ARCADA

Cultural Differeces In Elderly care

A Literature Review

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Cultural Differences in Elderly Care
Human Ageing and Elderly Service
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Abstract:

The care field deals with people from different cultural background. Caregivers need to be culturally competent, that is, understand that differences exist among cultures and that individuals have different needs. Cultural incompetency impacts on care outcome, and so do cultural difference of caregiver and elderly client. This could be detrimental to care giving and wellbeing of the elderly. People's cultural background shapes who they are, as mentioned by Laroche (2003). Culture care is imperative for caregivers to meet the cultural needs of elderly clients, manage differences and deliver best care possible. This study is a literature review based, focused on exploring and analyzing cultural differences in elderly care when caregiver and elderly client don't share some cultural background. It stresses on possible challenges as a result and equips caregivers with practical information on culture and its essence in elderly care. The aim of this study is to assist in molding a better culturally competent work force. The research questions used in this study are: 1) What is cultural difference from a care giver's perspective in elderly care? 2) How is daily care in an institutional or home setting affected by difference in cultural backgrounds of elderly and care giver? The theoretical framework used is based on Leininger's Culture Care Diversity and Universality theory, and the study was analyzed using the deductive content analysis method. Findings show that cultural differences in elderly care surfaces as result of client and care giver not sharing same cultural background, and could be as a result of migration & global mobility, and recruitment across borders. Language and communication issues, cultural incompetence skills, health and religious belief, and awareness issues are challenges that could impact on the daily care of the elderly as per the results. Caregivers need a culturally sensitive approach to identify, communicate and deal with these challenges. It will help achieve a positive care outcome and meet the needs of a culturally diversified clientele in effect improving on their health and well-being.

Keywords:	Kustaankartano, cultural differences, cultural competence, care, elderly, culture care diversity and universality theorty.
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Tiivistelmä:

Hoitoalalla kohdataan ihmisiä monista erilaisista kulttuuritaustoista. Hoitotyötä tekevien täytyy kyetä ymmärtämään niitä eroja, joita eri kulttuurien välillä ilmenee ja yksilöiden erilaisia tarpeita.

Pätemättömyys tällä alueella vaikuttaa hoitotyön lopputulokseen joka on haitallista vanhusten hoidolle ja hyvinvoinnille. Ihmisten kulttuuritausta, muokkaa heidän persoonallisuuttaan kuten Larouche (2003) mainitsee. Tämä tutkielma on kirjallisuuskatsaukseen perustuva ja on keskittynyt tutkimaan ja analysoimaan kulttuurieroja vanhusten huollossa tilanteessa, jossa hoitotyöntekijä ja vanhus eivät jaa samaa kulttuuritaustaa. Se osoittaa joitakin mahdollisia haasteita ja varustaa hoitotyötä tekevät käytännöllisellä tiedolla kulttuurista, sen merkityksestä ja vaikutuksesta vanhusten huoltoon. Tämän tutkielman tarkoituksena on auttaa muokkaamaan parempaa kulttuurillisesti pätevää työvoimaa.

Tässä tutkielmassa kesheiset kysymykset ovat: 1) Mikä on kulttuuriero hoitotyöntekijän näkökulmasta vanhusten huollossa? 2) Miten hoitajan ja vanhusten eri kulttuuritausta vaikuttaa hoidossa tai laitoksessa tehtyyn hoitotyohön?

Tutkielmassa käytetty teoreettinen tausta perustuu Leiningerin kulttuurisen hoidon moninaisuus- ja universaalisuus teoriaan. Tutkielma on tehty käyttäen deduktiivista sisällön analyysia. Tulohset osoittavat että kulttuurierot vanhustenhuollossa nousevat esiin sen johdosta että asiakas ja hoitotyöntekijä eivät jaa samaa kulttuuritaustaa ja ne voivat vaikuttaa maahanmuuttoon sekä globaaliin liikkuvuuteen kuten myös kansainvälisiin työmarkkinoihin. Kieli-ja kommunikaatioongelmat, kulttuurilliset taidot, käsitykset terveydestä, uskonnolliset uskomukset sekä tietoisuus asioista ovat haasteita jotkat voivat vaikuttaa vanhusten päivittäiseen hoitoon kuten tulokset osoittavat. Hoitotyöntekijät tarvitsevat kulttuurillisesti ymmärtäväisen lähestymistavan tunnistaa kommunikoida ja käsitellä näitä haasteita saavuttaakseen positiivisen hoidon lopputuloksen ja vastatakseen kulttuurillisesti moninaisen asiakaskunnan tarpeisiin parantaakseen heidän terveyttään ja hyvinvointiaan.

Avainsanat:	Kulttuurierot, kulttuurillisen, osaaminen, hoito, iäkkäät, kulttuurillinen moninaisuus ja niversaalisuus teoria.
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FOREWORD

I would like to thank Arcada University of Applied Sciences for giving me an opportunity to study in their institution, and for the learning experiences. A word of appreciation goes to my teachers who saw me through this whole study process. Special thanks to Solveig Sundell for her motherly support, care and encouragement. A warm heartily thanks also goes to Birgitta Dahl who's been my mentor and supervisor through this whole thesis process. I really appreciate her believe in me and my abilities, though I was blind at times to see my own strengths and how far I could go on my own. Though it's been a rocky climb, she edged me to push forward and strive for the best. Thanks for the help and support. Gratitude also goes to Kustankartano Center for the Elderly for commissioning the study and giving me the opportunity to work on it.

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Most especially, a million thanks to my Creator Jehovah God Almighty and my Lord and savior Jesus Christ. Thank you Heavenly Father for answering my prayers seeing me through as always. All glory, honor and praise belong to YOU!

I dedicate this work to my late parents Mr. Lucas Njue Bah & Mrs. Njue Regina Fri. May God rest their souls. You will forever live in my heart! Thank You!

1 INTRODUCION

Cultural Differences in Elderly Care is what this thesis is about. It is a literature review based thesis which is intended to be a guide to care givers, especially the commissioning party and those working with elderly. Given the fact that the healthcare field deals with people from diverse cultures, who in most cases might not share or have same cultural backgrounds, or might have the same cultural background but then, don't belong to the same sub culture, it is vital for differences in culture with regards elderly care to be addressed and looked into.

This thesis will focus in providing material on the research questions as well as state aim behind the study. It will elaborate on cultural differences and how differences in culture of both the care giver and receiver impact or affect elderly care, why it is important for these differences to be looked into or crossed examined and its relevance in elderly care field. It will also focus on those tools that could better enhance culture care, wellbeing of the elderly, best meet their needs in those areas where culture is an intertwining factor or those areas concerning their care that's been affected by cultural aspects. In all, this thesis aims at assisting the commissioning party in molding and building a better culturally competent work force.

The motivation behind the author choosing this topic has to do with the fact that the author happened to have worked in a multicultural health organization where differences in cultural backgrounds, and lack of knowledge on cultural norms and believe of others kind of sparked a whole lot of controversies and subsequent misunderstandings between colleagues, and clients respectively.

Upon the author's realization of Kustaankartano's interest on the topic and subsequently, it's featuring as a thesis topic among their thesis project, the author felt it was an opportunity not to miss out on. Not only will it help the author have a clear insight and understanding of cultural issues, cultural differences and its impact not only in working life, but also on a daily base to better relate with people, the elderly in particular. With knowledge on how to handle cultural issues, specifically in elderly care, the author

would be able to manage some of the challenges that could pop up as a result of literacy deficiency in this area, which was uncommon before. Not only will it be of help to the author, but as well to the reader and the commission party.

The author will also include the limitations of the literature review and will also indicate how the work scope was limited, what was included in the review, what was excluded and why. In order to establish a relevance for this thesis, a theoretical framework will be used to aid explain or give more insight about earlier research or information on cultural differences and elderly care. The theoretical framework chose for this topic is the Culture Care Diversity and Universality, Leininger's theory of nursing. The theory will be defined and its concepts explained, culture as well as its concepts in elderly care will also feature, be defined and explained.

2 BACKGROUND

This part of the study covers previous studies on the topic by various authors. It equally covers motivation behind the study, the aim and research questions, study limitations, the theory used in the study, its concept and culturally diversity and ageing.

2.1 Previous Studies

This section covers previous studies and extensive material relating to cultural differences and elderly care by various authors.

Cultural difference

With the world fast becoming a global village, significantly, it means people from different or diverse backgrounds, regions and races, meet to a certain degree. When people meet, there is usually a high possibility or tendency for exchange of ideas, views or some kind of interaction. As a result of meeting, exchanging ideas and interacting, it is soon realized that perspectives, behaviors, and views differ. These differences may be as a result of different norms, believes and practices not being identical or same. People think, feel, act and react differently, and it's these differences that distinguish one people or one society from the other. Cultural difference has to do with the differences of both visible and invisible aspects of two cultures or different cultures. As a result of culture being different in relative to another culture, the same culture might be perceived differently by people from diverse cultural backgrounds. When looking at or talking about cultural differences, one needs to be observant about the gratification it brings as well as the opposite side of the coin. (Laroche 2003, p.6-8).

Healthcare Diversity

Healthcare professionals as well as receivers are usually people from around the world, individuals with diverse backgrounds, and different works of life, different societal norms who share different cultural values, norms, believe, or in general, have different cultural back grounds. Differences in culture have major roles to play in healthcare deliverance, subsequently, healthcare professionals have come to realize it is imperative to understand the cultural values and lifestyle of different people. This is because the

health care sphere is becoming highly multicultural. When dealing with people from diverse backgrounds, knowledge on their various cultural values and lifestyle would help caregivers deliver the best possible care, since such information is required in nursing decisions and actions. (Leininger 1991, p. 3 - 4).

