



Overcoming Nursing Care Challenges in a Multicultural Health Care Setting

A Literature Review

Josephine Atanga

Quinta Ayong

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<p>Abstract:</p> <p>In today's multicultural society, nurses are faced with the task of providing culturally congruent care to immigrants of diverse cultural backgrounds. It presents challenges as this requires incorporating the cultural needs of the patient to provide quality and satisfactory care. To improve health outcomes within a cultural context, nurses and health professionals need to acquire specific knowledge, skills and attitudes in transcultural or cross-cultural nursing.</p> <p>The study is aimed at investigating the challenges nurses face when providing care to immigrants of diverse cultural backgrounds and the impact of multiculturalism on nursing care delivery. It also explored strategies that can be used to prepare nurses in cultural competent nursing care. The study is a literature review of 18 articles chosen from EBSCO, PUBMED and Google Scholar. The articles were published between 2000 and 2017 and analyzed using the deductive approach of qualitative content analysis. Madeleine Leininger's culture care provided the theoretical framework for the study.</p> <p>The findings found cultural differences in values, health beliefs and practices, health literacy level and communication difficulties as major challenges that resulted in unequal access to care for minority patients. Overcoming these challenges requires the training of students and nurses in educational programs that support cultural competence and creating policies that accommodate cultural diversity to achieve positive health outcomes.</p> <p>To conclude, cultural accommodation and understanding in a multicultural health care environment is beneficial to the patient and the nurse relationship, improves the quality of care and increases job satisfaction.</p>	
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FOREWORD

We are grateful to the almighty God for giving us the opportunity to study in Arcada University of Applied Sciences and securing a future career in Nursing. We equally extend our sincere gratitude to all the wonderful teachers for their guidance throughout the programme and not forgetting our classmates for the good times we shared together as students. To all our family members and friends that have supported us in this journey, we say thank you and God bless you very much. We are extending special thanks to our children Jason, Kofi, Tebeng, Benilda and Leron who have been understanding and morally supportive to us throughout our study period. We will always love and cherish you.

To our mothers Pauline Nih and Mary Afor for spiritual guidance. We want to say thank you and may you live long to enjoy the fruits of your labour. To our spiritual leaders and prayer warriors who have prayed with us throughout this journey, may God richly bless your efforts.

I will also like to dedicate this thesis to my husband and best friend Effiok Okon Arching who passed away two months earlier before my graduation. You saw me through my nursing program and gave me all the support I needed to navigate through my program. I will ever be grateful to you for giving me what money cannot buy- Education. I promise to use my career as a Registered Nurse to save lives and impact the migrant community about the importance of health literacy. (Josephine)

1 INTRODUCTION

Any human community has some basic needs such as food, shelter, safety as well as health care services. The community thrives when these needs are satisfied as they encourage growth. This is true also for today's multicultural and diversified modern society. Our modern societies have gone a long way to provide the best of health care services to the community at large. However, the immigrant population is known to have increased risk for poor physical, psychological and social health outcomes. On a general perspective, immigrants vulnerability is linked to financial, socio-economic and environmental factors (Grabovschi, et al., 2013). The vulnerability to health and health care disparities results from a combination of cultural factors including language barriers, stigma and marginalization and they occur on a system, provider and patient level (Derose et al., 2007; Egede, 2006).

Previous findings reveal that ethnic minorities have cultural traits and health profiles that present complex challenges to health care practitioners in terms of access to equitable care. Thus, many countries especially multicultural societies like Canada, USA, Australia and the United Kingdom have recognized the need for linguistic and cultural competence. Health care services need to develop policies and structures to address health care disparities to provide appropriate access to care to diverse populations (Szczepura, 2005). In a multicultural society like Australia, health care professionals have reported difficulties with ethnic minority patients that results in them having inappropriate or diminished access to care, due to cultural differences. Thus, policy makers, service organizations and health care providers need to understand how people's cultural backgrounds influence their needs for services and decisions they make concerning their health and to effectively give care in line with the cultural contexts of the communities served (Yeboah et al., 2013).

The purpose of this study is to investigate challenges that nurses' encounter when caring for patients of diverse cultural backgrounds. To examine the effect of these challenges on nursing care delivery and to exploring ways of overcoming them in order to provide culturally competent and equitable care to all patients. The writers also got motivation to write on the subject out of personal experiences at practical training during the study period. The findings from the study may be used as a reference for additional

knowledge for nurses in Finland to providing culturally competent care to patients, as the society continues to experience a steady increase in its immigrant population.

2. BACKGROUND

2.1 Multiculturalism

The concept of multiculturalism has dominated discussions for the past 20-30 years in many countries of western civilization. It became widespread in the 1970s with the aim of accepting or tolerating cultural diversity. Multiculturalism is a new concept that is yet to be distinguished from globalization and liberalism and it is best known in the Anglo-Saxon world with practical implementation in Canada and Australia. Multiculturalism is often associated to international migration of people across borders. It is historically linked to the arrival of migrant workers and colonial immigrants, the arrival of their family members and the refugee flow in the 1980s and especially of 1989. Multiculturalism in everyday language is also regarded as identical to efforts to promote the integration of immigrants (Berkes, 2010). In addition, multiculturalism is of the view that cultures, races and ethnicities particularly those of minority groups deserve special acknowledgement of their differences within a dominant political culture (Eagan, 2015).

Multiculturalism exist in different forms and can be examined from different dimensions. Multiculturalism could refer to a demographic fact, a set of philosophical ideas or specific orientation by government or institutions towards a diverse population. Current debates on the value of multiculturalism focus on the policies and laws that are appropriate in dealing with diversity and immigrant integration. In these debates, opinions differ when it comes to the meaning of multiculturalism, its challenges and benefits. Proponents of multiculturalism suggest that recognizing and accommodating minority cultures increases their attachment and engagement in the larger polity. While critics argue that excessive emphasis on diversity undermines a cohesive collective identity and hinder common political projects. Research from Canada, Australia and many European countries indicate that many governments are adopting multicultural policies despite the political rhetoric around perceived problems of diversity. Although policy makers and academics find difficulties in striking a balance between majority preferences against minority interests, evidence suggests that multiculturalism facilitates immigrants' sociopolitical integration and contribute to their sense of civic inclusion. By integrating minority groups in main stream society, negative consequences of the feel-

ings of marginalization and exclusion are eliminated. Nevertheless, this view is not conclusive as the debate on multiculturalism remains an ongoing process (Bloemraad, 2011).

2.2 Multicultural Nursing in Finland

For the past 22 years, Finland has experienced migration in large numbers since becoming a member of the European Union. The recent influx of immigrants is a new phenomenon to the people and the issue of integration and creating social cohesion has become one of the most important challenges for political decision making in Finland and the whole of European Union. However, the Finnish population is becoming more aware of the change to a more open and multicultural society whereby immigrants are given the responsibility to learn Finnish language and customs while preserving their own culture (Koivukangas, 2002). The population of Finland rose to a new level in 2016. According to Finnish statistics, 34,905 persons migrated to Finland in 2016 which is a 21% increase more than the earlier year. This increase in migrants exceeded the 2013 records by 3,000 immigrants. Finland has seen an increase in migration that has grown to 16,823 persons from the previous year of 12,441 (Statistics Finland, 2017). If external migration remains constant in 2017, the Finnish population will increase by 21,909 as settled permanent residents (Country Meters, 2017).

Just like in other societies, clients with immigrant background in Finland are reported to be in a poorer state of health and wellbeing than among the general population. Immigrants have difficulties in obtaining social and health care services and information about the services despite the employment of professionals with immigrant background in the health care field (National Institute for Health and Welfare, 2016). There exist cultural differences visible in language, dress and diet that can be a challenge for patients, employees of different cultural backgrounds and for Finns in general. The health care system anticipates the need for more skilled and trained health personnel within and from other countries to manage the increasingly international community in Finland (Korpela, 2008).

2.3 Multiculturalism and Nursing Care

Recent statistics reveals that about 244 million people or 3.3 percent of the population of the world reside out of their country of origin. This is a 41 percent increase compared to the year 2000. Majority are immigrants who cross borders to look for better economic and social opportunity or maybe because of crisis (United Nations, 2016). The trend in the immigration of diversified migrant groups means that societies have to come to terms with a considerable cultural diversity, in terms of linguistic, cultural and socio-economic specificities that are different from the homogeneous population (Paula & Mendes, 2013). Other studies on ethnic minorities and health professionals also reveal structural and psychological factors as barriers to providing care (Parmet et al., 2017). Cultural diversity poses many challenges to health care systems whereby health professionals have to care for patients with different cultural backgrounds. Some of the challenges include lack of cultural sensitivity and understanding, health literacy and perceptions of expected versus perceived care. There are indications that these challenges are directly linked to higher levels of psychological distress in migrants (Hyatt et al., 2017). Nurses on their part feel that providing care to ethnic minority patients affects the flow of work, time needed to deliver care and the cost of providing interpreters which is stressful to both patients and nurses (Taylor et al., 2013). Multiculturalism thus has an impact in the provision of care in relation to cultural values, health beliefs and practices, language and health literacy status of immigrant patients.

Culture is a key element in multiculturalism and one of the concepts upon which nursing is based and defined. Culture refers to shared values, norms and codes that collectively shape a group's beliefs, attitudes and behavior through their interaction in and with their environment (Iwelunmor et al., 2014). In today's health care systems, the relationship between culture and health is central to delivering quality care to patients because of the way it influences health beliefs and behaviors (Hussung, 2016). To address cultural challenges in nursing, Leininger initiated and developed the theory of transcultural or cross-cultural nursing which is the area of nursing that centres on human care, health and environmental context (Watt & Norton, 2004). Transcultural nursing therefore, is a strategy used to addressing the patient's cultural needs, equal access to treatment, respect for cultural beliefs and practices including religion, diet, personal care needs and daily routines, communication needs and cultural safety needs

(Narayanasamy, 2003). Transcultural nursing is now a discipline in nursing and used in schools of nursing to prepare faculty and educate students to provide cultural and competent nursing care (Murphy, 2006). Cultural competency is a responsibility for all nurses and must be an integral part of the fabric of organizations as it benefits students, clients and health care institutions (Douglas et al., 2011). The study uses culture care theory as one of the models that supports cultural competency in nursing care.

