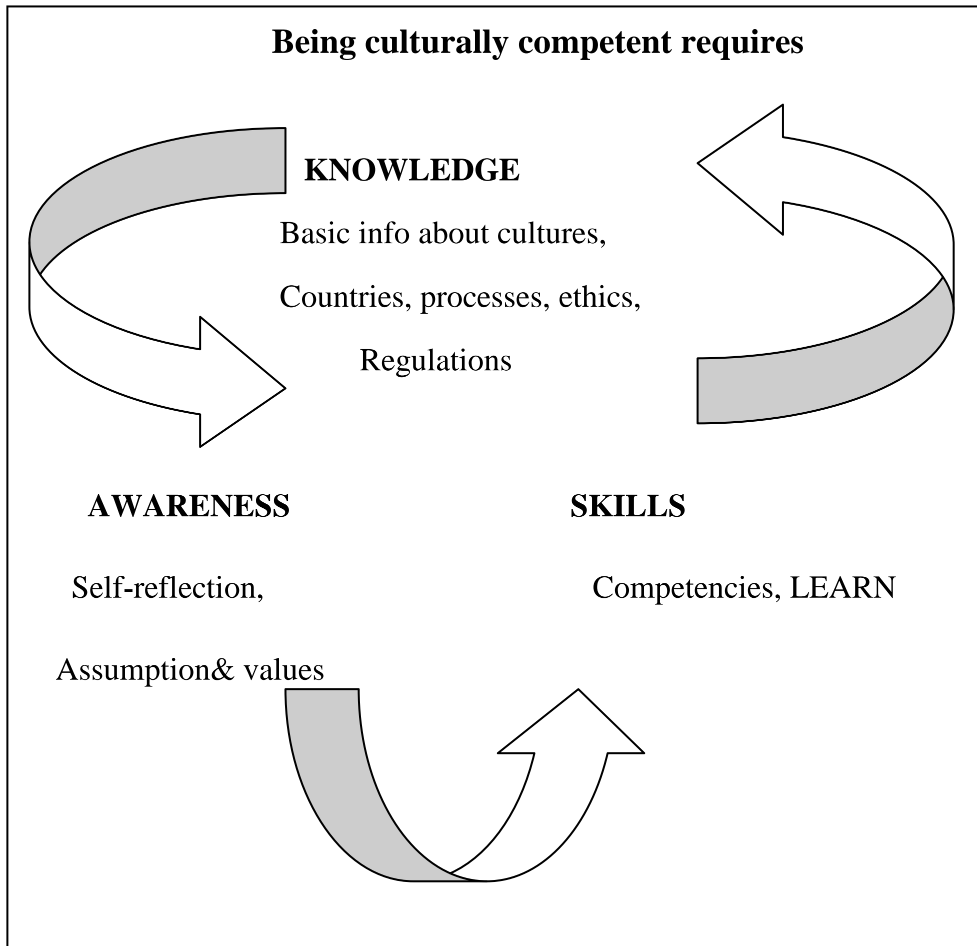
The main importance of cultural competence is reducing health disparities and improving access to high-quality health care for all regardless of cultural background. Health care that is respectful of and responsive to the needs of diverse population. Cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care in an inclusive partnership where the provider and the user of the information meet on common ground (Giger et al, 2007, p 100).

Cultural competence is important in promoting equity and consistency in health care, it increasing the number of racial and ethnic minority health care providers, it enhance communication between patient and provider, ensure adequate services for racial and ethnic populations and educating professionals (see Giger et al. 2007 p 97).In emphasizing importance of education (Anderson, 2004; Marcinkaw, 2003) noted that, study of religions promote the understanding and appreciation of similarities and differences across diverse populations. (Nazroo, 2003) added that, sociology studies provide knowledge about social problems that including: poverty, substance abuse, delinquency, racism, sexism, crises in education and health care, urban/environmental issues, and policy implications (see Calvillo et al 2009 p 139).

Cultural competence equips the healthcare provider with the knowledge of communication styles of diverse patients and families; incorporate clients' health literacy into care plans and health education initiatives, recognize, accept, and incorporate non harmful traditional, complementary, and alternative practices, and incorporate patients' cultural food choices and dietary practices into individualized care plans(Calvillo et al 2009 p141).For instance in case of a mental health disorder and the client account that God and the devil are having a war in his/her head, given this description a culturally competent healthcare practitioner will explore such a statement to determine whether the client is having auditory hallucinations/is using a cultural expression to convey that he is having difficult in making a decision (Mahoney, Carson & Engebretson 2006, p 231).