The health care sector does employ and cater for people from different cultural backgrounds. Knowing and understanding the values and norms of people as well as their attitudes tied to cultural issues will help care givers unintentionally do things that will undermine or offend the elderly's core believes. By so doing, the caregiver strives to ensure proper and successful healthcare provision or deliverance. (Varner & Beamer 2005, p. 6-7)

Caring for elderly clients with diversified cultural background as well as working with people from different cultural background that is not one's own could be quite challenging. This comes as a result of the fact that, rules of appropriate behavior varies both in and across cultures. How people behave or interact could be shaped by their interaction with members of own culture in comparison to that of other cultures, education, longevity of stay in a country, social class, and other personality traits. Information on what might arise when catering for a culturally diversified setup will help increase cultural awareness for caregivers, and subsequently, help in the management and avoidance of misunderstandings that might arise as a result of culture clash. (Galanti, 1999)

Culture care should be a concern for all care givers. It is of great importance for care givers to learn about the traditions, beliefs and way of life of clients as far as healthcare is concerned. Knowledge gained about how they believe and view healthcare will act as a tool to help caregivers respect and honor those views and believes, as well as ease its combination into professional care, thereby delivering a comprehensive care. Clients, their families and caregivers working hand in hand helps bring out a clear picture of what those cultural needs of a client are and how those needs affect their healthcare needs. Sub-cultures exist in every culture, so caregivers need to be aware and use professional tact when dealing with clients. Individual cultural assessment of clients are necessary to know them on an individual base, what kind of people they are, what they want and how they want their care, irrespective of the fact that at times, some client might share same values and norms. Caregivers need to avoid and overlook stereotypes

that pin assumptions on clients and their needs, but rather as a duty, focus on educating themselves on the clients as separate individuals in order to deliver a culture diverse care. (Orlovsky, 2004).

In order for caregivers to reduce health disparities among elderly, it is important to develop a culturally competence healthcare providers. This is because healthcare concepts such as illness, health, suffering and care are perceived differently and mean different things to different individuals. To provide a better care as well as avoid misunderstandings among care givers, elderly clients and their families, knowledge on various cultural customs and believes is necessary. (Lehman, 2012)

Cultural attitudes & perspectives towards ageing and the elderly care

Ageing does not only refer to an individual's chronological or physiological age, but also the attitudes, viewpoints and belief towards ageing. The way nations or individuals define who is considered an elderly has to do, or could be as a result of elements of social construction both at local and global level. The concept of who is an elderly comes as a result of interactions among individuals in the society. As far as assumptions and expectations on ageing is concerned, each culture holds its own perspectives or viewpoints on ageing, which in all, is part of socialization. Some define the elderly in measure of physical health while others define it in terms of chronological age. (AMA – Openstax college sociology cap, 2012)

According to the WHO, most developed countries have accepted the chronological age of 65 years and above as the definition of an elderly person, for this is the age within which an individual could start receiving pension benefits. At the moment, there is no United Nations numerical standard criterion to refer to an elderly population, though it has agreed on the 60 and above as curt off point in reference to older population. (UN population age structure, 2005)

Various cultures have different ways as to how they perceive elderly care as a whole. Coining up culture, health and ageing in different cultures might mean different things. The provision and reception of elderly care today, given today's trend of globalization; one is bound to have encounters that differ in terms of various cultures, how ageing is viewed and various ageing processes. As a result to differences in cultural settings, dif-

ferent cultures have own concept of illness, health and diseases, might have different reactions to treatment progress which could eventually lead to misunderstandings between senior clients and caregivers. Differences in linguistic issues in verbalizing medical problems, how different cultures view the origin of disease and how the human body functions could also lead to problems in care. As far as institutional care is concerned, the way old age is perceived in a culture will directly influence the quality of life in nursing homes in that culture. One culture might be fine with relinquishing total control of health condition and care of family member to caregivers and providers, while to another, relinquishing total control to caregivers and providers might be unheard of. People hold different beliefs as to the origin of diseases or ailments. What is considered as a sign of a disease or illness might vary from culture to culture. Relatively, elderly people hold strong commitments to traditional belief of health and illness and might prefer own traditional health care practices to modern ones. In most cases especially with elderly clients who are not that educated, in the absence of pain, fever, malaise and other symptoms, diagnostic and other health related results might hold no meanings to them. (Holms & Holms, 1995)

The elderly in USA, Western world, the East and Africa

In the United States, the older adult population is divided into three life stage subgroups. The first category is the young-old, ranges between the ages of 65 - 74. The middle old which is the next category of the elderly are those ranging from the ages of 75 - 84 years of age. The last group called the old-old are individuals from the ages of 85 and above. In a nutshell, individuals are considered as elderly in the US when they are 65 years of age and above, though categorized in the above three life stages. Attitudes on the elderly have changed lately due to the confined setup of nuclear family. It is no longer common to find older adults living with their children or grandchildren. It is believed by researches that modernization and industrialization contributed to lowering the power, prestige, respect and influence once held by the elderly.
(AMA – Openstax college sociology cap, 2013)

The western concept of elderly in contrast to African concept

In developed countries, the chronological age 60-65 which is roughly equivalent to retirement age plays an important role in defining old or elderly. The physical decline accompanied by old age or as a result of an individual ageing, as to the allocation of roles usually assigned to elderly people is another socially constructed meaning which is seen to having a significant impact in defining ageing or the elderly. Realistically, in including a definition of elderly according to an African context, the ages will be 50 or 55, which could still be problematic in data comparability across African nations. Due to the fact that many individuals in Africa don't have official records of their birthdate, chronologically defining ageing or who an elderly is, can differ greatly from traditional or community settings, given the fact that they define when a person is an elderly. In all, an African definition of who is an elderly correlates within the chronological ages of 50 – 65 and above, depending on the region or the country. The ages are the ages within which an individual becomes entitled to retirement benefits and pensions which is the default definition of an elderly. It could also be related to functional ability related to work force as well as political and economic situations. (WHO Survey-2013)

In a nutshell, basics for defining who is an elderly or old age in developing countries falls under three main categories, that is chronology, change in capability and change in social role. In defining who is an elderly in Africa, it seems more appropriate to use the combination of chronological, functional and social definitions to coin the said concept of who is an elderly. (WHO Survey – 2013)

Ageing and elderly care from a global perspective

Around the world, the elderly and elderly care varies from culture to culture. In the western world and Australia, the elderly are independent and are expected to manage their own care meanwhile in a majority of Asian and African cultures, the care of the elderly lies on the families of those elderly individuals. Care for the elderly in the western world by the family members is often voluntary and not seen as an obligation as the case maybe in most African, Mediterranean and Asian cultures. Ancestral reverence is very important and respected in these cultures, thereby making it a high privilege to be in the company of the elderly. It is often considered shameful to not take care of ones parents at their old age or ageing stage of their lives in African, Asian and Mediterranean cultures. (AMA-Openstax college sociology cap, 2012)

In the western world, family members might only intervene in the care of their elderly only if the elderly individual needs help and assistance or when the elderly is not in good health. Western cultures encourage independence and individuality. They strive to strike a balance between allegiance to their elderly and individual freedom. In effect, the elderly living with their children or grand-children is often in most cases very rare and usually considered a hassle. In the United Sates for example, elderly care by a relative are in most cased based on what the caregiver will get in return in future, either in the form of inheritance or in some instances based on how the elderly supported the care-giver in their earlier years. The American protestant work ethics makes mention of the fact that when an individual is retired and no longer working, he or she losses the main value placed on them by the society. Due to the financial strain entailed in soliciting professional care, many people in the US view elderly care as a burden. Many people are employed outside the family and are usually unable to provide the required need and support for the elderly. Notwithstanding, there are other demographic groups who don't treat ageing and the elderly the same way. Though most people are reluctant to place their elderly in care outside their homes, there are certain groups who are most likely not to do so, which are the African Americans, Asians, and Latinos. (AMA– Openstax college sociology cap, 2012)

Finland being an EU member state and a developed country also holds the age 65 years and above as the age where one is considered elderly. According to the Finnish National Pension act, an individual is eligible for old age retirement fund at age 65 and above. Until 2002, the age where one was eligible for the said retirement pension was 65 years old, till its reformation in the same year. A more flexible approach was introduced, which took effect as of 2005 due to the raise in the country's ageing population and the negative effects of early retirement as early as 62years before the reformation. According to the new flexible approach which took effect as of 2005, people were allowed to retire at 63 years of age, but then, strong financial incentives were given to encourage those who chose not to retire till age 68 to encourage and keep them working till the attained the target age of 68. (Kunz, 2007)

The elderly in Finland are encouraged to live independently, through the Finnish policy on ageing for as long as possible in their own homes, so just like most developed countries, Finland encourages independence of its elderly. Finland's population is ageing the

fastest than that of its fellow EU member states, thus, the country is seen as front runner as far as new ageing policies in the EU are concerned. Finland holds its elderly in high esteem and believes they should be provided the best care possible, be it in their own homes, service homes, institutions etc. as need be. In as much as independence of the elderly is the norm, the government strives to make sure its elderly are well catered for. Finland is the only EU country where age discrimination in working life is prohibited by law. (Kunz, 2007)

Culturally, elderly people in Finland will prefer to be called mainly as the aged, or senior citizens. ‘Older people’ is seen mainly as relating to people over 85 years of age and above. Most elderly people in Finland live and manage their own lives individually or with the support of their family and friends. They stay active and help their children which could be financially or babysitting as well as light repairs and little household chaos (for those with children). About 86 percent of elderly in Finland live in their homes. Those over 65 years receive long term assistance from family, spouses, municipal home help or home nursing while those 75 and above receive similar assistance too. Services for the elderly are provided by the municipality according to their needs, resources available and priority. Finland’s policy of elderly care is interwoven into its municipal healthcare and its social welfare policy. (Haataja et al, 2003)

The elderly are provided with home nursing when needed, this arranged by the municipal healthcare centers. Intensified home nursing and home care is usually in the elderly persons homes for those who need a 24 hour care and assistance, usually not intended for long term use. Short term, part time and interval institution care supports the elderly with regards their lives in their homes to cope with their daily lives in the day. They to call for help at late hours with the help of security wrist bands and phones provided by the municipalities and at times, private associations (NGOs) or foundations. Long term institutional care is usually for elderly in need of long term care for a period of 3 months or more, when the nurses and other care givers can no longer provide them with the needed care. They are therefore moved to long term care words in hospitals and in old people’s homes. (Haataja et al, 2003)

2.2 Motivation

The motivation behind the author choosing the topic had to do with the fact that, the author on moving to Finland was employed in a multicultural environment. Challenges popped up as a result of lack of knowledge on the cultural norms and believe of both colleagues and clients. This as the author can now attest, was as a result of differences in cultural backgrounds given her present knowledge on culture and its impact on the behavior of people. The author immigrating to a country far from home country with different cultural norms values and believes as well as meeting and working in a multicultural setup sparked interest on topic. As a health care professional, providing care services to persons from diversified background in most cases is an unavoidable issue in the author's case. Another motivational factor for the author choosing the topic was as a result of the author needing to improve on, and increase her cultural competence skills. The author being a professional in the care field, it means it is imperative to cultivate cultural competence expertise and skills to be able to care for the cultural needs of culturally diversified clients. Alternatively, working on the study was another way for the author educating self. Having a clear view and understanding cultural traits shared by people from different cultural backgrounds is of great importance. Knowledge on attitudes, point of view of individuals from diverse cultural backgrounds, will help shape the thought mind of the author as far as cultural issues in general are concerned, then narrowed down to elderly care. It will help undermine as well as manage some of these challenges that pop up as a result of literacy deficiency of other cultures not only to the author but the reader as well as commissioning parties.