3. THEORETICAL FRAMEWORK

The theoretical framework is the foundation from which knowledge is constructed for a research study. It serves as the structure and support for the rationale for the study, the problem statement, the purpose, the significance and the research questions. It also provides a grounding base or an anchor for the literature review and most especially, the methods and analysis (Grant & Osanloo, 2014). The theoretical framework used in this study is the Culture Care Diversity and Universality Theory by Madeleine Leininger.

3.1 Culture Care Theory Diversity and Universality

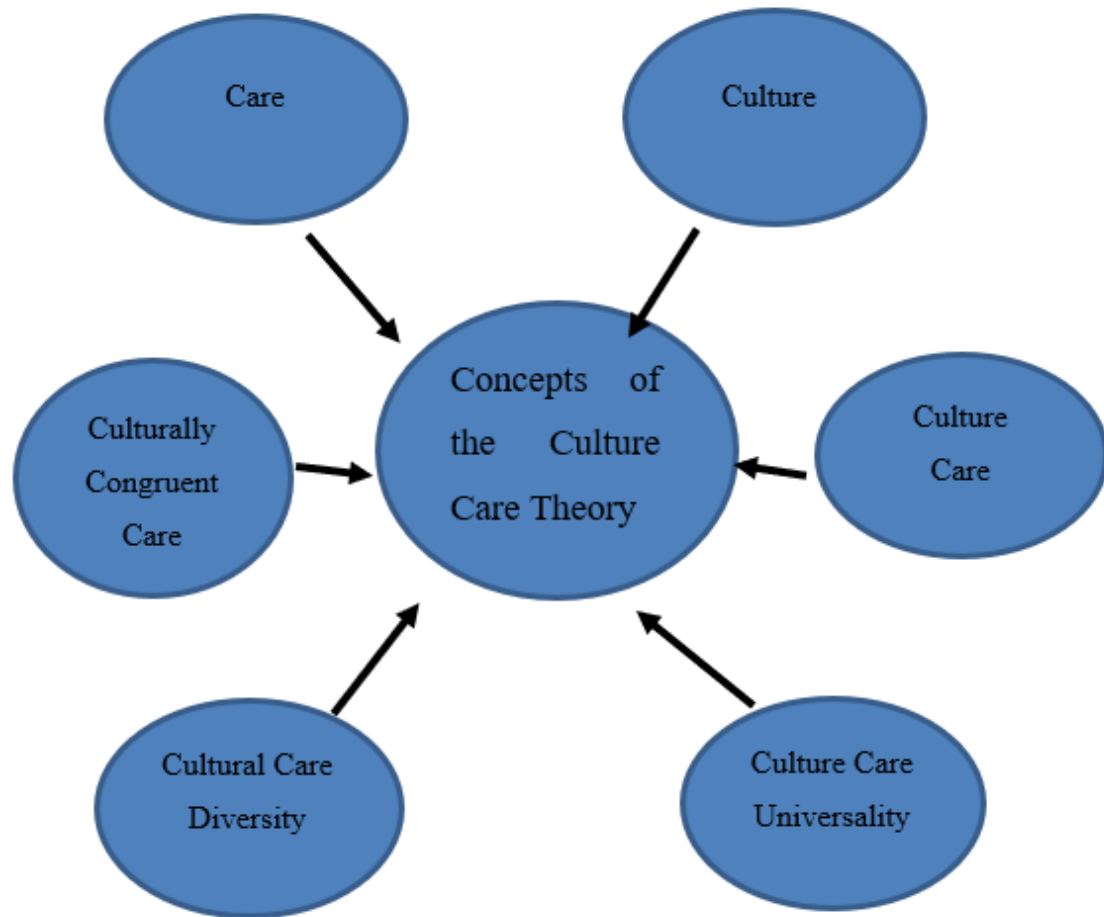
Madeleine M. Leininger is the founder and a leader in transcultural nursing and human care theory. The culture care theory also known as transcultural theory is derived from the field of Anthropology and made relevant in the field of nursing. Transcultural nursing focuses on comparative study, analysis of different cultures and subcultures in the world with respect to their caring behavior, nursing care and health - illnesses values, beliefs, and pattern of behavior. The theory seeks to develop a scientific and humanistic body of knowledge to provide culture-specific and culture universal nursing care practice. The theory is built on the premises that people from different cultures are in the best position to determine what kind of care they would require from professional caregivers (Alexander et al., 1989 pp. 146-150). According to Leininger, nursing is essentially a transcultural phenomenon with the patient and nurse having different cultural orientations. The nurse having knowledge about the patients' values, beliefs and practices are integral to providing holistic nursing care (Lea, 1994).

Goal of the theory

The goal of culture care theory is to use culture care research findings to provide culture-specific and / or generic care that would be culturally congruent, safe or beneficial to people of diverse or similar cultures for their health, well-being, healing and to help people face disabilities and death. The theory challenges nurses to discover transcultural human care knowledge and to use it as a guide to provide culturally congruent care and contributing to the fundamental base of nursing practice (Leininger, 1991 p. 39).

Theory Concepts and definitions

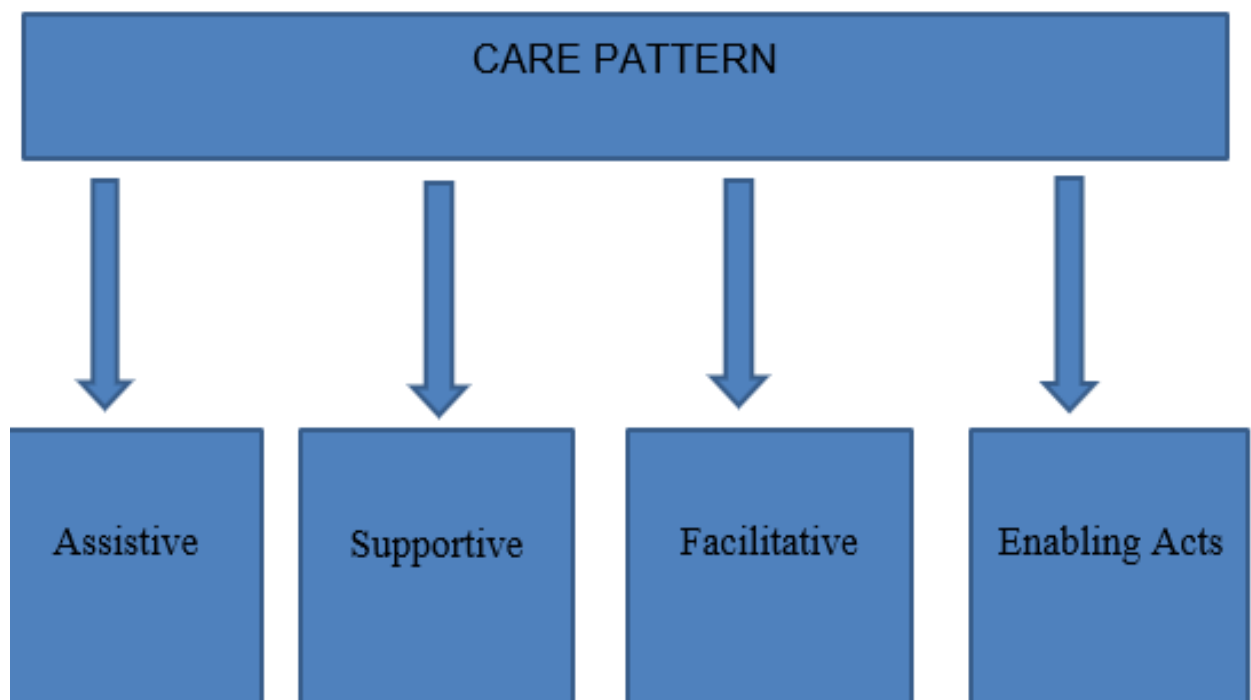
The Culture Care theory consists of several central concepts. Some of them are; Care, Culture, Culture Care, Culturally Congruent Care, Cultural Care Diversity and Cultural Care Universality. Culture care is the subjectively and objectively learned and transmitted values, beliefs and patterned lifeways that assist, support, facilitate or enable another individual or group to maintain their well-being, health to improve their human condition and lifeway or to deal with illness, handicaps or death. Culturally congruent care is knowledge acts and decisions used in sensitive and knowledge ways to appropriately fit the cultural values, beliefs and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities or death. Cultural care diversity refers to the variabilities and / or differences in meanings, patterns, values, lifeways or symbols of care within or between collectivities that are related to assistive, supportive, or enabling human care expressions. Cultural care universality refers to the common, similar or dominant uniform care meanings, patterns, values, lifeways or symbols that are manifest among many cultures and reflect assistive, supportive, facilitative or enabling ways to help people (Leininger, 1991 p. 45). Illustration of the theory concepts are shown in figure 1 below.



The most important of these concepts are care and culture and more emphasis would be placed on both. Culture and care are tightly embedded into each other to explain, interpret and predict phenomena related to nursing. Care refers to a phenomenon related to assistive, supportive or enabling behavior towards or for another individual with evident or anticipated needs to ameliorate or improve a human condition or lifeway. Leininger's care pattern are assistive, supportive, facilitative and enabling acts, or attitudes that influenced the well-being or the health status of individuals, families, groups and institutions, as well as general human conditions, lifeways and environmental context (Leininger, 1991 p. 32). Leininger states that care is the essence of nursing, the dominating and unifying aspect of nursing. She sees care as entangled in social structure and different aspect of culture. Care has different forms expressed in different ways and that the process of care is diverse and universal. She prefers the ethnic methods as the most desirable methods in the study of care as it is directed towards finding out the reality about people, their views, believe systems and the way their lives are patterned. Understanding these differences and similarities between and among cultures will help sup-

port nursing as a discipline and care profession through transcultural care knowledge. The knowledge will serve as a base to guide nurses' decisions and actions in assisting people under different human conditions or circumstances. When cultural care knowledge is gotten directly from the people, it will serve as the truest base knowledge for culturally congruent care. That way, people would benefit from and be satisfied with nursing care practices being served to them (Leininger, 1991 pp. 35-36).