According to Papadopoulos (2006) cultural competence provides a comprehensive guide to gain knowledge and understanding of culturally diverse individuals and groups, a foundation to explore ethnic and cultural differences, ability to recognize and challenge racism and other forms of discrimination and oppressive practice and helping professions use the knowledge to engage in positive and meaningful relationships with culturally diverse population (see Andrews 2010, p80s).

The figure below shows the requirements to be culturally competent



Source: Providing culturally competent care.

Self learning packet 2004.

Figure 5

6. DISCUSION AND CONCLUSION

The fact that the world has become a global village that accommodates everyone regardless of race, sex, age, or social class, what is important is to accept the reality and learn to live together in the village. And thus why this thesis work aimed at exploring through literature review, the importance of cultural competence in provision of care because it is a must that the foreigners/immigrants will require healthcare and other services in the Village/host country.

The findings are analyzed in accordance with the Papadopolous 2006 and Campinha-Bacote 2008 model for developing cultural competence which has four concept that include: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence as the basis for the theoretical framework.

The research question that guided the author throughout the process was how does cultural competence affect the provision of care?

The findings found that if sociocultural differences between caregiver and recipient are not explored and communicated, client dissatisfaction, no adherence and poorer health and care outcomes may result.

The current situation in the field is that care is going through a cultural crisis; the caregivers do not have enough time for every client, they lack cultural education and preparedness to deal with situation, and lack diversity in leadership that have really determined the care outcome.

According to the reviewed literature and the reality on the field is that a practicing healthcare profession should explore and examine his/her self before going out to offer service to the others including their families. The self exploration plays a part in helping him/her to avoid cultural mistakes or imposition and guide him/her through the process of culturally competent care to all regardless of their background. It is at this stage of care that the care givers learn how different people communicate and relate to one another and through this the caregivers are able to develop professionally and preserve integrity. Caregivers should have personal awareness because it help them to realize that no single group or individual have a single story. Thus respect comes in and assistance follows through cultural guidelines.

It is the responsibility of the caregiver to continue striving for more knowledge because the more knowledge one have position him/her self at a better place to work with diverse group. It builds confidence and the caregiver is able to learn more of the client.eg history, belief, and behavior towards care. The caregiver should aim at learning the client language because it opens up and build in trust, improve satisfaction, understanding becomes easy and the client can express him/her self better. It reduces stress, the care giver and the client are able to negotiate care, the family and friend becomes easy to understand and accommodate them in care and the care giver fill well equipped and prepared for the job.

The care giver should see the client as his /her partner in care so that he/she can influence care. She should focus on a win, win strategy. For instance incase dealing with an elderly person who had not seen foreigners before, the caregiver should wear a servant heart to win acceptance. If the client is in pain the caregiver should show empathy and try to fill that person. Care givers should also remember that the respond of the client will depend on their integration and a positive safe care result in satisfaction, effective communication and effective interaction whereby a caregiver should not mind time spent on a client.

Another important aspect of care that care provider should have on their finger tips is knowledge about religion and food. This knowledge act as a reminder that everyone has a background, nationality and a belief. One becomes humble and is able to respect and accept other. Avoids stereotyping, hostile/insult as it was to the Muslims &Islam in Canada after the 9/11 attack in the USA. If the people in New Brunswickers had information & knowledge about diversity they would have not associated Muslims with terrorism or even have an eye change when they noted one was a Muslim.

A culturally competent healthcare provider should be able to challenge racism, discrimination, and behave in culturally social ways. He/she should engage in the process of becoming culturally competent, and attend any available course offer at work place to improve his/her performance at work, and she/he knows so well that cultural competence is not an event but a continues process. And by respect, negotiation, acceptance and knowledge he/ she will be able to have positive effect in care. That is satisfaction, adherence, and reduced health disparities.

7. CRITICAL REVIEW

The study was very interesting, a learning process and a new page of experience in the researcher's life. He learnt through the process of writing and shared the information as it was recommended for a culturally competent healthcare provider. Cultural competence is a topic not only for those in the healthcare department but also anyone else around the globe including tourist.

Despite the fact that the topic was very interesting and the researcher's choice who thought he had a lot to write due to the fact that he was among the minority/immigrant the researcher must admits that it has not been easy sailing through the process of writing this work.

There were so many materials about cultural competence and every article that the researcher led he found it interesting in its own way and that made it difficult in choosing the materials to use and consumed more time reading the articles. The researcher feels that this study could have been better if he had time to observe the clients and interview healthcare providers this are people who could have given him the current and updated situation in the field.