2.3 Aim

The aim of this study is to assist in molding a better culturally competent work force. The study will analyze and present a relevant literature on how the different cultural background of client in relation to that of the caregiver impacts on elderly care delivery and reception. Loopholes that might surface as a result of the cultural incompetency of the caregiver will equally be focused on. Identifying those popped up challenges as a result of different cultural background of client and caregiver will help reduce cultural misunderstandings. Prior knowledge on culture and its impact in providing and meeting

the cultural needs of elderly will help minimize conflicts that might arise as a result of culture clash or misunderstanding to both the caregivers and clients.

2.4 Research Questions

This study is a literature review based. It molds a relevant literature on how different cultural backgrounds of clients in relation to that of care givers affect elderly care. The literature reviewed sorts to answer the following research questions:

1) What is cultural difference from a care giver's perspective in elderly care?

2) How is daily care in an institutional or home setting affected by difference in cultural backgrounds of elderly and care giver?

The above research questions sorts to assist the reader as well as commissioning party on shading light on what is meant by cultural differences in elderly care, specifically from a care giver's perspective. It will explain the various relevant terminologies and at the same time, bringing to focus how differences in cultures of the caregiver and receiver impacts on health care provision on the part of the care giver, and reception on the part of the elderly. Having knowledge on various cultures and the role cultural differences play in elderly care could help minimize challenges that may arise as a result of culture clash to both clients and colleagues respectively.

Literature provided herein will bring out possible available answers to the research questions as well as shade light on material related and relevant to the topic. In all, the literature reviewed will assist in acquiring more knowledge on the topic and will assist in answering the questions. The research questions are covered throughout the whole thesis and the material herein is directly connected and linked to the research topic and questions respectively.

2.5 Limitations

The writer encountered limitations in the area of access to gerontological journals and articles. Though some books as well accessible articles and journals made mention of how the elderly felt about diverse cultures and how they responded to it with regards their care, most studies available were on cultural differences in healthcare in general

but not much on elderly care specifically. In that effect, some areas of the review outcome might not be an exactly effect of how different culture affect elderly care reception due to the generalized aspect. A generalized view of people of all age groups might not be considered exact and specific in an elderly person's perspective, in effect, not an exact representation of cultural issues and its effect on their care.
Most of the gerontological articles and journals were only available on purchase or for a fair which the author could not get access to, this limiting the scope of the research and access to material.

2.6 Theoretical Framework

Culture Care Diversity and Universality Theory

The theoretical framework consists of theories, concepts and issues which embeds a research study. (Kumar, 2011, p.40)

This study used the Culture care diversity and universality theory as its theoretical framework. It will help explain why it is important for care givers to be culturally competent and how cultural competence in elderly care will help not only the caregiver, but also the elderly, thereby, improving on their wellbeing. The culture care diversity and universality theory by Leininger, (1991) focuses on a diversified worldwide view of care and nursing of humans in various cultures by describing, explaining, and predicting the differences and similarities therein. The theory was developed to discover and identify those features of care that are universal and diverse so that care givers and nurses will be able to provide people with different or similar background with cultural congruent care. In effect, helping people regain and maintain health, wellbeing, and maybe face death in an appropriate cultural manner. (Leininger, 1991)

Madeleine M. Leininger, in her book culture care diversity and universality defined Culture care diversity as "*the variables 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".* And Culture care universality as *"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".*

Changes of the 21st century such as social, cultural, political, economic, health care as well as technological factors worldwide are bound to pull people together, making the caring and nursing profession different and very multinational from how it used to be in the past. In effect, nurses and caregivers need to have a comprehensive view of different cultures and similarities as they work with people of diverse cultural backgrounds. Knowing that cultures have specific meanings, expressions and structure of care trans-culturally will help and guide care givers to gain a better understanding and knowledge of client's world and their normative expectations. By understanding different cultures, nurses and care givers will be able to work and function effectively with people having different values, beliefs, nursing and caring ideas, health, caring, illness and disabilities. In effect, providing care in ways they expect and that is meaningful to them. Humans in every culture do anticipate or experience care or non-caring behaviors within own familiar cultural settings. Leininger's theory of culture care diversity and universality works in line with the international law on culture human rights which states that every human being has the right to culture. (Leininger, 1991)

These rights include the right to the development and enjoyment of cultural life and identity. In all, it states that no right can be used at the expense or destruction of another thus, right to culture is limited to the point where it infringes on another human right. In other words, cultural rights cannot be invoked to justify the denial or violation of another human rights and fundamental freedom. (Ayton-Shenke, 1995)

In affirming with the international law, Leininger envisaged and made mention that nursing practices now and in future will be culture specific due to the human rights law on culture, which is highly needed in today's legalistic multicultural world. Culture care diversity and universality theory proposes that, nurses and care givers working with people from diverse cultural background need prior preparation and knowledge on factors influencing their ability and ways of functioning effectively together as a result of cultural issues. This will not only benefit the clients, for they'll be provided with the best possible care and services, but then, the care givers and nurses in effect will not feel ineffective and helpless as a result of culturally difference issues. (Leininger, 1991)

When working with the elderly, one has got to put certain issues into consideration as far as cultural differences is concerned. Researches carried out in the past as well as current issues on culture and care needs to be looked into. What create the solid base for this thesis are earlier researches as well as the theoretical framework.

Due to the so many cultures and eventual differences, as health care professionals, one has got to be abreast with the many cultures as well as have knowledge of the many differences therein. When there is lack of communication and knowledge as far as cultural difference is concerned, heath care workers and clients might most probably encounter difficulties relating to care deliverance on the part of the caregiver and care reception on the part of the elderly client. This could be quite frustrating and uncomfortable. Cultural competence in elderly care plays a vital role, for in its absence; clients might lose trust in personnel which might eventually lead to closure or seizure of treatment plan. (Ihara, 2004)

According to the Charter of the United Nations stated in preamble on human rights, one of the purposes of the UN is the achievement of international cooperation in solving international problems which are of economic, social, cultural and humanitarian in character as well as encouraging human rights respect including freedom for all without restriction to race, sex, language and religion. (UN Charter, 2013)

In accordance with the international law, every human being has the right to culture. These rights include the right to the development and enjoyment of cultural life and identity. In all, it states that no right can be used at the expense or destruction of another thus, right to culture is limited to the point where it infringes on another human right. In other words, cultural rights cannot be invoked to justify the denial or violation of another human rights and fundamental freedom. Using cultural relativism as grounds to deny or violate a human right is an abuse to the right to culture (UN Challenge to human rights and cultural diversity, 1995).

2.7 Central concepts

This study focuses on the sunrise model to depict the theory of culture care diversity and universality. To promote culture care and diversity, any nursing or care profession that makes claims of providing care on the local, national or global level to people seek-

ing care services is compelled in making discoveries that transcultural nursing and care can only be acquired through a global comparative view.

Cultural difference

Culture as a learned pattern, shared and transmitted believes, norms and ways of life guides the thoughts, decisions and actions of a particular group or society. (Leininger, 1991)

Elderly care in every culture has own cultural constituency. Health, wellbeing and illness status could be expressed, known and structured differently in various cultures, hence the difference. For the nursing and care profession to be recognized as transcultural, global and universal profession, discovering what is universal and could be identified in human care in all or most countries of the world is of vital importance. One needs to know the difference that prevail within and among cultures since there definitely will be symbols, functions, rituals, and structures that exist among or between cultures. (Leininger, 1991)

To fully understand and predict culture care, cares need to use care influenced by religion, language, technology, economics, education, cultural values, beliefs and the physical environment of the people they are providing care for, since they all work hand in glove in the roles they play in healthcare. Healthcare providers need to be flexible when designing their programs, policies, services, all aimed at meeting the needs of a diversified population most likely to be encountered given todays' modern trend on globalization. (Leininger, 1991)

Cultural competence

Cultural competence in healthcare acts as a tool to healthcare professionals to engage in assistive, supportive and facilitative care acts all geared towards fitting into the cultural values, beliefs and way of life of clients with aim to providing quality healthcare.

Cultural competency in healthcare delivery, a care model developed by Dr. Josepha Campinha-Bacote in 1991 has same goal as Leininger's sunrise model of culture care diversity and universality as can be observed. The cultural competence in the delivery of healthcare services states that heath care professionals should continually strive to deliver the best possible care by constantly being aware of the cultural background of the

client i.e., work within the cultural context of the client. As stated in the model, being culturally competent is a process and not a state of being. In other words, becoming culturally competence and not being culturally competent. The model is made up of five constructs which are **cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desires.** (Campinha-Bacote 1991-2010)

Leininger's Sunrise model recognizes three major modalities which guide nursing judgments, decisions as well as their actions in order for them to provide a culturally congruent care which satisfies, benefits, and is meaningful to care receivers. Leininger's sunrise model (1991) is made up of three modalities which are **cultural care preservation or maintenance, cultural care accommodation or negotiation, and cultural care repatterning or restructuring.** Leininger's sunrise model will aid care givers in providing a culture congruent care. Culture congruent care aims at providing a meaningful, beneficial and satisfying healthcare and wellbeing services with the help of cognitively based, assistive, facilitative, supportive enabling acts, all tailored towards fitting individual, group as well as institutional cultural values, beliefs, and way of life. (Leininger, 1991)
In all, Leininger's sunrise model of the culture care diversity and universality theory and Dr. Campinha-Bacote's cultural competency in healthcare delivery have one goal, focus and intent. They both focus at aiding nurses and care givers in providing care receivers with the best possible care and wellbeing services, and for the caregivers to always put the cultural background of care receivers into perspective and work within the cultural context of the client.