According to Leininger, the care aspect of nursing is what makes the nursing profession different from other disciplines. Studying care is important because it is essential for human survival at birth, for human growth, to recover from illnesses and to remain well. Being able to understand the role of the care giver and recipient in different cultures is essential in providing culturally congruent care. According to Leininger, it is easy to predict the wellbeing of the health of people when we understand care. To her care is one of the most important phenomena in nursing which has to be written and understood fully. Care has been used in a manner so that it becomes a guiding light in nursing therapy as well as explaining nursing practice. Figure 2 below is a demonstration of Leininger's care pattern.



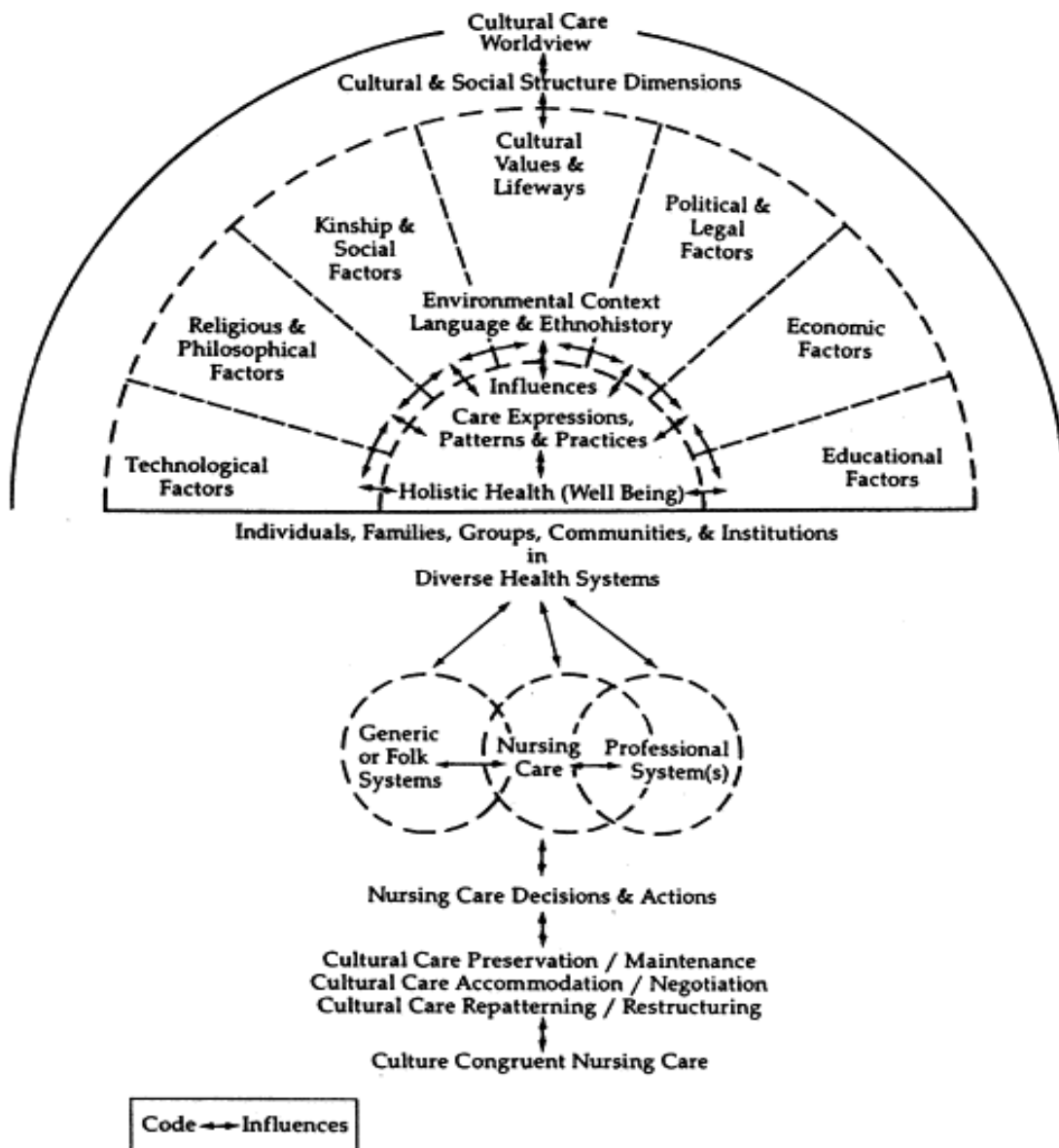
Culture is the other concept that is central to the theory. Culture according to Leininger, is the learned and transmitted values, beliefs and practices that provided a critical means to establish culture care patterns from the people. These cultural beliefs, values, norms and patterns of caring have a strong influence on human survival, growth, illness states, health and well-being. Culture can be discovered in the actions, practices, language, norms or rules of behavior and in symbols that are important to the people. Culture defines people's perception for living, remaining healthy or for dying. She further states that all cultures have folk, indigenous, generic or naturalistic lay care system that can influence an individual or group's access to quality care. Both systems can provide human care that is healthy, satisfying, beneficial and congruent with the client's culture care values and needs. However, there will be differences in professional nursing care and the patient's generic care that will prove challenging to the nurses. It is important that nurses recognize these differences and make appropriate changes to satisfy the needs of the patient. Combining generic and professional care in meaningful ways could lead to people seeking healthcare services to receiving culturally congruent care. On the contrary, the non-alliance of generic and professional care might lead to culture conflicts, noncompliance behaviors, cultural stresses, imposition practices and a host of unfavorable nursing care problems within nursing services (Leininger, 1991 pp. 36-37).

3.2 Sunrise Model

Leininger's Sunrise model is a conceptual and holistic research guide and facilitator developed to assist researchers discover multiple dimensions related to the theoretical tenets of the Theory of Culture Care. The model requires nurses to expand on their worldviews and incorporate new dimensions to understand and provide effective cultural care (Pereira De Melo, 2013). The Sunrise model presents seven cultural and social structure dimensions. They are technological and philosophical factors, kinship and social factors, economic factors, cultural values and beliefs, political, legal, and educational factors. These factors have great influence in the care, health patterns and expres-

sions of individuals, families, groups and institutions. The model also shows diverse health care systems ranging from folk health care practices to nursing and other professional systems. Leininger asserts that to provide culture-congruent care, health professionals should be able to blend generic and professional care to benefit the client. She prescribes three models that should guide nursing decision and actions. They are cultural care preservation and-or maintenance, culture care accommodation and-or negotiation and culture care restructuring and-or patterning (Zoucha & Husted, 2000).

Figure 3. Sunrise Model to depict Theory of Culture Care Diversity and Universality (Leininger, 1991)



The culture care diversity and universality theory is relevant in nursing in that it encompasses all cultures, racial, ethnic or minority groups and is applicable to subgroups within the dominant societal culture. The theory applies to families, individuals, groups, communities and institutions in diverse health contexts (McFarland & Eipperle, 2008). The theory constitutes substantive knowledge base to guide nurses' decisions and actions in assisting people under different human conditions or circumstances.

4. AIMS AND RESEARCH QUESTIONS

The aim of the study is to investigate challenges that nurses' encounter when caring for people of diverse cultural backgrounds. To examine the impact of multiculturalism on nursing care delivery. Lastly, to explore the nursing intervention to assist nurses and health professionals provide culturally competent care. The following research questions were formulated;

1. What are the nursing care challenges when caring for people from diverse cultural backgrounds?
2. How do multiculturalism affect the delivery of nursing care?
3. What are the nursing care intervention methods for providing culturally congruent care?

5. METHODOLOGY

The methodology section of a research paper provides clear and precise information of how an experiment is carried out and the rationale for why specific experimental procedures are chosen. It describes what is done to answer the research question and how it is done to bring justification to the experimental design. This section also explains how the results are analysed (Kallet, 2004). The methods used in this study is qualitative research. Qualitative research uses observation, interview method and is inductive in nature. The instrument used in qualitative research to collect data includes interview, observation and analysis of data. Analysing qualitative research requires one's judgment and creativity. It also requires working with large amount of data which has to be efficiently managed as it deals with previous works published such as getting information and researching through published academic journals (Al-Busaidi, 2008). This method is known as literature review. A literature review enables one to demonstrate knowledge of previous work in the field and to situate One's own research in the context of One's work (University of Sydney, 2016).

5.1 Data Collection

In materials collected provide information that is relevant to the thesis topic and the research questions. Data was retrieved mainly from Arcada's electronic databases such as EBSCO (Academic search elite and CINAHL), PUBMED and google scholar. The following search terms were used for data retrieval "Nursing Care Challenges", Multiculturalism and Nursing Care", "Nursing Care, immigrants and elderly care". Nursing AND Cultural Competence", " transcultural nursing AND Education AND cultural diversity" The following key words were also used "multiculturalism", "nursing care" "Health Literacy", "immigrants", "Cultural beliefs", "Education" "Policy", "ethnic minorities" "Health belief" "social Isolation" "Interpreters", "policy".

The following inclusion and exclusion criteria were applied. The articles are in English, scientific, detailed, free and easily accessible. The article selected have a publication range between 2000 and 2017. Exclusion criteria on the other hand consists of non-scientific articles, articles that required payment, articles written in another language other than English, articles published earlier than 2000, non-scientific articles, articles

with abstracts only and charged articles. Table 1 below shows the inclusive and exclusive criteria as mentioned above.

Table 1. Criteria for inclusion and exclusion

Inclusion criteria	Exclusion criteria
Articles in English	Other languages
Published between the years 2000 - 2017	Articles before 2000 excluded
Scientific articles	Non-scientific
Detailed articles	Abstract only
Free and easily accessible	Charged

After going through a thorough search process taking into consideration the inclusion and exclusion criteria for selection, a total of 18 peer-reviewed articles were retained for the studies. Table 2 below gives a detailed description of the articles including the authors, year of publication and the sources.