There were no specific articles about cultural competence in provision of elderly care. Most of the materials were about cultural competence in nursing or transcultural nursing. And so the researcher had to look for something related, interesting and that gave more information about his topic. He even had to modify the topic to fit the materials that were available to him.

The theoretical frameworks was simple and user friendly, transferable to different professions, Focused on both culture and structure and categorized the result into four, this made it easy for the researcher to understand each part of becoming culturally competent. The theoretical also fit the work because it emphasized on changing the behaviours of the professional practitioners and their interactions with people from different cultural background towards a positive results.

The limit of how old the research materials should be was quite a challenge since the topic was as old as from 1978 and the limit was 10 years. The researcher could find very interest lines to pick from an article but since the reference was before 10 years he had to drop them.

8. RECOMMEDATION AND FURTHER RESEARCH.

There is need to conduct research on the importance of including foreigners in the leadership and its effects in care.

The author would like to advice healthcare providers to wear a servant heart so as to deliver culturally competent care.

The author would recommend teachings on cultural competence in instructions like schools and a practical training of the same. And to the foreign healthcare profession the author would like to remind them that their activeness in the host country will determine their position in that society.

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10. APPENDIX

List of selected articles for the study.

Authors/source	Title	Year	purpose of the article	Findings
Baker Cynthia	Globalization and the cultural safety of an immigrant Muslim community	2007	To further understanding of cultural safety by exploring the social health of a small immigrants community of Muslims in a relatively homogeneous region of Canada following 9/11.	Those who participated experienced a sudden transition from cultural safety to cultural risk following 9/11.cultural safety experiences included a sense of social integration in community & invisibility as a minority. Cultural risk stemmed from being in spotlight of an international media to becoming a visible minority.
Castro, A and Ruiz, E. The effects of nurse practitioner cultural competence on Latina patient satisfaction.	Effects of nurse practitioner cultural competence on Latina patient satisfactory.	2009	To explore relationship between degree of cultural competence in nurse practitioner & measure client satisfaction among Latinas.	patient were satisfied with Latina nurse practitioners who were certified, received training in cultural competence, spoke Spanish, masters level & decreased clinic waiting time
David T. Cowan and Ian Norman	Cultural competence in Nursing: New meanings	2006	To show how shortage of caregivers in develop world challenge provision of healthcare and how this countries would benefit from introducing encultural courses to migrate nurses/caregivers.	Migrant care providers from EU working in the UK experienced problems associated to cultural diversity.

Calvillo Evelyn , Clark Lauren, Jean E. Ballantyne, Dula Pacquiao, Larry D. Purnell and Antonia M. Villarruel	Cultural Competency in Baccalaureate Nursing Education	2009	To developing And implementing curricula for cultural competency, teaching content, specific integrative learning strategies, methods for Evaluating nursing students' cultural competence and recommendations for effective implementation of the integrated curriculum.	The AACN (2006) has established standards directing the profession to actively work toward the incorporation of content addressing diversity, political and sexual orientation, and discrimination against persons of diverse race, ethnicity, ability, status, age, and gender, at all levels of practice.
Giger Joyce, Ruth E. Davidhizar, Larry Purnell, J. Taylor Harden, Janice Phillips and Ora Strickland	American Academy of Nursing Expert Panel Report: Developing Cultural Competence to Eliminate Health Disparities in Ethnic Minorities and Other Vulnerable Populations	2007	(a) assess current issues related to closing the gap in health disparities and achieving cultural competence, (b) discuss a beginning plan of action from the Expert Panel on Cultural Competence for future endeavors and continued work in these areas beyond the 2002 annual conference on Closing the Gap in Health Disparities, (c) provide clearly delineated recommendations to assist the Academy to plan strategies and to step forward in taking the lead in reshaping health care policies to eliminate health care and health disparities.	The article provides measurable, achievable outcomes that reduce or eliminate health disparities commonly found among racial, ethnic, uninsured, underserved, and underrepresented populations residing throughout the United States. it also emphasis on education as a key to eliminate health disparities