Culture care diversity

Culture care diversity identifies differences in acceptable ways of care such as the meanings, value of care, patterns and care symbols that exist within and between cultures or different group of people which enables them to carry out care expressions. (Leininger 1991)

Culture care universality

Culture care universality identifies those common or similar care patterns or traits, values and meanings that are evident and perceivable among many cultures. It reflects the

various ways used by people to assist, support, and facilitate care and help of people. (Leininger 1991)

Culture congruent care

Cultural congruent care provides a meaningful, beneficial and satisfying healthcare and wellbeing services to people through cognitively based, assistive, facilitative and supportive enabling acts. The care acts, all tailored towards fitting individuals, groups, institutional cultural values, beliefs, and way of life (Leininger 1991)

2.8 Cultural diversity and ageing

The world made up of different cultures and subsequently differences in those cultures, ageing experiences occur on different scales. Ageing in an industrial society might not be same with ageing in a hunting or agricultural society. Seniors in each society have experiences they go through that are most likely not identical or close to similar to what other fellow seniors experience in other societies or cultures. (Holmes & Holmes, 1995)

Growing old in an Eskimo society could be pretty hard due to hard climatic conditions environmental hazards and limitation to natural resources. On the other hand, ageing in an agricultural society might be less stressful, the wellbeing of the elderly more secure due to the traditional societal values and the soliciting of help from external family member. Since climatic conditions are more favorable, there is access to more natural resources and so the needs of the elderly can be catered for more easily compared to those of an elderly in an Eskimo society. Seniors in an industrial society have a whole different experience compared to those of Eskimo and agricultural societies. Industrial societies have more wealth, resources to cater for their seniors but then, are more individualistic in nature and encourage independence of the elderly. Their value system places a lot of emphasis on self-reliance, independence and freedom of choice, so the elderly tern to rely more on self, in a rare cases family members, friends and hugely on the state for support. (Holmes & Holmes, 1995)

In all, one must approach a society in a holistic manner in other to know how that society managers and copes with its ageing problems. By studying the physical environment,

economic patterns, social structure, traditional and cultural values, procedures as well as the evolvement of that society through its cultural history, it will be of help to gain more insight and knowledge about that society and the experiences undergone by its senior population. (Holmes & Holmes, 1995)

2.8.1 Culture and its characteristics

Learning about cultures is of vital importance in elderly care not just because of the possibility of caring for seniors from diversified backgrounds or elderly from backgrounds different to that of the caregiver, but also because recruitment is carried out nowadays on a global scale. Culture being the coherent, learned, and view of a group of people, means one can actually learn about other cultures which could be quite interesting and would be very rewarding in various fields, the health care field not left out. (Varner & Beamer, 2005)

The whole concept behind culture is that it helps people know or have a sense of who they are, have a sense of belonging, what they should do as well as what manner of behavior to exert. By impacting behavior, moral, productivity, values and patterns of life, it turns to influence actions and attitudes.
By knowing the characteristics exerted by people of different cultures and backgrounds, one could easily have an understanding and study any group of people.
Some of those characteristics include:

Language and communication
Verbal and non-verbal communication differs from one culture to another. Apart from the fact that there exist a multitude of foreign languages on a global scale, some nations have major spoken languages with dialect, idioms, accents and jargons within the same language group. Gestures and body languages might be universal in expression but then, their manifestations and meanings might be different. (Haris & Moran, 1996)

Sense of self and self
Expression of self-comfort is expressed differently by cultures. While self-identity and appreciation can be expressed by one culture in a macho manner, another culture can

express theirs in a humble bearing in one place. Some cultures might be specific and closed as to determining ones space, might put distance between individuals during conversations, while others could be more open, changing and stand more closely. In all, cultures have different ways of validating self. (Haris & Moran, 1996)

Food and feeding habits

The selection, preparation, displays and consumption of food differs among cultures. One man's pet might be another's delicacy, this falling within a cultural context. An elderly from a Buddhist background will be very comfortable when it comes to consuming pork for example, meanwhile, the same rule will not apply to Jewish and Muslim seniors. Feeding habits and eating frequencies also differs among cultures. While some use chopsticks or fingers, others might use cutleries from knives, spoons and forks, and yet, which hand handling what cutleries could also facilitate the distinction of one people from one another. In all, health care professionals need to link the dietary patterns of senior clients to their cultural backgrounds, for issues such as religious and health beliefs held by senior clients have great significance to them. (Haris & Moran, 1996)

Relationships

Human relationships organizations such as gender, age, status, kinship, power, wealth and wisdom are fixed by culture. In all, the family is the most predominant in these. In one culture, a family might be huge while in another, it might be small. Elderly or senior people might be highly valued, honored and respected in one culture but then in another, they are ignored. Women wearing veils to appear different in one culture might be a norm but then in another culture, they could be seen as equal and sometimes superior to men. (Haris & Moran, 1996)

Value and Norms

Need varies among culture and so is behavior and how it is prioritized. A culture sets norms of behavior for its value system and this differs from culture to culture. One culture might be completely honest within people of own society but then, are relaxed when it comes to the application of that same rule to foreigners or persons from other cultural background. (Haris & Moran, 1996)

Belief and Attitudes

It could be quite hard to ascertain people's beliefs and attitudes in regards to how it affects their relationship with self, others and the world. Various cultures might have different or identical beliefs. People turn to have a general concern for a supernatural which is evident in religious practices. Religious traditions turns to affect the way people see life and death, be it directly or indirectly. While people could have different religious practices such as Buddhism, Christianity, Islam etc. all turn to shape how people in those societies view things and how they might act to a certain degree. Sub cultures might exist within for example the Christian faith where a catholic Christian for example might adhere to blood transfusion but in the same Christians faith, a Jehovah's Witness will not adhere or give consent for any blood transfusion, due to religious reasons. (Haris & Moran, 1996)

It is a taboo serving Jewish elderly client pork, but then, the same elderly will very well enjoy consuming beef. The same rule applies to a Muslim. In all, belief and attitudes furnish actions and behaviors.

In a nut shell, the above characteristics do not make up an overall of what it takes to fully understand people from diversified cultural backgrounds but then, fall in the scope, along others to help identify or know the cultural background of an individual.

(Haris & Moran, 1996)

2.8.2 Cultural understanding and sensitivity in elderly care

In order to have a cultural understanding and be sensitive to other cultures, one must seek to make room for other cultures especially when dealing with elderly people from cultures other than ones' or the culture one is usually familiar with. By so doing, cultural differences will be respected and one would not be labeled as an ethnocentric individual, in other words, an individual who looks down on other cultures and sees them as inferior to ones' own. Cross cultural experiences helps people to be more broad minded and culturally prone. It improves on one's human interactions and will help care givers to become more aware of impact of own culture upon them. (Haris & Moran, 1996)

Cultural understanding will help subdue culture shocks that might come as a result of care, in the case of this study, increase professional development, organizational effectiveness and in effect, maximize intercultural experiences in elderly care.
One has first got to increase cultural awareness to be able to effectively manage cultural differences. Understanding the concepts of culture and the characteristics of culture or triads people of different cultures exert is primordial to the study of cultural specifics.
Appreciating the impact of one's culture on one's mindset and behavior is important, as well as those of colleagues one works with and clients' one provides care for.
(Haris & Moran, 1996)

2.8.3 Cultural competence in elderly care

"*It is more important to know what kind of person has a disease than what kind of a disease a person has" a say by* Sir William Oslar, quoted by Yehieli et al, (2004) in their hand book of caring for diverse seniors.
The above quote applies and works positively in culture care and diversity, and in other words, tells caregivers they need to have more insight as to the cultural background of clients they are caring for, there-after, focus can be made on the health condition of the client, all aimed at their wellbeing. Cultural nuances might surface if a culturally congruent elderly care is not provided. Organizations and care givers need to consider these nuances which might affect the health and status of elderly clients. (Yehieli et al, 2004)

Cultural nuances that might pop up includes

Cultural communication styles
Communication occurs in a variety of ways in different cultures, both verbal and non-verbally. Some cultures might be laud in expressing self, and others more quite, others close to each other while communicating, and others stand apart. Other cultures might touch and some don't, others exercise eye contact and some don't. In all, care givers must strive to emulate the cultural communication patterns of their senior clients. (Yehieli et al, 2004)

Cultural competence continuation

Cultural competence in elderly care has to be continues in process. This means, one could be conversant with a specific culture but then lacks competence in cultural issues regarding another culture. It is an ongoing process because acquiring and developing knowledge of the cultural nuances of various cultures takes time.

To improve on one's ability in working with a culturally diversified clientele, caregivers and institutions need to honestly assess self about how they feel about people of other cultural background. This will help caregivers to consciously improve on their abilities in working with elderly people from different backgrounds. (Yehieli et al, 2004)

2.8.4 Cultural competence behaviors

Cultural competence behaviors run from a spectrum of either maximum or minimum appreciation of other cultures.

These characteristics include

Cultural destructiveness which could be people belonging to hate groups or other forms of violence groups against other cultures and are usually not interested at being culturally competent. They could be in the support of the destruction of people from other cultural backgrounds.

Cultural incapacity deals with people who would rather prefer to be on their own and not in close interaction with people from other cultural backgrounds. They are unable to relate effectively with people from other cultural backgrounds than theirs and deliberately avoid people from other cultures. (Yehieli et al, 2004)

Cultural blindness involves people who have little or no exposure about other cultures and differences therein. They are willing to learn, though feel their culture is the best and universal, and often wonder why people from other culture don't think and act the way they do.

Cultural pre-competence deals with people who have little knowledge, understand and respect other cultures and know there are good and bad aspects about every culture. People belonging to this category are also aware and know their culture is not necessarily the best.