Table 2. Summary of Articles Selected

No	Author(s) / year	Article	Source
1	Maren J. Coffman/2004	Cultural Caring in Nursing Practice: A Meta-Synthesis of Qualitative Research	Journal of Cultural Diversity
2	Niina Eklöf et al /2014	Nurses' perception of working with Immigrant patients and interpreters in Finland	Public Health Nursing
3	Naser A Al Abed et al / 2014	Editorial: Older Arab migrants in Australia: Between the hammer of prejudice and the anvil of social isolation.	Contemporary Nurse. A journal for the Australian Nursing Profession
4	Manusco Lorraine /	Overcoming Health Liter-	Journal of Cultural

	2011	acy Barriers. A model for Action.	Diversity
5	Salman, Khlood Faik / 2012	Health beliefs and practices Related to Cancer screening among Arab Muslim Women in urban community	Health Care for women International
6	Margareth S. Zanchetta and Iraj Poureslami / 2005	Health Literacy Within the Reality of Immigrants' Culture and Language	Canadian Journal of Public Health
7	Gerrish, Kate Chau et al / 2004	Bridging the language barrier: the use of interpreters in primary care nursing	Health and Social Care in Community
8	Debra Jackson and Deborah C Saltman / 2011	Editorial: Recognizing the impact of social exclusion: The need for advocacy and activism in healthcare	Contemporary Nurse: A journal for the Australian Nursing Profession.
9	Gele Abdi A et al / 2016	Health Literacy: The missing link in improving the health of Somali immigrant women in Oslo	BMC Public Health
10	Jennifer Bennett Kimbrough / 2007	Health Literacy as a Contributor to Immigrant Health Disparities	Journal of Health Disparities Research and Practice
11	Emina Hadziabdic et al / 2015	Boundaries and Conditions of interpretation in multilingual and multicultural elderly healthcare	BMC Health Service Research
12	Kalengayi, Faustine Kyungu Nkulu et al / 2012	It is a challenge to do it the right way" an interpretive description of caregivers' experiences in caring for migrant patients in Northern Sweden	BMC Health Services Research
13	Anne-Marie Wallin and Gerd Ahlstrom / 2010	From diagnosis to health: a cross-cultural interview study with immigrants from Somalia	Scandinavian Journal of Caring Science
14	Sevald Høy and Elizabeth Severinsson / 2010	Professional and Cultural Conflicts for Intensive Care Nurses	Journal of Advanced Nursing
15	Tracy B. Long/ 2012	Overview of teaching strategies for cultural competence in Nursing Students	Journal of Cultural Diversity
16	Debesay et al / 2014	Facing diversity under	Journal of Advanced

		institutional constraints: challenging situations for community nurses when providing care to ethnic minority patients.	Nursing
17	McClimens A et al / 2014	Recognising and respecting patients' cultural diversity	Nursing Standard
18	Josipovic Patricia / 2000	Recommendations for culturally sensitive nursing care	International Journal of Nursing Practice

Work Division

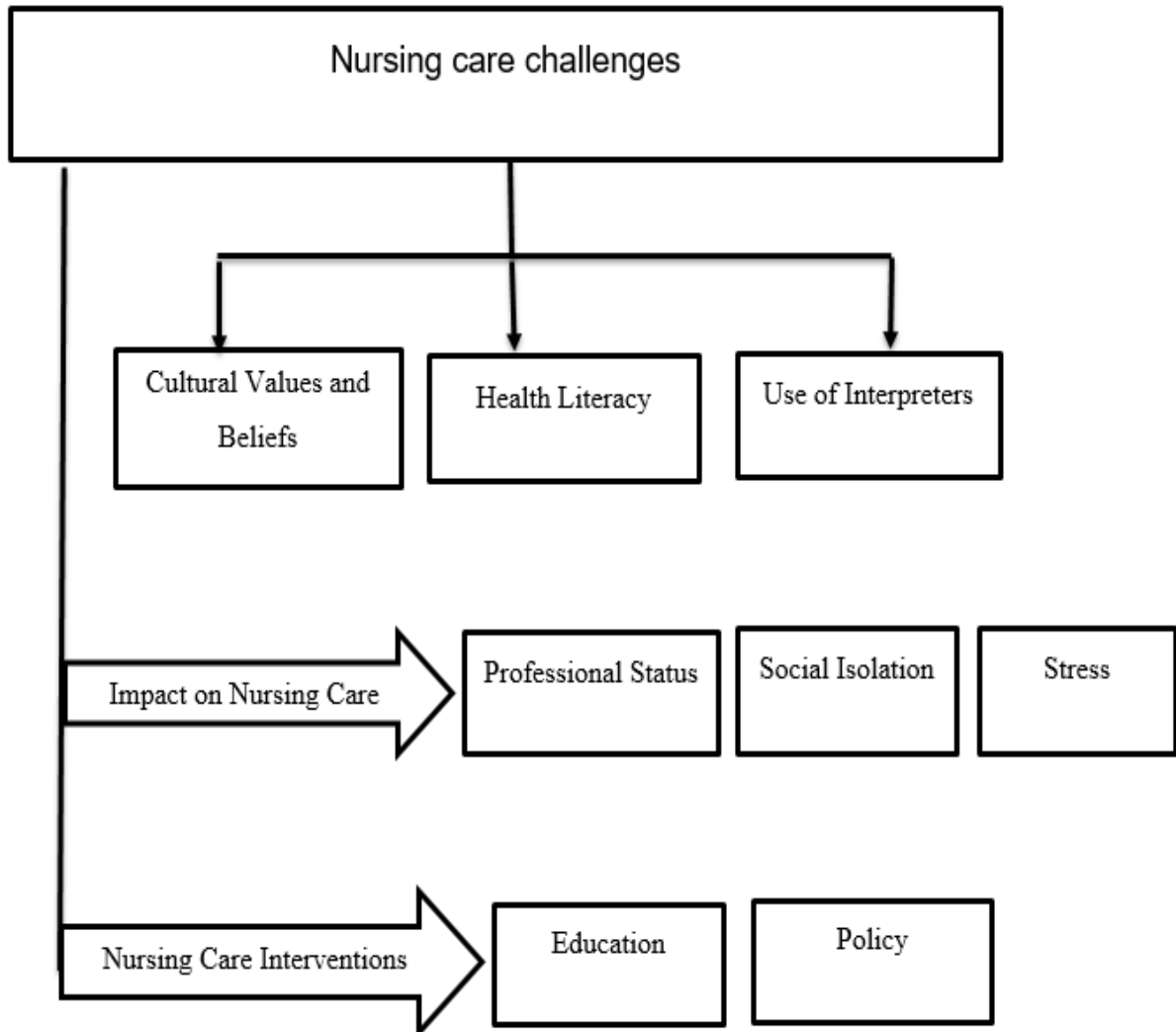
The thesis is divided into three parts and the workload share equally between the writers. The authors together worked on the first part which constitutes the introduction, background, theoretical framework and methodology. In the findings and second part of the study, the authors agreed to share the 18 articles equally between themselves for analysis to be done separately following the coding themes. Quinta presented analysis on cultural values health beliefs and practices, professional status, social isolation and education. Josephine did analysis on health literacy, use of interpreters, stress and policies and procedures. The third and last part of the studies covers the discussion down to the references. Together we merged the discussions from the individual findings and references to come out with a single and final version of the thesis.

5.2 Data Analysis

Qualitative content analysis is one among several research methods used to analyse text data with the goal of providing knowledge and understanding to the phenomenon under study. Data might be in electronic form, open-ended survey questions, interviews, observations, books, articles or manual. Qualitative content analysis focuses on the characteristics of language as communication while paying attention to the content or contextual meaning of the text. The content of text data is subjectively interpreted through a systematic classification process of coding and identifying themes or patterns. There are three different approaches to interpreting text data in qualitative content analysis. The

conventional, directed and summative approaches are all used to interpret text data from a predominantly naturalistic paradigm (Hsieh & Shannon, 2005). Conventional content analysis is used to describe a phenomenon and most appropriate when existing theory or research literature is limited. Directed or deductive content analysis uses theory or prior research to validate a theoretical framework or theory. It identifies variables of interest and their relationships to determine initial coding schemes. Summative content analysis identifies and quantifies certain words or content in text with the purpose of understanding the contextual use of the words or content (Hsieh & Shannon, 2005).

The data for this review was analysed using directed or deductive approach of qualitative content analysis. The retained articles were read several times with emphasis on the titles, abstracts and contents to ensure correlation with the research questions. Concepts were formed initially from prior research and theory and then linked to texts in the data. The first and last categories labelled nursing care challenges and nursing interventions were derived from prior research and the theory. While the impact of multiculturalism on nursing care as a subcategory developed out of the texts in the process of analyzing the data. Details of the coding process is shown in figure 4 below.



5.3 Ethical Consideration

Ethics are norms for conduct that distinguishes between what is acceptable and unacceptable behavior. Many institutions, disciplines and professions have set standards of behavior to help members to coordinate their actions or activities and to establish the public’s trust of the discipline. Ethical norm is very important in research because it promotes the aims of the research such as knowledge, truth and avoidance of error (Resnik, 2015). The study was conducted in conformity with Arcada’s standards set for

scientific writing and knowledge. Prior to writing, the research topic was reviewed and approved by the thesis supervisor to ensure there was no violation of human rights. In evaluating and reporting data, the authors were honest and careful when describing and using quotations from the texts to avoid misinterpretation of data. Guidelines on quotations and referencing were maintained mostly through paraphrasing. The appropriate guidelines for issues such as fabrication, falsification, dishonesty and plagiarism were equally followed and respected.

6. FINDINGS

In this chapter, we are going to be discussing the factors that are found to be challenging to nurses and health professionals in a multicultural health care setting. The impact of multiculturalism on nursing care and nursing interventions or strategies that can be implemented to assist nurses provide care that is culturally congruent or competent to patients of diverse cultural backgrounds.