Mahoney, S. Jane, Elizabeth Carlson, and. Engebretson, C. Joan	A Framework for Cultural Competence in Advanced Practice Psychiatric and Mental Health Education	2006	To present a framework for educators to use when addressing culturally competent advanced psychiatric nursing practice	Development of cultural competence is a link to reduced mental health disparities. Advanced nursing practice that is processed within a negotiating space allows incorporation of cultural information in to client care.
L.Cynthia. Foronda	A Concept Analysis of Cultural Sensitivity	2008	To uncover the current meaning of cultural sensitivity through concept analysis	Effective communication, effective intervention and satisfaction
Tuohy, D. McCarthy, J. Cassidy, I and Graham, M	Educational needs of nurses when nursing People of a different culture in Ireland.	2008	Discuss experiences experienced by registered nurses while nursing people from different culture in Republic of Ireland	How to deal with cultural issues, Accessing & using of interpreter service, planning & taking action in improving nursing care for clients from different culture were the themes that emerged in the interviews.
Jacqueline L. Burchum Rosenjack	Cultural competence: An Evolutional Perspective	2002	Need for conceptual clarity, which is essential for effective communication related to cultural competence, practice, education, administration & research.	Attribute of cultural competence are identified & cultural competence is best described as nonlinear dynamic process that is never ending &ever expanding that is built on increasing knowledge and skill development

Josepha Campinha-Bacote	The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care	2002	To present Campinha-Bacote's model of cultural competence in health care delivery & show the Process of Cultural Competence in the Delivery of Healthcare Services	The article demonstrates how a care provider can use Campinha-Bacote model to develop & implement culturally responsive healthcare services
. Madeline M .Maier-Lorentz	Transcultural nursing its importance in nursing practice	2008	It shows how essential & important transcultural nursing is in healthcare today due to ever increasing multicultural population	Care provider must have necessary knowledge & skills in cultural competence. To ensure patient satisfaction & positive outcome .Article indentify factors that define transcultural nursing & analyzes methods to promoting culturally competent nursing care.
Taylor Rosemarie Angela and V Mary. Alfred	Nurses' Perceptions of the Organizational Supports Needed for the Delivery of Culturally Competent Care	2010	The purpose of the study was to explore nurses' perceptions of ways in which the health care organization can support them in the delivery of culturally Competent care	It was found that caring for culturally diverse clients was challenging and frustrating for most participants, cited challenges included: language barriers, lack of training, difficulty with cultural differences, lack of organizational support, and reliance on culturally diverse staff members. Few organizational supports existed for delivering culturally competent care.
Margaret Andrews, Jeffrey R. Backstrand, Joyceen S. Boyle, Josepha Campinha-Bacote, Ruth E. Davidhizar, Dawn Doutrich, Mercedes Echevarria, Joyce	Chapter 3: Theoretical Basis for Transcultural Care	2010	The article shows how increasing diversity in global and local populations intensified the realization that current models of health education and health care delivery are not ade-	The reader is Provided with a broad foundation for transcultural nursing and health care drawn from the social and behavioral sciences, philosophy and nursing to assist

Newman Giger, Jody Glittenberg, Carol Holtz, Marianne R. Jeffreys, Janet R. Katz, Marilyn R. McFarland, Gloria J. McNeal, Dula F. Pacquiao, Irena Papadopoulos, Larry Purnell, Marilyn A. Ray, Mary C. Sobralske, Rachel Spector, Marian K. Yoder and Rick Zoucha			quately responsive to the changing needs of populations and how . Widening health disparities across populations within countries and worldwide heightened the need for more comprehensive models and theories for care delivery that address social inequalities affecting population based health outcomes	educators, practitioners and students to develop approaches to reduce differential outcomes of health care and education in populations
Balcazar,YolandaSuarez Balcazar & Tina Taylor-ritzler	Cultural competence: Development of a conceptual framework	2009	To describe the development of a conceptual framework for cultural competence that could help and guide the training of rehabilitation practitioners, students and researchers	After eliminating redundancy, 18 unique cultural competence models were identified. A synthesis model was first Developed which included four components. After an empirical validation of the model, a new model with only three Components emerged.
Vydelingum Vasso	Nurses experiences of caring for South Asian minority ethnic patients in a general hospital in England	2005	The purpose was to describe the nurses/care providers' experiences in caring for South Asian clients in a medical directorate of general hospital in the South of England.	Eight themes identified included: change in service, false consciousness of equity, limited cultural knowledge, victim blaming, valuing of the relatives, denial of racism, ethnocentrism & self disclosure.
Mary Curry Narayan	Six steps toward cultural competence: A clinicians guide	2001	The article describes a six step model clinicians, nurse/therapists can apply to provide culturally competent care to home care patients.	Finding is that respecting patient involves respecting their cultural beliefs, values, and practice. this results in optimal heath outcomes.