Cultural competence now encompasses people who have deep respect, knowledge and understanding about other cultures and can easily relate, interact, and feel comfortable

with people from diverse cultures. They have knowledge on the history, language, soci-oeconomic and other aspects that might affect people of a particular culture.
Cultural proficiency embraces people who are extremely competent and have deep knowledge about people of diverse cultural background. This could be as a result of having a parent(s) originating from those backgrounds or just by spending huge amounts of time with people of that cultural background. As a result, they might no longer be considered as outsiders but seen as part of that culture. (Yehieli et al, 2004)

2.8.5 Cultural competence recommendations

In as much as culture plays an integral role in elderly care, caregivers need to understand that there are other aspects such as literacy level, educational background, income, gender, which might affect or influence the health status of the elderly client. In striving to become more culturally competent in caring for the elderly, care givers should strive to do the following among others.
i) Aware of own cultural values and beliefs as caregivers and be able to recognize its influence on one's behavior and attitudes. One also needs to be aware of the cultural values of the elderly and be able to recognize its influence on how they respond to care.
ii) One needs to be aware of the historic events of particular ethnic groups and strive to understand how it might have affected them be it on a professional or personal level through oppression, stereotyping or discrimination. (Yehieli et al, 2004)

iii) Be aware of the role of seniors in different ethnic groups or the ethnic group being taken care of.
Make senior clients more comfortable by striving to emulate the communication style of their culture.
iv) Strive to be aware of the cultural taboos of ethnic groups of the senior clients.
Care givers should try to learn a few introductory words in the language of the elderly before proceeding with a translator. That way, the senior client will feel more relaxed since a friendly and trust worthy environment has been created by that simple gesture on the part of the caregiver. (Yehieli et al, 2004)

v) It is recommended to speak loudly but politely, clearly and slowly to senior clients when trying to convey information regarding their care. Listening to clients actively and gently asking questions is also advisable.
vi) Care givers should avoid patronizing and intimidating behaviors to elderly clients, especially clients from non-western cultures are they place extreme value to age.
Some families from different cultures than that of care givers might not cherish the idea of releasing depressing or complicated details about the health conditions of their elderly family member especially if they are terminal details, so caregivers needs to check with the family of the senior client. (Yehieli et al, 2004)

vii) Eye contacts is vital when communicating in some cultures while in other cultures, it is seen as a sign of disrespect or intimidation when eye contact is maintained with a senior person.
viii) By being genuinely humble, and willing to learn, a cultural blunder might be under looked if it occurs, for most seniors appreciate and respond positively when the caregiver exert a sincere and respectful attitude.
Health institutions and elderly homes should have at list one staff member who is of the same cultural group as the seniors.
(Yehieli et al, 2004)

3 METHODOLOGY

In creating the structure of this thesis, the author used Arcada's thesis guide (2009), information from the text books "the literature review" (Machi & McEvoy, 2009) and "Doing a literature review in Health and Social care: A practical guide" (Aveyard 2010)
This study seeks to shed light and bring out the cultural differences that might exist within the elderly care field especially when the caregiver and receiver are from different cultural backgrounds. It will help bring out information on how helpful knowledge on cultural backgrounds of clients can be of help in deliverance and reception of elderly care and how the presence or absence of cultural competence can impact care.

3.1 Deductive Content Analysis

Deductive content analysis according to Elo & Kyngäs (2008) is used when the information to be analyzed is based on past material or previous information related to the topic.

Deductive content analysis is the method used by the writer in analyzing the research articles. It was decided as the best possible tool to use to review the research articles in this study based on the fact that, this study relies on researches or material from previous studies in the past, and theories to gain information with regards the research topic. For the writer to obtain the results, the selected articles were read with the research questions in mind.

The focus on reading the articles was to abstract information that answered the research questions. The overall findings answering the questions were then summarized in table form, (see appendix 4 & 5) with specifics tabulated in the table, each raw representing findings from each article. Thereafter, created categories and sub-categories from information obtained, mainly aimed at segmenting the phenomena of interest which provided answers to the research questions having in mind the context of the articles read.

Literature review

A literature review is said to be a comprehensive study which aims at interpreting literature or material relating to a specific topic. In a literature review session, the main issue is the identification of research questions and seeking to answer those questions with the help of literature search as well as analyzing the relevant literature to the topic. (Aveyard 2010, p. 1-3)

The literature review helps the writer in creating an understanding between the research problem and material or body of knowledge available on the topic. By so doing, it helps the researcher gain more understanding on the research area, thereby bringing clarity and focus to the research problem and in another aspect, helps broaden the knowledge of the researcher based on his or her research area. Thus the researcher will be able to select a methodology that is capable of answering his or her research questions, thereby increase confidence in methodology. (Kumar 2011, p. 30-33).

3.2 Data collection

Data collection of this study was done through data base and web search. Information obtained was from pre-existing scientific research materials. Since this paper is a literature review based thesis, material from secondary sources and past research related to the topic came in handy. The material obtained by the writer was put into consideration to be sure they met the required academic standards and provided info answering the research questions and equally relevant to the research topic. Articles used were chosen with care and the writer strove to ensure that they were up-to-date and had relevant information to the research problem.

This study used material and information from text books obtained from Arcada's library, articles, journals, all from the internet and Google books.
The material obtained from the web such as the articles and journals were retrieved from data bases such as EBSCO HOST, Google scholar, Google searches, SAGE, and FinElib Springer Link Contemporary Journals. Material found from these data bases, alongside text books obtained from Arcada's library provided information and literature for this research topic cultural difference in elderly care.

In order to lay hands on the right kind of material relevant to this topic, a number of key words were entered in the data base and search engines. The key words were interchanged and modified which helped to swell up the keywords, thus helping the search and information retrieval. In data bases such as SAGE and FinElib Springer Link, search terms such as cultural diversity in elderly care, diversity AND elderly care and many other search terms helped the writer in getting access to material used herein. In search data base such as EBSCO, the interface is designed with the use of 'AND', where possibilities exist to create extra rows of 'AND' as need arises. The idea behind this interface is to help combine key words in twos, threes or more as the writer wishes. In that light, the author therefore lengthened the search terms to for example, culture care AND the elderly, diversity AND elderly care, cultural diversity AND ageing which facilitated the search as more results got displayed.

See appendix 1 for table of keywords used, appendix 2 to view a summary of the search, the databases, search engines and search results in figures, and appendix 3 for table of data collected.

3.2.1 Inclusion and exclusion criteria

Characteristics that are predefined to feature as part of a research study or process are viewed as the inclusion criteria of that study.
The inclusion criteria must respond to the objective of the study and provide scientific answers to the accomplishment of the search.
Exclusion criteria on the other hand are those characteristics that are ruled out or not included as part of a research process or study. Exclusion criteria seek to leave out criteria that don't meet up with the objective of the study or are not relevant to it. (Velasco 2010)
In all, inclusion and exclusion criteria rules in or out criteria that are eligible or not eligible to participate or be part of the research process. In order to rationalize the inclusion and exclusion criteria of a research process or study, as stated by Aveyard (2010), giving clear information about the limit of the review and also creating a focus on the literature search is needed. The inclusion and exclusion criteria was created in this study to aid the author in establishing a framework of what information is required to supply answers to the research questions and also aid shed light on what material was not necessary to feature in examining the review.

The author was able to create the inclusion and exclusion criteria and limitations realistically enough to focus on the research area. The inclusion criteria were articles written by scholars, materials written in the English language, articles with abstract or summaries having contents related to the topic and are full text materials, material related to culture care and elderly care, provided information answering the research questions and ranged within the years 1999 - 2013 and could be accessed free of charge.

The exclusion criteria included bias material, material written in languages other than the English language, materials not written by scholars, articles or journals prior to 1999, unscientific materials, paid materials since the research was not funded, material

not relevant to the topic and which could not provide information in answering the research questions.

Table 1 Summary of inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Written by scholars	Not written by scholars
Written in English language	Not written in English language
With abstract or summary	Without abstract or summary
Be in full text	Bias content
Be related to the research topic	Not relevant to the study
Be accessed free of charge and no payments required	Paid or chargeable material
Within 1999 and 2013	Articles & journals prior to1999

The criteria for the found materials used were that they contained the key words and did provide relevant, useful and factual information to the topic.

3.2.2 Description of material

A majority of the search hits were citations, patterns and links not relevant to the topic and out of date. Of the total thirty-seven that the author found to be relevant to the topic, fifteen were articles, and the remaining twenty seven were journals, abstracts, other relevant material to the topic and a Google book.

Of the fifteen articles found, the author had to narrow it down at the level of data collection to eleven to be used in the result section of this study which provided answers to the research question. Scientific articles used by the author in the review section of this study were mainly studies done in Sweden, Australia, Netherlands, United Kingdom and the United States.

Part of the materials obtained was used in the background of this study while the other part (eleven articles) was used exclusively in the results area of the research. That is, provided answers to the research questions. The writer made sure material used in the background of the study was not used in the result area of the study. Apart from the articles used in this study, text books also came in handy which helped in providing useful

scientific information and built the background knowledge of this work. Websites and journals that focused on cultural gerontology, culture and differences in elderly care were also used.

3.3 Validity and reliability

According to Phelan & Wren (2005), validity simply refers to how effective and accurate a test or research measures what it aims at measuring or researching, while reliability is the degree to which an assessment tool produces stable and consistent results.
In the case of this study, it therefore signifies if the study has been able to measure and meet its objectives, and if the research methods used has been able to scientifically establish results meeting the requirements.
In complying with validity, the author did a careful study of chosen articles and material. Since the study is a literature review based research, material used were from already existing sources and were scientific and reliable sources, written by professionals who were knowledgeable and versed in the field. (Phelan & Wren (2005)

Reliability serves to quantify the precision of measurement or replications and thus, leads to the trust worthiness of the scores produced with the instrument on repeated trials. In other words, it determines how the measurement of knowledge produces similar results given different conditions. (Gushta & Rupp, 2010)

For the fact that the same or similar data is produced by different researches on a repeated scale, given different research methods, the research material herein can be viewed as reliable since data obtained from the different research articles boil down to the same kind of result in the end.