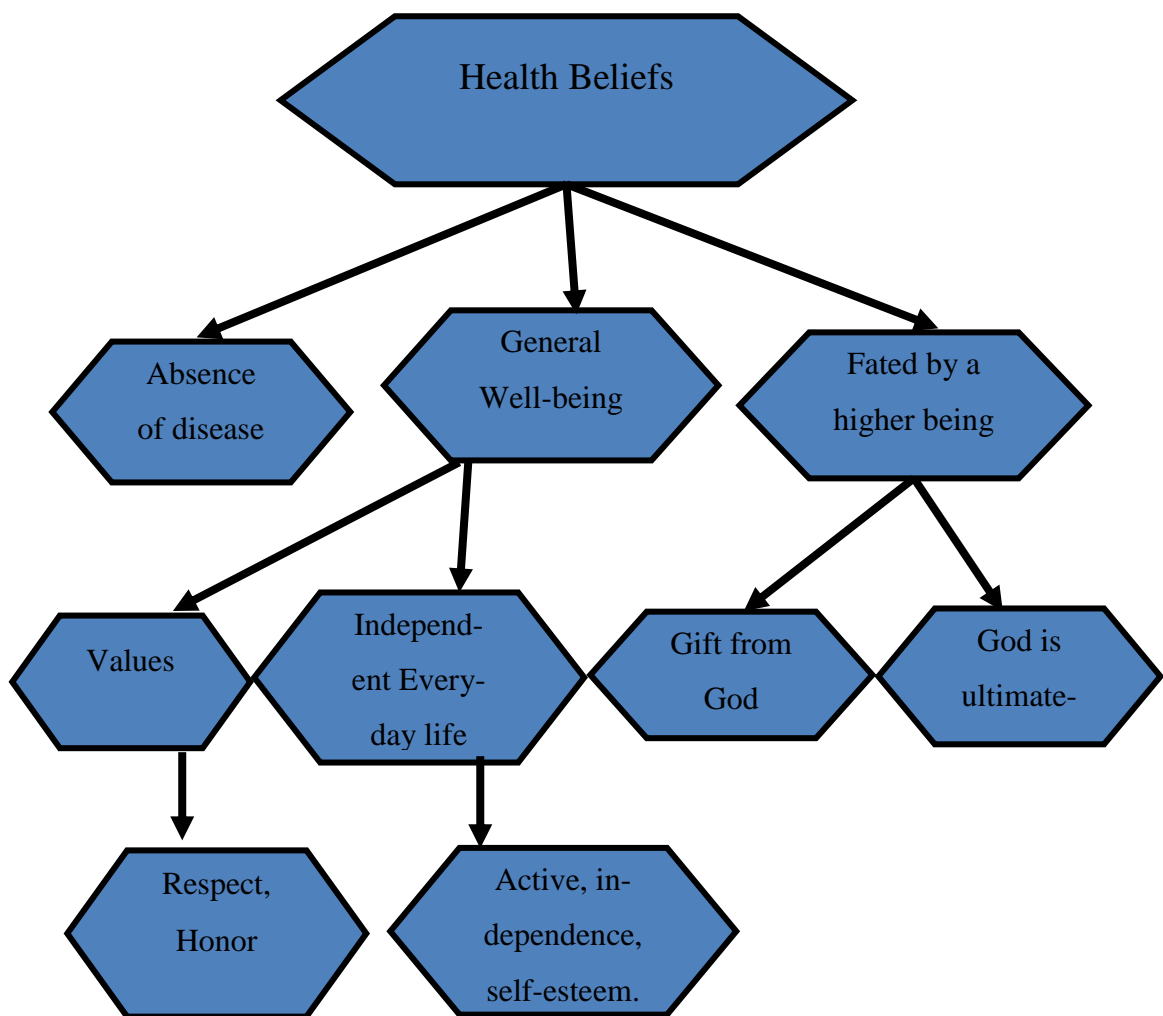
6.1 Nursing Care Challenges

Nurses and health professionals have difficulties understanding the way clients of various cultures think, feel and behave when it comes to matters of health. The studies identified cultural values, health literacy and the use of interpreters as specific clinical challenges that nurses' encounter when providing care to people of diverse cultural background.

6.1.1 Cultural Values, Health Beliefs and Practices

Cultural values, beliefs and practices are major barriers in health care and a source of conflict and misunderstanding between health professionals and patients of minority populations. The misunderstanding can lead to biased or inappropriate access to care in the clinical encounter. In addition to values and beliefs, etiquette, taboo and obligations, social and kinship networks are also problematic. As health professionals, it is important that nurses recognize and understand differences that can lead to poor patient-nurse interactions and to incorporate the needs and concerns that are specific to cultural heritage and historical encounters of medical systems (Mcbain-Rigg & Veitch, 2011). Beliefs about health vary between individuals, families, cultural groups and social classes. Studies have shown that people's perception of health are culturally constructed. Health could mean a balanced relationship between people, between people and nature, and relationship between people and the supernatural world. Empirical research on the ethnic minority people of Somalia in Sweden shows differences in people's perception of health even with a particular culture. Health for some is them consider the absence of disease, health could mean a general wellbeing and to others health associated with

one's destiny. The first category is an attribute of someone having a properly functioning body and free of medications. Health as a general wellbeing are values such as the ability to live independently in everyday life. Lastly, health as destiny is a gift from God and God is the sole determinant. Their reactions to disease diagnosis is guided by their perception of health which in turn influences their decision to pursue treatment. Nurses have to understand the patients experience and their reactions to disease diagnosis in order to give the best support that is needed for well-being (Wallin & Ahlström, 2010). Below is an illustration of health views as seen in figure 5 below.



Health practices and religious obligations commonly seen among immigrants and minority patients include modesty in appearance, decent behavior and consistently acting with cultural and social morality. Islamic religion for instance prohibits male/female close physical contact including eye contact and hand shaking with someone of the opposite sex except related by birth or marriage. Modesty and shyness in disclosing personal and private information and privacy in marital issues and family planning. These practices may prevent a woman from seeking health care services (Faik Salman, 2012).

People from Middle Eastern cultures are known to place great importance on traditional medical practices and beliefs about illness, disease and death with most of them passed on from generation to generation. Unlike in the USA, the national health care delivery system in Arab countries focuses on treating symptoms rather than preventive health care. With this understanding, it is unlikely that Arab Muslim women will participating in medical procedures and secondary prevention practices for breast and cancer screening. They may abstain if the health care system does not consider their cultural and religious beliefs even if they understood its importance. These cultural and religious obligations may also affect a woman's decision to have physical examination, refuse treatment and hinder discussions related to sensitive health issues. Consequently, these women will fall behind unable to meet their health needs. Nurses should take these factors into consideration and to education and support these people so that there might be a change in behavior (Faik Salman, 2012).

Food preparation and preferences are also strong indicators of an individual's cultural background and can be very sensitive to the patient. People whose food intake is governed to some extent by cultural beliefs. Minority patients might feel that their identity is being threatened or devalued when their customs and preferences are ignored. It is a religious ritual for Muslims to abstain from food and drinks during certain times of the day during Ramadan. Patients of other cultures would rather eat with their hands than to use a cutlery. These cultural codes if not known can be misunderstood by those who do not have any knowledge of that culture. There are also issues with gender preferences as most female patients prefer female to male staff to carry out intimate tasks. It is recommended that nurses apply the practice of culture safety that seeks to affirm and respect cultural expressions and avoid practices that demean or disempower minority groups (McClimens et al., 2014).

Individual and family held values of ethnic minorities could be a challenge in health care. Values held among some minority groups can be conflicting to persons of the opposite culture. Respect for older people within the Arab Muslim community is of great importance. Older people command respect and authority as decision makers and spokespersons for the family. In this regard, young people must respect their opinions, accept their directions and guidance as well as honour and care for older persons in the family. Children are expected to take care of the daily needs of their parents including providing food, accommodation, personal care, emotional and social support and household assistance especially where there are physical or financial limitations. The non-respect of these values leaves older feeling devalued, disempowered and humiliated. The situation is made worst in Western societies where freedom of choice, autonomy and privacy are viewed as essential rights to everyone. The common practice of institutionalizing older people in aged care facilities or nursing homes is unacceptable among Arab Muslims because it evokes feelings of shame and guilt. They feel less respected and isolated without expected family support. In addition to that, older people may experience traumatic feelings of social isolation and prejudice particularly if they do not share a common language or cultural practices with other residents or staff (Al Abed et al., 2014).

6.1.2 Use of Interpreters

An interpreter is a person who translates orally from one language to another. Using an interpreter is such a complex issue that involves taking into consideration aspects like ethical issues. The interpreter's competence is a fundamental requirement as inadequate training of interpreters may have an effect that is negative on the quality of interaction between the nurse, patient and interpreter (Eklof et al 2014). When there is misunderstanding due to ineffective communication between the healthcare workers and the patient, it leads to barriers in accessing healthcare, decrease in trust in the quality of care received and patient safety risk. For example, elderly immigrant patients are at risk of receiving lesser health care because of language barriers. To overcome these barriers, there is therefore the need of interpreter's services that will deliver high quality health care irrespective of age, sex or religion. These interpreter's services should provide objective and neutral explanation of medical terms. When interpreters are used, there are

not without obstacles such as the interpreters themselves and the organization system (Hadziabdic et al., 2015).

Europe and North America according to statistics have the largest number of immigrants. Finland has not been an exception. In 2010, the percentage of people with foreign mother tongues in Finland was 4.1% in a population of 5.6 million. According to statistics Finland, Language barrier plays a major adverse impact on the health of people. The largest foreign language groups in Finland are Russians, Estonians, English and Somali. With the rise of immigrant population especially in developed countries, there is therefore the need for translators and interpreters in many sectors of the society that play an important part on the health of immigrants. The use of professional interpreters increases the quality of care of people who speak a foreign language.

The health care sector has a greater need for interpreters and translators when dealing with non- Finnish speaking immigrant population. Majority of health care providers and nurses in particular may not be adequately trained to handle the non-immigrant population while taking care of their needs. Some sectors of the society use interpreters to serve the needs of the population but in the healthcare sector this is not the case. The reason for this is that the need for interpreters who understand professional ethical issues relating to the healthcare is limited. With this challenge, ultimately the nurse and the patient cannot effectively communicate which makes it impossible to achieve desirable nursing care for the patient. To achieve desirable nursing care and to overcome barriers, there is the need for professional interpreters who mitigate the problem and improve the outcome for immigrant patient population. While professional interpreters can play a great role to mitigate the challenge of language barrier it is not without its own challenges as the use of interpreters can lead to unsatisfactory situations or outcomes for the patients or can even lead to errors (Eklof et al., 2014).

6.1.3 Health Literacy

The number of immigrants around in the world today continue to increase in the past decades and this increase is likely not to slow down in the near future. The growing number of immigrants face different nursing challenges, which affects quality of nursing care. Low health literacy is one of the challenges immigrants face when they move

into a new environment (Kalengayi et al., 2012). Health literacy is the ability to obtain process and utilize health information and services to make appropriate health decisions in order to get optimum care. Health literacy is focuses and pays attention on the skills that needed to navigate the healthcare system, articulate, being able to understand a health care condition and follow a plan of treatment. Health literacy affects all because the skills needed for dialogue and discussions, reading health information and make informed health decisions. The outcome of inadequate health literacy leads to mortality rate and affects quality of life (Ward-Smith, 2012). The environmental, political and the social factors affect health literacy as they play a great role in health. Skills such as knowledge of risk factor, understanding how the local health system functions and getting local health information affect health literacy Immigrant community (Gele et al., 2016).

A study carried out amongst Somali Women in Norway reveal major health problems as a result limited access to health information even though they have the greatest health problems. The study reveals that 71% of Somali refugees women in Oslo lack the knowledge and capacity to obtain, understand and utilize health information and be able to make appropriate health decisions. Immigrants faced challenges to make healthy lifestyle choices and the ability to manage their health through a complex environmental health care system. Health Knowledge deficit amongst immigrants is a major health problem as they fail to seek medical help. They do not feel they are sick enough to get medical care and the situation becomes worse when they finally decide to get help (Gele et al., 2016).

Another study carried out in Sweden amongst migrants reveals that low educational level of migrant leads to low health literacy. Educated migrants are knowledgeable about body and diseases. In contrast, migrants with low educational level has poor knowledge, problems to access, process and use available information. It is difficult to give information to these set of migrants because of the difficulty to be able to determine what they understand or how much information is still needed. The study suggests it is difficult to describe asymptomatic diseases to low educated immigrants because limited knowledge prevents them from understanding the relationship between and infection and disease and with the absence of symptoms, they do not believe they carry a virus that can be transmitted. Lack of education is a barrier to accessing information that are available, accessing websites or receiving medical pamphlets (Kalengayi et al., 2012).

Migrants in Sweden find it difficult to navigate the complex health care system because they are unfamiliar with the health care system and they have no experience how it works. Migrants' past experiences in health care, the structure and organization of Swedish health care system such as using distant communication technology and centre care policy affects the care between care givers and provider. Migrants find it difficult to understand referral process to see a specialist. Using information technology to access educational and self-material, to book or cancel appointments, communicate with health care providers via phone, to navigate websites or use emails are challenges that affect the quality of care immigrants receive (Kalengayi et al., 2012).

A research study about Latino immigrants in USA suggests low quality of health care due to low health literacy. Low health literacy comes about because of low level of education, language barriers and lack of regular primary care. Health literacy is a predicament of health outcomes and behaviours. Understanding the relationship between health literacy and quality of care brings about interventions that will increase quality of care amongst immigrants. The studies reveal that low health literacy influence the quality of care of immigrants more that education, English language proficiency, health insurance coverage or having a primary care physician. Immigrants with higher health literacy report a 60.9% and 58.1% of higher quality of care with higher health literacy (Calvio, 2016).

6.2. Impact of multiculturalism on nursing care

Cultural differences, language issues in health literacy and interpreting services for immigrant and ethnic minorities puts the nurse, patient as well as the institutions under constraints. This interference interrupts the care process and might lead to unsatisfactory health outcomes.

6.2.1 Professional Status

Several studies have reported how multiculturalism or cultural diversity affects nursing care delivery. Nurses complain of established routines and procedures being challenged because of unfamiliar cultural expressions, norms and values of immigrant patients. With changes in the cultural and ethnic diversity of the Norwegian society, community nurses face challenges because they have not been adequately prepared to deal with the increasingly diverse population. Given these circumstances, nurses reported difficulties dealing with boundary issues related to intimate care. With limited control over the patients with whom they interact, nurses are made to break away from usual knowledge practices in their interactions with patients from ethnic minority population. They express feelings of insecurity due to the inability of predict the patient's reaction to certain situations. They fear causing offence doing tasks such as bathing, urinary catheterization and the administration of medications that require rectal suppositories. They also expressed fears of crossing cultural boundaries and the patients' reactions to discomfort when the nurse is thought to have come too close (Debesay et al., 2014).

The nursing ethics of openness with terminally ill patients' contrary to that being a taboo among minority ethnic patients interrupted nursing duties. Unlike the nurses discussing about dying to give the patient hope in dying, ethnic minority patients approach death in a different way and nurses are being prevented from following normal routines. Also, nurses face conflicting views about activity and rehabilitation related to provision of exercise to maintain or regain physical activity. Minority patients' families would prefer little activity after a stroke than to engage in the active phase of rehabilitation during illness for their relatives, as opposed to normal hospital routine treatment for all patients. Due to the lack of experience in the expectations of minority patients', nurses find themselves in a dilemma if they should respect the patients' beliefs or proceed as usual. When underlying standards are challenged, the preparedness of nurses is also challenged thus resulting in insecurity and uncertainty that can interrupt their nursing duties (Debesay et al., 2014).

Nurses blame the lack of human resource organizations rather than their individual capacities and skills to cope with situations that they had not been adequately prepared for. They have little or no opportunity to update their knowledge or to develop new

competencies related to minority groups. Nurses expressed the need to have more opportunities to deal with a more heterogeneous group of patients (Debesay et al., 2014).

In a similar report, critical care nurses in Norway have had conflicts with patients/families that interferes with the care process. Nurses in intensive care express dissatisfaction engaging with ethnic minority patients compared to the way that they would routinely interact with other patients. Differences in expectation of care may cause misunderstanding between patients and nurses. Minority families have the tendency of maintaining cultural norms and self-determination as opposed to the nurses' responsibility to control the clinical environment in the interest of their patients. In the mist of this misunderstanding, there is perceived lack of reciprocal respect between families and nurses. Unlike non-ethnic Norwegians, common practices such as non-respect of visiting hours, long vigil and loudly noises in the event of death of a family member are noticeable among culturally diverse patients. Assuming that behaviours occur as a result of communication barriers, nurses think that it is their responsibility to limit such activities and to maintain a safe and peaceful environment for all clients (Høye & Severinsson, 2010).

Again, culturally diverse families want to participate in the care of the patient whereas nurses consider themselves as the total caregiver. Family members find it difficult to hand over patients completely to professional care givers. They try to help nurses in turning patients and doing small exercises even after the patient is moved from home to the hospital. Nurses find such moves redundant because they never discussed collaboration with families meanwhile these families consider it a right to maintaining traditional norms that is in total contrast to Norwegian families who tend to be more comfortable letting professionals undertake the task of caring (Høye & Severinsson, 2010).

6.2.2 Social Isolation

Social isolation is a state in which an individual lacks a sense of belonging socially, lacks engagement with others, has minimal number of social contacts and are deficient in fulfilling quality relationships. It could also mean the absence of relationships with family or friends and with society on a broader level. Social isolation has been linked with a variety of functional, psychological and physiological ill effects (Alspach, 2013).

The fact that there exist these cultural differences between nurses and immigrant patients in health care, patients may decide to stay away from health services due to fear of stigma and negative judgement, marginalization, distress and lack of resources to improve their situations. Nurses are in the best position to establish trust and develop familiarity in their daily encounters and involvement in the difficult life journeys of patients suffering from social isolation. Nurses should ensure that the advocacy and activism requested to ensure a sustainable, safer and more just society for all people is supported in the most fundamental of clinical settings (Jackman & Saltman, 2011).

The ongoing global conflicts around the world has given rise to perceived racism and stereotyping of some minority groups that might increase their risk of social isolation and decreased ability to benefit from health care services. Arabs around the world especially in Western countries are targets of prejudice. This has resulted in negative health and wellbeing outcomes in issues around self-esteem, social withdrawal and further marginalization. Older Arab migrants especially are subjected to the negative effects of stereotyping and racism. They are particularly vulnerable with complex health issues associated with limited literacy and communication skills. Their quality of life is affected because of unequal opportunities and environmental stressors. Despite increasing cultural diversity and productivity in contemporary Australian society, many cultural groups still have limited health care services. Providing effective health care for older ethnic minorities can be challenging due to a higher prevalence of chronic and disabling diseases, limited ability to access services in the community and issues associated with linguistic and cultural differences. That notwithstanding, nurses need to increase their awareness of cultural attributes, understanding attitudes and beliefs of minority groups to improve health outcomes and reduce health disparities (Al Abed et al.,2014).

6.2.3 Stress

Stress is the way in which one's body responds to any kind of demand or treat. It is also the body's way of developing protection strategies. Stress can either be negative or positive. Positive stress helps one to rise to challenges by staying focused, energetic and alert. Negative stress affects one's health, mood, poor judgements, overwhelming situations productivity, relationship and quality of life (Segal et al., 2017). The inability to deal with work situations such as challenges in a multicultural work places contributes

to negative stress that impacts nursing care. Use of interpreters and low health literacy in a multicultural work environment can lead to negative stress especially when there is lack of respect of cultural values on both the patients and the nurses. The result of this is poor delivery of nursing care to patients.

The decision to use an interpreter is an issue that is complex as it involves practical and ethical issues that must be acknowledged from the start to the finish. The nurse must base the decision to use interpreters on the needs of the patients and not on cost. Based on a qualitative study carried out in Finland nurses made known of the fact that the use of interpreters is cost driven which is affected by the immigration status of the immigrant or guidelines that are related to the cost of interpreters. Many of the health care centers that are funded by municipalities have very strict guideline for the use of interpreters. Without the use of interpreters, the results of strict guidelines lead to many stressful encounters between the nurse and the patients (Eklöf et al., 2014).

In explorative and descriptive studies carried out in a multicultural elderly health care in Sweden, the lack of clear guidelines in the use of interpreters lead to stressful encounters between the nurse, patients and the interpreters. Arranging the time to use interpreters with limited access in the use of interpreters is time consuming. Emergencies that require the use of interpreters lead to stressful encounters between the nurse and the patients because interpreters are not readily available. Nurse assistants and other staff members are unaware of the guidelines of using interpreters. Staff members who are bilingual feel exploited because they offer interpreting services with no extra pay. It is stressful for these staff members to carry out their own job description with extra work of unpaid interpreting services they offer to the facility. When staff members act as interpreters to the elderly, these elderly patients are unable to make complaint if they are not satisfied with the quality of care they receive. They are afraid of losing their bilingual staff as such compromise the quality of nursing by refusing to complain (Hadziabdic et al., 2015).