3.4 Ethical consideration

Upon choosing to write on this topic, a short thesis plan was written and a brief rundown of how the thesis will proceed in writing was presented to supervisors in charge at

Arcada's University of Applied Sciences thesis body, and Kustaankartano, the commissioning body. The topic was approved by the school, being among the thesis projects presented to it by Kustaankartano. The writer was then given the approval by the school and the commissioning party Kustaankartano to go ahead with the research and writing. Prior to starting the study, the writer read Arcada's thesis guide, and equally applied its rules to Good scientific writing. The Good Scientific writing guide Arcada provides to its students is to ensure and help they avoid mal-practices that might occur in the process of thesis writing, of which they need to strive and avoid. The guide helps students with issues such as plagiarism, honesty issues, issues on ethics etc. (Arcada 2009)

As emphasized (Machi & Mc Evoy 2009, p.19) state that bias and opinion cannot be completely removed from thesis writing, the author strove to make sure they were kept in check and controlled, and did strive to analyze the research data in an unbiased and objective manner. The author hided to Arcada's rules with regards procedure for good scientific practice by documenting all research material, quoting sources and material used where needed. This thesis had no new material nor was any interviews carried out since it is a literature review based research. It relied on past research relevant to the topic, material used was published material, and therefore no new research was carried out by the author.

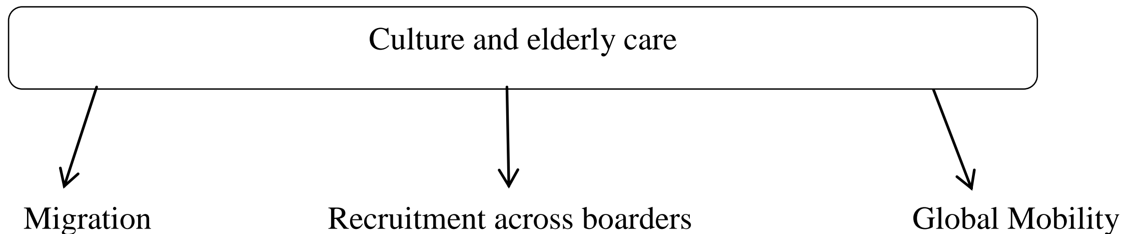
4 RESULTS

This section covers findings from articles in answering the research questions. The author read selected articles, underlined information or material that proved relevant in answering the research questions. Since the study had two research questions, two colored pens were used for the underlining, a color representing findings relevant to answering each question. Thereafter, categories and sub-categories were created from information obtained and segmented in the area of interest the author felt were reasonable, with guidance from the research scope. The results or findings are therefore presented in those categories and subcategories as seen below.

4.1 What is cultural difference from a caregiver's perspective in elderly care?

This part answers the first research question of the study.

Factors that could instigate different cultures in elderly care



4.1.1 Migration

According to the literature reviewed, migration has a vital role to play as far as instigating different cultures in elderly care is concerned. (Emani & Safipour, 2013, Komeric et al 2012, Dellenborg et al 2012, Heikkilä et al 2007, Scharlach et al 2006, & Congress P.E. 2004) all mention it in their various studies.

Cultural difference in elderly care could come about as a result of globalization, multiculturalism, immigration into the health care sector. It could mean focusing care on clients from different cultural backgrounds and providing elderly care services in an inclusive, supportive, and free from discriminative manner to everybody in the elderly sphere. According to the reviewed literature, difference in culture as far as elderly care is concerned could be as a result of migration. In effect people are bound to provide elderly care services to a diverse population as well as cater to their cultural needs.
Caregivers need to have capacity in providing professional and adequate elderly care services to a population of diverse identity, values, belief and ethnicity. Caregivers also need to develop their cultural skills as far as care giving is concerned and equally understand that elderly care giving differs across cultures. (Komeric et al, 2012).

As was noticed from the studies, international migration increases transculturalism, in effect meaning elderly clients and care givers might not share same views with regards

heath and illness. Studies show that care givers need to undertake transcultural training to be able to provide a culturally competent care to an elderly diversified population as well as explore meanings in cultural encounters. Caregivers also need to improve on cultural sensitive issues and recognize that culture is created and could be negotiated in encounters. In all, caregivers need to understand that cultural difference intersects in complex ways with issues such as age, gender, class, education etc. (Dellenborg et al., 2012)
Findings from the literature reviewed showed that cultural differences are bound to exist in a diversified cultural setting. In that effect, care givers are expected to make adjustments in their cultural understandings and know that elderly people from different cultures have different perspectives and ways through which they want their care done. (Heikkilä et al., 2007)

Caregivers coming in contact with care giving behaviors or norms that are not identical with own cultural ways of proving elderly care could results in differences, as was identified in the studies. As a result of differences, caregivers should realize various cultures have different ways of providing care and treating elderly people. Differences may pop up as a result of caregivers providing services to elderly people not from same family setup as them or same cultural backgrounds as theirs. As a result, institutionalization does not mean abandonment of loved ones as some cultures see it but rather the relinquishment of the care of loved ones to professionals trained in the field. (Scharlach et al., 2006)

4.1.2 Recruitment across boarders

From the reviewed literature, recruitment of elderly caregivers from different countries into mainstream care system or into other countries to work as caregivers as a result of rise in ageing population of employing country leads to encounters of different cultures, thus differences. It also means breaking recruitment barriers. (Scharlach et al, 2006, and Johansson & Andersson 2008)

As per the literature reviewed, one could perceive that, caregivers need to develop cultural competence skills and understand it as an ongoing process which could be quite

challenging in big cities than smaller cities or remote areas as a result of huge number of diversity in cities. There is also need to undertake training programs in cultural issues, diagnosis, treatment and communication patterns to effectively provide a cultural competent care. Caregivers need to assess clients from a multidimensional cultural perspective so as to gain cultural understanding of the elderly they are providing care for. There is also need to explore and understand the care belief and religious belief of clients. It could mean migrant caregivers abandoning their cultural belief especially those that are in violation of solidarity such as gender equality, since some cultures as stated in the study view the care field as a female domain, a phenomenon not applicable in many other cultures. (Johansson & Andersson 2008)

4.1.3 Global mobility

The literature reviewed show that, differences in elderly care could be as a result of global mobility into the health care sector. It should be noted that, differences in elderly care are similar to those reported in other countries according to the studies. In effect, differences come about due to the needs of the elderly being different as a result of cultural issues and could be more complex from culture to culture. Global mobility affecting elderly care as a result of many cultures involved in the care field could also raise prejudice and racist tendencies from caregiver to client or vise-versa.
(Warburton et al, 2009 and Badger et al, 2012).

Studies show that, as a result of increase or rise in elderly population, there is need for extended care, meaning people from different culture get employed to cater for the ever increasing elderly population. It leads to people providing care services to older people not necessarily their family members or people from same background as them. This results in differences, stemmed from difference in cultural issues. For caregivers to provide cultural sensitive, safety and competent care, there is need to embrace a range of other cultures, acknowledging and recognizing that differences exist such as in way of life and patterns. (Spijker et al, 2004)

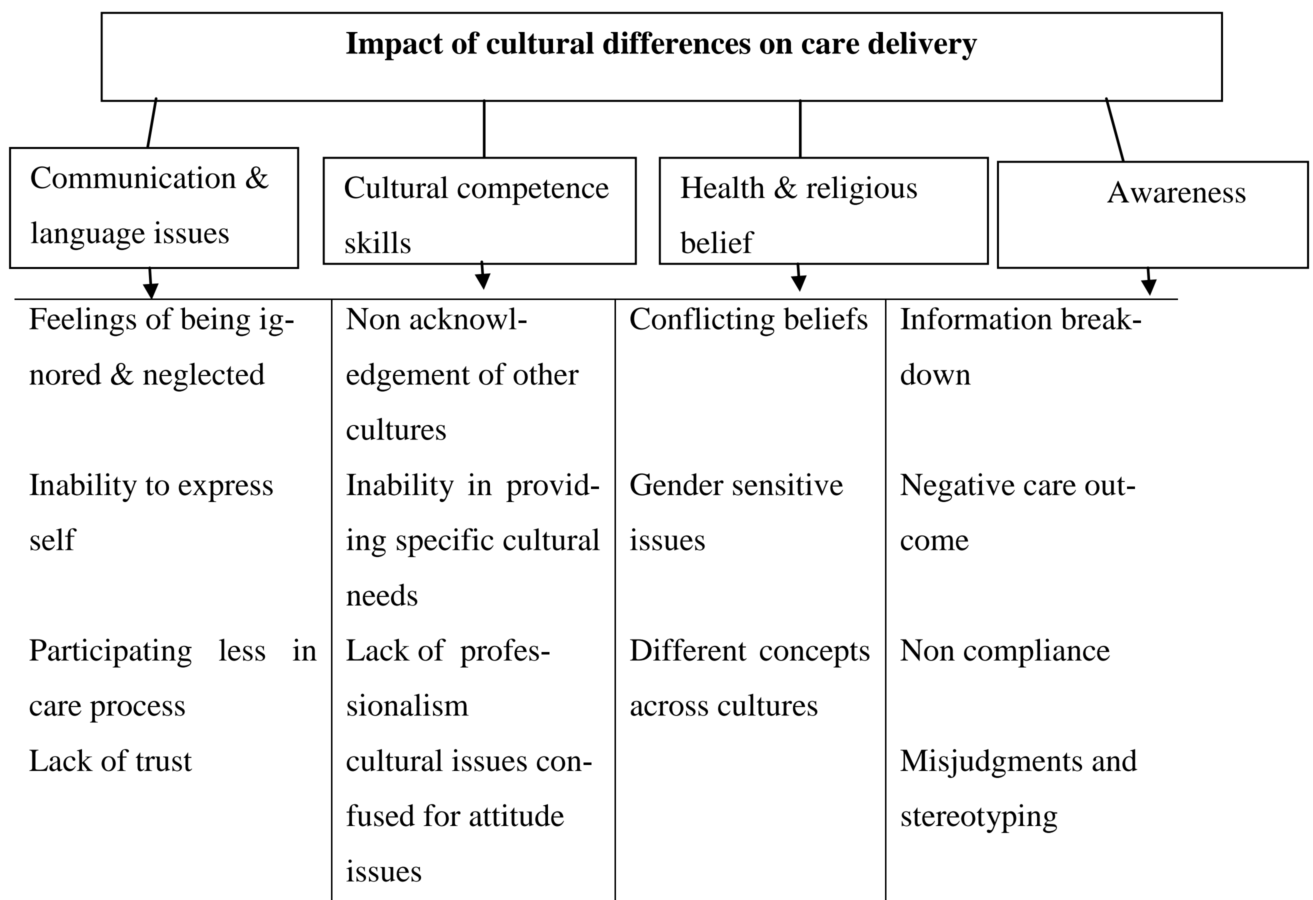
From the reviewed literature it could be noted that, differences could mean different ways of providing care as a result of belief or patterns of life not identical. It could also

mean differences in explanatory alternatives for health and disease in elderly care and acknowledging cultural sensitive issues exist in elderly care. (Moody H.R, 1998)

4.2 How is daily care in an institutional or home setting affected by difference in cultural backgrounds of elderly and caregiver?