In yet another explorative study carried out in the effective use of interpreting services, nurses complained about stressful encounter with the use of family members especially children who act as interpreters. It is difficult and stressful for the nurse to release sensitive information to children. Because of this, nurses have to edit out sensitive infor-

mation thereby compromising the nursing care the patient receives. Nurses report stress in editing information, which compromise nursing care of the patients. The Nurses report lacking awareness on the use of interpreting services and the inability to access interpreting services due to lack of guidelines. Confidentiality is a major concern in the use of interpreters in a close community of migrants. Limited availability of interpreting services, budget crisis and clear indications on when to use an interpreter is problematic to the health care staff. Because of this, many stressful encounters exist between the nurse and the patient that affects the quality of nursing care that the patient receives. Nurses that are not adequately trained to work with interpreters experience stressful encounters when caring out their jobs with the use of interpreters (Gerrish et al., 2004).

The presence of interpreter during an appointment has a negative interaction as it impedes and affects the relationship between the patient and the nurse if the patient sees the interpreter as a stranger. This is true if the patient is a child. Especially for minor children interpreter can be seen as strangers who will impede them from talking. This will cause children not responding to the nurse's questions (Eklöf et al., 2014).

Protection of privacy is a major challenge in using interpreters in small communities. Because of mistrust, many patients are reluctant to use interpreters in such small communities. In cultures that have limited contact with gender, it places a major challenge if the nurse must always provide a gender specific interpreter. Taking the case of the Somali community, Somali women prefer women interpreters and it is the duty of the nurse to respect this culture by providing women interpreters. Using family members as interpreter is stressful to the family as it is changing roles in the family especially if children are the ones interpreting (Eklöf et al., 2014).

The perception that the patient has about the interpreter is a challenge. The interpreter at time is a friend or a helper or as a total stranger. Patients ask for services that are not related to health issue. For example, patients bringing papers that need translation, and excursion to appointments. This type of close relationship between the interpreter and the patient places stress on the nurse who expects the interpreters to be professionals (Eklöf et al., 2014).

The lack of professional interpreters in daily work practice places stress on the day to day healthcare workers. In a survey carried out in Sweden reports are made on the use of professional interpreter as a result of circumstances that arises based on personal feelings of healthcare staff and how easy it is possible to get an interpreter. Professional interpreters are used at doctor's appointments, meeting with local authorities to decide on care plan as in contrast with using family members and staff with day to day encounter with the patients (Hadziabdic et al., 2015).

In addition to stressful challenges carried when nurses use interpreters, immigrants that have low health literacy also encounter major challenges. In a focus group study group carried out in USA medication compliance is a major challenge for non-English speakers. The basic idea of taking high blood medication for chronic illness for a long time is stressful; Medication sharing of prescriptive drug with family members and friends when they complain of the same symptoms is a common practice and a major challenge to stop due to low health literacy (Kimbrough, 2007). Prescription written by doctors are problematic and stressful to the immigrants who come from rural towns. The immigrants from rural areas according to the studies find it difficult to understand prescription written by doctors, how to navigate the health care system and keeping up with appointments. Because of this, minorities die 6 years earlier just because of their inability to understand simple prescriptions (Edmunds, 2005).

When immigrants move into a new environment from a background that has no structure in healthcare system they quickly notice a vast difference in the health care system. Some immigrants come from rural towns where they are not used to visiting medical doctors. When they become sick, they use close friends, family members or herbalists through home treatment. The idea of booking appointments to go see the medical doctor is cumbersome and stressful. They view the complex health care system such as referrals to see a specialist as stressful and problematic. The idea of long medical family history questionnaires is stressful and pointless to them. When the interview with the health care worker is intimidating, it leads to miss health appointment, which further exacerbate their illnesses (Kimbrough, 2007).

When immigrants move into a new environment from a background that has no structure in healthcare system they quickly notice a vast difference in the health care system. Many immigrants come from rural towns where they are not used to visiting medical doctors. Some are being treated with home remedies by family members or close friends with herbs. The idea of booking appointments to go see the medical doctor is cumbersome and stressful. They view the complex health care system such as referrals to see a specialist as stressful and problematic. The idea of long medical family history questionnaires is stressful and pointless to them. When the interview with the health care worker is intimidating, it leads to miss health appointment which further exacerbate their illnesses (Kimbrough, 2007).

It is also reported in another study that prescription written by doctors is problematic and stressful to the immigrants who come from a rural town. They encounter difficulties in understanding prescriptions written by doctor, how to take their medications, appointment dates and how to navigate their ways around the health care systems. Because of this, it is reported that minorities die 6 years earlier just because of their inability to understand simple prescriptions (Edmunds, 2005). In another focus group study in USA medication compliance also described as a major challenge for non-English speakers. They report difficulties in understanding instructions and directions on the medication labels. . The basic idea of taking high blood medication for chronic illness for a long time is stressful. Taking antibiotic medication completely even when they feel better cannot be comprehended. Medication sharing of prescriptive drug with family members and friends when they complain of the same symptoms is a common practice amongst immigrants (Kimbrough, 2007).

Language barrier is a major problem immigrant's face in health literacy. The inability of the immigrant to describe their symptoms because they lack the basic understanding of language, function of body parts, and the inability to describe their illness is reported by interpreters as a major stress. Understanding the basic anatomy of the human body will go a long way to help the immigrant describe accurately what it is going and where the problem is (Kimbrough, 2007).

Because of these nursing challenges and impact the multicultural health care environment faces, there is the need to come up with ways in which these challenges can be overcome.

6.3 Nursing Interventions

With the growing migration trend across the globe, nurses have to prepare to accommodate diversity to meet up with growing demand to provide high quality and equitable care to all patients. This can be achieved through educational requirement and policies that support and sustain culturally competent practices as elaborated below.

6.3.1 Education

One way of overcoming nursing care challenges is through education. Nurses need to be trained to provide culturally competent care to address the unique needs of ethnic minorities. Culturally competent nursing care education should begin at the student nurse level and restructuring the curriculum towards preparing a culturally competent graduate. Previous nursing education research in the USA indicated that most nursing programs comply with national standards of including cultural competence within their curriculum but still fall short of the most effective methods of application. The report suggested that emphasis should be more on practical developments of culturally sensitive care than on knowledge and theory. This would require culturally competent nurse educators to teach and equip faculty with needed knowledge and skills to understand ethnic and cultural differences and then have effective cultural encounters in the clinical setting. While introducing cultural competence programs that teach skills and strategies necessary to address specific cultural mores of an ethnic group, other methods of acquiring knowledge and personal experience about a culture's, attitudes, values, beliefs and behaviour is also necessary to deliver patient focus care. Examples include group discussions, presentation by ethnic minority speakers, case scenarios, lectures and group discussions (Long, 2012).

Furthermore, transcultural knowledge is important when caring for ethnic minority patients. This will help nurses to become sensitive to cultural differences and gain under-

standing of transcultural concepts. Many nurses have expressed the need for transcultural knowledge to enable them deliver culturally sensitive nursing care considering that their own nursing education training did not give them the foundation needed. Education is not just limited to learning transcultural nursing in the classroom but having personal encounters with ethnic minority patients helps nurses to learn about different cultures. Nurses can also improve their abilities in cultural competence by learning to live in foreign communities and in foreign countries or better still being a minority themselves at some point in their life (Coffman, 2004).

Nurses can acquire cultural competence through an understanding of overseas nursing practices and different health care systems. Nurses can be sent to different countries around the world to study about a variety of different nursing practices. The information that they get from overseas studies would be used not just for certificate recognition but also as an educational resource that could be developed for much further use by individuals and organizations. Nurses should be more open to accepting different ways of practicing nursing different from that which they have been educated (Josipovic, 2000).

Lastly, incorporating other nursing models that propagate the significance of cultural competence would help nurses work with patients and respect their cultural diversity. Campinha-Bacote's model of cultural competence presents constructs that helps educate nurses in respecting diversity to provide equitable care. The five constructs are; cultural awareness that deals with self-examination and in-depth exploration of one's own cultural and professional background. Cultural knowledge is seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. Cultural encounters encourage nurses to engage in cross-cultural interactions with people from culturally diverse backgrounds. Cultural skills focus on the ability to collect relevant cultural data about the person's present problem and accurately performing a culturally-based physical assessment. Lastly, cultural desire motivates the health care professional to want to, rather than having to engage in becoming culturally aware, knowledgeable, skilful and familiar with cultural encounters (McClimens, 2014).

6.3.2 Policy and Procedure

Policies are set of goals, principles and rules that are adopted by organizations in order to achieve long term desirable goals. While procedures are the step to step specific methods used to achieve day to day positive operation. They influence all actions and activities set forth by organizations to produce desirable results (Business dictionary, 2017). In this light, it is therefore recommended to have clear policies and procedures in a multicultural health care environment to overcome challenges in working with interpreters and addressing low health literacy problems. Having clearly defined policies and procedure in working with interpreters and addressing low health literacy create a better multicultural healthcare work environment. Having institutional commitment is important in ensuring equity and quality care for immigrants. Nurses and doctors are not able to provide quality care to patients due to institutional factors such as budget cuts, work overload and time constraints. Institutions must come up with policies to provide the resources, conditions a great work environment necessary to provide quality care to its immigrant populations (Hudelson et al., 2014).

Overcoming health care challenges by using good interpreting services to overcome nursing challenges is required to provide quality care to immigrants. Using qualitative interpreting services ensure that the interpreter is familiar with medical terminology and understands professional discreet. In-house professional interpreters who speak multiple languages will ensure that emergency services can be met to improve the quality of nursing care of immigrants. Collaborating with family and social services play a great role to make sure that the health care needs of immigrants are improved. Religious leaders and non-statutory agencies help to assist the health care needs of immigrants. Providing instructive programs and information materials about the health care system of the country on how it works will help immigrants overcoming the complexities of the health care system. Getting the health care workers provide education and teachings on the functionality of the health care system and healthy lifestyle. Providing policies on clear guidelines on the type of services immigrants are entitled to help improve quality of health care for immigrants. With empowerment through information, immigrants can seek to use information to better their quality of nursing care (Priebe et al., 2011).

Providing culturally congruent care, expanding health care services to all ethnic groups, increasing diversity in health care workers and providing interpreters is important in reducing health disparities amongst immigrant populations. Plan community connections to build, understand and maximize effectiveness of program that benefit health literacy will overcome low health literacy in the immigrant community. In a research carried out in the Indonesian community in USA, the strength of the community in fighting health literacy is effective with the use of community leaders who are better trusted than interpreters or healthcare workers. Asylum seekers, see nurses and interpreters as government informants who work in favor of the government. Considering this, they prefer to work with their own community leaders who are trusted (Manusco, 2011).

Health disparities that exist between ethnic and immigrant group are related to lifestyles and structural inequalities. Having healthcare policy makers at all levels of government accept diversity and address diversity through culturally and linguistically policies and programs serve as a means to bring a solution to health disparities (Kabayashi et al., 2008). Incorporating elements such as culture, literacy, education, assessment, and community health promoting efforts help to bring about solutions to health disparities. Address and intervening in health disparity requires the combined joint efforts from the social, cultural, political, and clinical and public health (Sheehan et al., 2009).

Healthcare providers and policy makers should develop culturally acceptable and responsive health care systems in different communities that are intended to address the health needs of their population. To provide and plan intervention approaches that seek to create educational and self-care health material that are sensitive to the intended audience's age, gender, ethnicity, religious and cultural beliefs (Zanchetta & Poureslami 2005).

Innovations in national policies are needed to bring major changes. The strategies for collaborative work between the immigrants serving agencies and the health care system addresses health literacy needs of immigrants. Programs aimed at promoting short term social integration of new comers to the immigrant's new country will aid immigrants quickly adjust and overcome health literacy crisis. Incorporating literacy profiles and language preferences of the immigrant health consumer in the identification section of the personal medical files will help identify the health literacy needs of immigrants.

Health care providers should be formally trained to use plain language with a multicultural perspective. Cultural competence education should be increased to undergraduate and graduate health programs (Zanchetta & Poureslami 2005).

Through adult educations, health literacy can be addressed by developing partnership with institutions, such as healthcare centers, physician groups, and community based organization. Health literacy abilities are necessary, so people can function properly as citizens, consumers and patients. Incorporating health literacy into curriculums, and creating new health literacy initiatives will bridge the gap of health disparities. Analyzing critical health literacy with patients that can be equipped to understand causes of health disparities, navigate the healthcare system and work with others as health advocate in the families, communities, and work places. Health literacy built on social justice in adult education seeks to honor the dignity of adults and nurture their ability to be able to exercise control over decisions that affect them (Prins & Mooney, 2014).

7. DISCUSSION

7.1. Discussion in relation to findings

Among the many problems identified as nursing care challenges in a multicultural setting are cultural values and beliefs, health literacy and the use of interpreters. The findings reveal that there exist differences in health care systems in every society and that underlying beliefs and perceptions of health is greatly influenced by cultural organizations. Previous studies found that there is a direct relationship between a patient and her health and the influence of culture on health beliefs and practices. The authors argued that because perception of health and well-being, illness and disease are culturally defined, understanding the significance of culture is critical to providing appropriate health care (Flowers, 2004 ; Hearnden, 2008).

Our findings also showed that differences in health perception may lead to misunderstanding between nurses and patients that influences the care process with the nurse respecting professional standards of care and the patient's need to preserve cultural norms. Such differences may lead to patient withdrawal, treatment adherence, and stress and job dissatisfaction. This assertion correlates with another study that stated perception of illness such as the fear of judgement and stigma attached to some disease diagnosis among religious and ethnic minorities could lead to abstinence from treatment and routine medical procedures. Adherence in terms of keeping appointments or scheduled hospital visitations which are essential for proper assessment and treatment of health problems becomes very difficult (Parsons et al.,2006). Nurses express their frustration of not being able to work within professional standards coupled with limited resources to deal with individual needs of the growing immigrant patient population. This is like other findings which noted that Nurses had difficulties learning and remembering the cultural preferences due to a great diversity among culture, language barriers and lack of resources (Hart & Mareno, 2014). The education of nurses to be culturally competent through diverse teaching method is imperative to culturally based nursing care to their patients. The cultural education perspective will provide the knowledge and skills nurses need to make an impact in transcultural nursing care (White, 2006).

The research acknowledges that overcoming language barriers by using interpreters increases the quality of care that immigrant patients receive. Policies and procedures serve to eliminate and give clear guidelines through elimination of misunderstanding and creating a great working environment (Ferry, 2006). When policies and procedures are clearly followed and implemented by interpreters, nurses and patients, it becomes easy to overcome nursing care challenges. Working with interpreting services with clearly defined roles and boundaries through policies and procedures eliminate stress from both the patients and nurses and create great multicultural work environment that increases quality of nursing care of the patients. Policies put in place on education work to encourage nurses to become culturally competent nurses.

7.2. Discussion in relation to Theory

Leininger long predicted that with the growing increase in multicultural societies, there will come a time when nursing practice will reflect different kinds of nursing care which are culturally defined, classified and tested as a guide to provide nursing care. Therefore, for nursing to be relevant to the client and the world, transcultural nursing knowledge will be imperative to guide all nursing decisions and actions. These decisions would have to take into consideration individuals', families and groups caring behaviours, values and beliefs based on their cultural lifeways with the aim of providing effective, satisfying and culturally congruent care (Alexander et al., 1989 pp.149-150). So, by recognising these variations, the nurse can avoid stereotyping and understand that not all people will respond positively or in the same way to the standards or routines in nursing care (McFarland, 2014 pp. 350-352) The theory provides practising nurses with an evidence-based, versatile, useful and helpful approach to guide them in their daily decisions and actions regardless of the number of clients under their care or complexity of their care needs. It guides practice by assisting nurses to be culturally aware of and sensitive to individual cultures, groups, families, institutional, community, societal, national cultures and eventually to global human cultures (McFarland, 2014 p.354).

It is the only theory that focuses on the relationship between culture and care on health and wellness. Cultural factors influence the health and wellbeing of people, reason why

nurses need an in-depth knowledge of different cultures to enable them provide care that is individualized, meaningful to people of diverse cultural backgrounds. It is unlikely that nurses would know about the cultural-based, health-related beliefs and practices of all patients. However, nurses can gain knowledge and skills in cross-cultural communication to help them provide individualized care that is based on cultural practices (Maier-Lorentz, 2008).

8. CONCLUSION

The research is not without its own limitations. One of the biggest challenges has to do with the scope of the review. The research is not limited to a particular geographical area but covered a host of countries within Europe, USA and Australia. The writers focused more on the universality of the problems in question than on any geographic location. The studies identified multiple and diverse challenges related to immigrant patients, but the findings were narrowed to the few directly connected with health care and leaving room for further research. The findings of the studies will add to previous knowledge in the field of nursing and used as a teaching documents to prepare nursing students to become culturally competent to care for patients from diverse background in working life.

To conclude, diversity is a noticeable phenomenon among patients and health care professions in our societies. This requires nurses and health professionals to be sensitive to cultural beliefs and needs, specific knowledge and skills of the patients' world. To achieve this, health care services need to adjust to the culturally diverse patients' needs and providing information according to their understanding and values for a successful health outcome for the patient. For nurses to provide culturally sensitive and appropriate care, educational programs need to be developed that provides nurses with skills that are adequate and knowledgeable in transcultural care.

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APPENDICES

Appendix 1. Search Process

Data Bases	Search words	Year range	Number of hits	Retrieved articles
EBSCO (Cinahl)	Multiculturalism, AND challenges AND nursing care	2006 – 2009	3	1
	Nursing care, AND, education, AND, multicultural	1991 – 2015	35	4
EBSCO (Academic search elite)	Transcultural Nursing, communication, barriers	2005-2016	50	3
	Nursing challenges, AND, stress, AND, work	1990-2016	32	1
	Immigrant, AND, nursing care, AND, Finland	2010 -2016	3	1
	Nursing, AND, social isolation, health care	1994 – 2016	143	3
	Nursing care, AND, multicultural workplace, AND, communication.	2008 – 2016	1	1
	Health Literacy And impacts or effects or consequences And Nursing Care	2015	13	1
	Multiculturalism AND nursing	1991-2012	23	1

	Nursing Care, challenges, interpreters and translators	2006	1	1
	Health Literacy And Importance	2000-2017	152	3
	Nursing Care, And Multicultural And Challenges And barriers And Difficulties And issues And problems And limitations And multicultural And workplace	1995-2015	9	1
	HealthCare, And Workplace, And communication barrier	2003-2015	6	3
	Communication skills, And Healthcare, And Nursing student	2006-2016	13	1
	Nursing AND Cultural Competence	1997-2017	282	2
	Policies And Procedures And Performances	2000 to 2017	498	1
	Nursing care and challenges or barriers or difficulties and use of interpreters	2003-2017	2	1
	Literacy and Health disparities	2005-2017	116	1
	Working with Interpreters And Challenges or barriers or diffi-	2004-2014	4	1

	culties and health care			
	Ethnic differences And Functional Health	2005-2015	5	1
	Health Disparities Research And Immigrants in the United States	2007-2017	8	1
	Health Literacy And quality of life	2002-2017	87	1
Google Scholar	Health And Literacy And Culture	2006-2017	5 650 000	2
	Boundaries And conditions And Interpretation And Multicultural work place	2010-2017	1.690.00	1
	health literacy And cultural competence And immigrant health And health communication	2000-2017	14 800	1
	Multicultural, AND, healthcare, AND, Finland	2000-2016	5,490,000	1
	What is the Purpose of policies and procedures	2000-2017	469.000	1
	Stress ,Symptoms, signs	2000-2017	714 000 000	1

Appendix 2. Components of Culture. Available at https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/culturaldiversity_february2000_e.pdf?la=en