This part proceeds in answering research question two of the study, following same pattern as question one, from themes, categories and sub categories as presented below.

4.3 Factors that could impact care delivery in institutional and home setting when caregiver and elderly are from different cultural backgrounds.



Lack of common understanding			Discrimination
			Issues of disrespect and trust
Difficulties meeting needs of clients			Racist tendencies
			Diversity in care delivery
Lack of awareness			
Difficulties in sensitive care delivery			

Categories and sub categories of factors that could impact care delivery in home and institutional settings when caregiver and elderly client are not from same cultural background

4.3.1 Language and communication

From the literature reviewed, studies have pointed that language barrier and communication breakdown present problems in elderly care. Some of these problems or hitches include,

Feelings of being ignored and neglected

As per the literature reviewed, language barrier affects all levels of treatment with communication breakdown from caregiver, receiver and health organization as a whole. As could be perceived from reviewed articles, elderly people are particularly vulnerable to linguistic incompatibility. Communication is seen as being central and essential prerequisite in elderly care and clients might feel less attention is paid to them as a result of communication breakdown. (Komaric et al, 2012 and Heikkillä et al 2007)

Inability to express self

With regards the literature reviewed, complications in care delivery and reception are likely to arise as a result of communication breakdown. There may be lack of solidarity between caregivers and clients as a result of linguistic or language breakdown. Clients not being able to express wishes, and care preferences not being understood and not be-

ing able to understand, might leave clients frustrated and dissatisfied in care outcomes which might lead to isolation at some point. Linguistic expressions not being understood and language barrier might eventually lead to miscommunication and misunderstandings. As a result, gaps created between caregiver and elderly clients caused by language barrier are likely to make elderly clients participate less in their care processes. (Heikkillä et al, 2007 and Dallenborg et al 2012)

Lack of trust

The literature reviewed shows that, lack of trust creeps in the care giving setup as a result of language barrier in communication. As a result, client might feel they have insufficient information about their care and in effect, might spring up issues of trust and non-compliance. Some clients even prefer speaking their native language when discoursing personal health matters. Language and communication barrier affects common understanding as far as the elderly care process is concerned. It hampers care deliver in situations where caregiver and elderly client don't share same linguistic background. Care giver might not be too sure of the informed consent of the client as a result of information non clarity. (Scharlach et al, 2006, Congress et al 2004 and Johansson & Andersson, 2008)

Difficulty meeting needs of clients

The findings show that, communication breakdown may affect care delivery and reception when care giver and receiver don't share same linguistic background. Meetings the needs of the client might be hard as a result of language failure or barrier since client might not be able to express self properly, caregiver not being able to understand client or the other way round. This in effect might cause dissatisfactory feelings and also limit interaction between client and caregiver. Emani & Safipour, 2013)

Lack of awareness

Findings also show that, lack of awareness and in-acceptance may happen as a result of communication breakdown between client and caregiver. Clients might be reluctant accepting care services from a caregiver not sharing same cultural background as them as a result of language barrier or linguistic differences. In that effect, clients might not be able to get information pertaining to their care, which could hinder access to certain care

services. Misunderstandings and misjudgment might pop up as a result of language barrier in care. Some elderly people revert to using their first language or use a language the care giver might not be familiar with, making care giving quite challenging. Gaining deep understanding and building a relationship with elderly might be hard to accomplish in instances where linguistic barriers abound. Appropriate and adequate information transmission between client and caregiver is affected as a result of hindrances caused by barrier in language. (Emani & Safipour, 2013, and Warburton et al, 2009)

Difficulty in sensitive care delivery

According to findings, inadequacy in language by the caregiver affects care delivery and issues such as emergency stuff or matters requiring emergent attention linked to the care of the client might be affected. Communication and language clarity is very vital in situations where the elderly client is cognitively impaired or has sensory impairment, for breakdown in communication hampers the care outcome. Elderly people who are cognitively impaired easily switch to their mother tongue or first language which might impact and hamper on the care delivery. (Badger et al, 2012 and Spijker et al, 2004)

4.3.2 Cultural competence skills

Cultural incompetence in the care profession impacts on elderly care outcomes as mentioned by some researchers and studies. Some of the challenges encountered as a result include,

Inability to understand and negotiate differences

Given a highly culturally diverse background or care setup, findings indicate that, being culturally competent is vital in elderly care outcomes. As per the results, the caregiver's participation in the daily care of the elderly might be devalued if he/she lacks cultural competence skills. Furthermore, being culturally competent means the caregiver needs to be aware of the challenges that might likely occur as a result of differences in cultural background of caregiver and client. These differences could be such as gender issues in the care delivery, shake of hands, dietary patterns, and eye contact. The caregiver should be able to manage them, for in situations where there exist ignorance, deviation of care delivery might be eminent and could lead to care outcome non satisfactory. A static cultural concept by the caregiver hampers understanding between clients and

caregiver, leading to less interaction and inability to provide competent care. (Dellenborg et al, 2012)

Inability in providing specific cultural needs

From the findings, care giving is likely to be affected by cultural sensitive defined issues such as values, norms, and roles. In effect, care needs to be tailored towards cultural sensitive issues including culturally specific services, geared towards meeting the cultural traditional needs of the client. As a result, caregivers need to understand that different cultures have varying needs and belief about heath, illness, disease and treatment. (Scharlach et al, 2006 and Congress P. E., 2004).

Lack of professionalism

Findings show that in the absence of cultural competence skills in elderly care, insensitivity to culturally defined issues pertaining to the care of the client might be minimized and not properly handled, leading to a nonuser friendly care. As per the results, not being knowledgeable about the complexity of cultural difference could lead to the caregiver unintentionally reinforcing stereotypes by assuming some cultural behaviors and norms as universal predictors of people's behavior. (Emani & Safipour, 2013)

Cultural issues confused to attitude

From the literature reviewed, findings show that caregivers having expert knowledge about other cultures could lead to stereotyped attitudes about other cultures, in effect, affecting care delivery. Culturally competent in elderly care does not necessarily mean having expert knowledge about other cultures, but rather being able to distinguish cultural issues from attitudes among clients, assessing clients as individuals and not making conclusions about clients based on knowledge one has on their cultural background. (Warburton et al, 2009)

4.3.3 Health and religious beliefs

Health and religious beliefs impact on care as stated my many studies.

Conflicting beliefs

Findings show that, how the elderly people perceive diseases and how treatment is carried out might determine how they respond to care. Dietary patterns impact on the care of the client and need to be put into perspective by the caregiver as far as the clients daily feeding is concerned, which could be linked to religious beliefs. (Komaric et al, 2012, Congress P.E, 2004, Spijker et al, 2004, Badger et al, 2012, Dellenborg et al, 2012 and Heikkillä et al 2007)

Gender Sensitive issues

Various studies mention gender issues and how it impacts care outcome. As perceived from the studies, elderly clients from different cultural backgrounds are likely to refuse care assistance coming from caregivers of the opposite sex as a result of their religious and cultural belief. Gender sensitive issues were noticed as a predominant issue in home care settings which made care deliverance quite stressful especially to male caregivers. Females in particular were not that comfortable with issues regarding personal care such as shower or other intimate stuff being handled by male caregivers. Elderly clients didn't feel safe or secured with the presence of male caregivers in their homes. In effect, they could choose to not allow them into their homes to deliver care services. In all, findings show that gender issues are eminent in elderly care delivery and therefore impacts on care. (Dellenborg et al, 2012, Congress P. E, 2004 and Jahansson & Andersson, 2008)

Different health concepts across cultures

Findings from studies identified that, with preventative care, elderly clients and caregiver/mainstream care body might not share same care values and importance to preventative care. Medical checkups is a phenomenon common in many cultures but uncommon in others. Clients might turn down mainstream elderly care approach and resort to own cultural approach which might affect care outcome.

In all, health and religious belief of clients and caregivers impacts on the daily life and care of the elderly clients. (Congress P. E, 2004 and Harry M. R. 1998)

4.3.4 Awareness

Lack of awareness by both the caregiver and client affects care giving outcomes as mentioned in many studies.

Information breakdown

Findings show that clients from diversified background are not usually familiar with mainstream care delivery methods, and may have negative ways in assimilating the care delivery which could affect care outcome. The elderly might not be literate in care issues such as preventative measures and medical checkups. Clients might not be informed with regards the quality and type of care to expect. As a result of some cultures viewing psychiatric disorders as a social stigma, elderly clients might show up for treatment only at the latter stage of the disease due to lack of information and awareness. (Warburton et al, 2009, Komaric et al, 2012, Congress P.E. 2004)

Negative care outcome

Findings from studies show that, service information might be viewed by clients as confusing and intimidating. Lack of information about various cultural groups could make care delivery quite frustrating. A lack of cultural awareness and one dimensional non-holistic approach of care delivery leads to misunderstandings in care outcomes. Ethnic discrimination in care processes are eminent in the absence of awareness in cultural sensitive issues, in effect, leading to low interaction between caregivers and elderly clients. (Scharlach et al, 2006 and Emani & Safipour 2013)

Non Compliance

Findings indicate that, a lack of awareness and ignorance about other cultures could lead to hesitant and non-compliance to care reception, and in effect, leading to inequality in elderly care. To provide cultural congruent care, caregivers need to be aware and informed about the life of the elderly client prior to admission into institution, for information or lack of information pertaining to their lives prior to institutionalization impacts on their daily care outcome. (Badger et al, 2012 and Spijker et al, 2004)

4.3.5 Cultural diversity and incompatibility

Misjudgment and stereotyping

From findings, it was identified that cultural issues could be misunderstood for attitude issues all as a result of misjudgment. Clients may feel disrespected, intimidated and harbor feelings of being discriminated against. In effect, it could lead to care appointments not being honored, client non-compliance to care program and may alternate to using preferred methods of treatment. Feelings of detachment may emerge, which may result in caring being less emphatical and unfriendly, for clients may be viewed as dramatic, abusive, and insensitive depending on the circumstances as a result of non-compliance. In effect, a mutual lack of trust is eminent from both client and caregiver. (Komaric et al, 2012 and Dellenborg et al 2012)

Discrimination

Findings identify that, incompatibility in culture might lead to elderly clients preferring care services mainly from caregivers from own cultural background which in most cases might not be taken kindly by the caregiver who may feel looked down on or discriminated against. (Scharlach et al, 2006, Warburton et al, 2009 and Moody H. S. 1998)

Disrespect

Findings identified generalization and stereotyping impacting on care outcome. As an effect of generalization, understanding of clients may be hampered. Superiority issues might arise as a result of client and caregiver not sharing same cultural background. Client and family may treat caregiver from a different background worse than they would treat caregivers from same background as them which impacts the health care outcome. As a result, it may lead to discriminatory tendencies between clients and caregivers and in effect, level of interaction. (Congress P.E, 2004, and Emani & Safipour 2013)

Racist tendencies

Studies identify the fact that, discrimination and inadequate elderly care are eminent in settings where clients and care givers don't share same cultural background. As a result, racist tendencies might emerge leading to social intolerance, no- integration into main-

stream care society, which could lead to more isolation, vulnerability to poor social and health outcomes. (Warburton et al, 2009 and Spijker et al 2009)

Personnel care issues and diversity in care delivery

Findings show that the high demand on caregivers and huge number of elderly needing care services might make it hard for caregivers to provide cultural congruent care. (Spijker et al, 2004)

The culture care diversity and universality theory by Leininger, (1991) focuses on a diversified worldwide view of care and nursing of humans in various cultures by describing, explaining, and predicting the differences and similarities therein. As an overview, the results indicate that, cultural differences in elderly care provide a connection with culture care diversity and universality theory.

5 DISCUSSIONS

This topic was chosen by the author as a result of working in a multicultural setup and coming into contact with differences and eventual difficulties in care delivery processes due to differences in cultural backgrounds of both the client and caregiver.

Focus is emphasized on cultural differences in elderly care and goes further to enumerate how differences in cultural background of caregiver and receiver could impact care delivery and reception as mention in the background section of this study.

This study enumerates two research questions, with first question stating what cultural difference meant from a caregivers viewpoint and the second, finding out how differences in cultural backgrounds of caregiver and client affects elderly care in institutional or home settings.

Cultural differences in elderly care, as could be observed from the researched articles, come with challenges. It is those challenges that were looked into by the author. Challenges involved in the care delivery as a result of cultural diversity of client and caregiver included language and linguistic barrier which as per the studies enumerated in this thesis, affected almost all areas of care where a laps existed. Other issues included values, norms, religious and health beliefs, gender issues in care, misjudgments, preju-

dice, and misunderstandings as a result of linguistic difficulties, racist tendencies and static cultural beliefs.
In working with a culturally diversified clientele, caregivers could increase cultural awareness and strive not to do things which might undermine the cultural right of the elderly, in effect respecting the human rights law of freedom to enjoy own culture. In as much as challenges are eminent as a result of different cultures involvement in the care sector, caregivers needs to be able to identify those challenges, strike a balance and come to reasonable consensus to be able to manage those differences. They need to understand that ageing happens differently in various cultures, acknowledge that healthcare concepts are viewed, translated differently and mean different things in different cultures. In effect, elderly people might have different views as to how they view health, causes of illness and even who and how they prefer to be cared for or treated as mentioned by various writers in this study such as Galanti (1999), Lehman (2012), Orlovsky (2004)

A rise in global ageing therefor means more need of health care providers as people age with the passage of time. This in effect means rise in foreign employment of caregivers, eventually the mingling of different cultures.
Since residents in care homes and institutions have different needs, preferences and demands in their care, shaped mostly by their cultural backgrounds, Leininger (1991) in her culture care diversity and universality theory states that caregivers on the other hand need to be culturally competent to provide a culturally congruent care that carter to the needs of the ever increasing diversified population. Caregivers need to measure and analyze own reaction and attitudes towards other cultures to be able to deal with elderly population from diverse backgrounds.

It equally means care givers need to assess clients from a multidimensional point, first as individuals from different cultural groups, as persons unique in own personality traits, as a human beings with health problems or ageing associated difficulties, but not as individuals from specific cultural background, for no single individual could ever be a true representative of a particular culture as mentioned by Campinha-Bacote in her model of cultural competence (1991).

Caregivers need to understand that with the advent of new age demands on the health care sector, learning about various cultures and creating awareness about sensitive cultural issues to be able to provide a satisfactory culturally specific and congruent care is an ongoing process. This could be because one cannot boast of knowing everything about every culture or every elderly being cared for. On the contrary, even after acquiring knowledge about a culture, it is usually best to know clients on a one on one base and assess their needs as individuals and not as a representative of some cultural group. Differences exist among cultures and should be understood by caregivers to be able to impact such info to those confined under their care. They also need to realize that there is a multicultural dimension and trend to care in today's age. Therefore phenomena such as health, illness, disease, care processes, preventative measures, health care appointments and checkups translate differently across cultures. What is accepted in one culture could be a taboo in another.

Negative relations that exist among caregivers and clients in most cases are linked to lack of awareness, cultural misunderstandings and language or linguistic issues. Challenges as a result of cultural differences could be managed and intervention measures implemented to tackle those challenges, though details were not stated or properly examined in this study.

6 CRITICAL ANALYSIS

As per this study, the author was unable to lay hands on some good and more resent material due to the fact that most of them were to be paid for, and since this study had no financial backing, the author had to make do with what was available free of charge. Unfortunately the author could not lay hands on some material that could have been valuable or important to this study.

As could be noticed by the author, almost all the articles used in this study identified only the down sides of cultural difference in elderly care. Focus was mostly made on the negative side the differences bring, and little or nothing said with regards which positive impact differences in culture has over elderly care.

In all, just a single article made mention of the cultural difference as being a strength and used it as a strength base strategy in care, opposed to the ten other studies that focused more on the down side of cultural differences in elderly care and nothing about its positive sides.
As per the sampling, proper sampling were done as per the studies, in exception of one study were respondents of the research questionnaire were limited to permanent staff of that institution, of which about 90% represented the mainstream culture. This means part time workers most of which were foreigners and students were left out of the study. As a result, study was biased and not accurate in its results and therefore, the outcome of the results influenced.

Culture care diversity and universality theory was the theory used in this study. The author realized that within the course of the study, a range of other researches have been conducted on culture care and diversity, some agreeing with Leininger's theory and others having contrasting thoughts and contradictory ideas to her theory.
The materials used herein where all in the English language. It should be noted that, the author left out material written in Finnish that might have been able to impact and be instrumental to this study. Since Finnish is the day to day language in Finland, studies and materials in the Finnish language about the topic were left out.

7 CONCLUSION AND RECOMMENDATIONS

The daily care of the elderly both in an institutional and home setting are affected by diverse issues, in this study, specifically when caregiver and elderly client are not from same cultural background. As per the reviewed articles, those issues that impacted elderly care were on the downside, meaning, they affect care delivery negatively.
With the challenges being recognized, measures are needed to tackle, handle and manage those difficulties impacting on the care outcome negatively. There are possibilities for these issues or differences to be used as strengths and not necessarily seen as weakness or on a downside.

It is therefore proposed and suggested by the author that further studies and research be carried out on the topic and instead of focusing on the negative side of cultural differences in elderly care, focus could be made on the positive sides, viewing differences in culture of care giver and receiver as strengths and not necessarily weaknesses.
As follow up to this study, findings measures to manage and solve issues impacting on the care delivery and reception of the elderly, needs to be looked into effectively, since this study did not give an in-depth coverage on that. This study therefore leaves and gives room to other students to find solutions to problems and challenges as a result of cultural differences in elderly care.

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APPENDICES

Appendix 1: Phrases and key words used

Words & phrases related to culture	**Words & phrases related to elderly**	**Words & phrases related to elderly care**
Culture	Elderly	Elderly care
Cultural diversity	Older adults	Health care
Cultural competence	Old people / old persons	Culture centered care
Culture care	The aged	Cultural congruent care
Cultural differences	Elderly clients	Elderly care diversity
Cultural perspectives	Old age	
Different cultures		

Cultural universality		
Cultural rights		
Cultural gerontology		

Appendix 2: An illustration of how material was retrieved

Data base and search engines used	**Terms used in the search**	**Range years used**	**Search results**	**Articles, journals & material used**
Google scholar	Cultural diversity in elderly care	2004-2013	32400 including patterns and citations	3
	Cultural competence in health care	2004-2013	93600 including patterns and citations	1 article and 1 Google book
	Culture care	2004-2013	16000000 including patterns and citations	1
	Health disparities and culture in elderly care	2004-2013	1456000 citations and patterns included	1
EBSCO HOST	Cultural diversity and elderly care	1998-2013	35	4
	Elderly and cultural differences	1998-2011	138	1

	Culture care and the elderly	1998-2011	101	3
	Diversity and elderly care	1998-2011	79	3
	Cultural diversity and ageing in Finland	2004-2013	3779	2
	Culture and elderly care	2004-2013	322	2
	Ageing in Finland	2004-2013	33	1
	Elderly care in Finland	2004-2013	1620000 patterns and citations included	1
	Elderly populations of Finland	2004-2013	6770000	2
SAGE KNOWLEDGE	Inclusion and exclusion criteria	2013		2
	Content analysis	2003		1
	Cultural diversity and elderly care	2006-2013	94	1

FinElib Springer Link Contemporary Journals	Cultural diversity and elderly care	2008-2013	4528	2
Google search	Cultural differences in elderly care	2004-2013	745000 including citations and patterns	2
	Cultural perspective of ageing in Finland	2004-2013	5990000	None
	What age to call an individual elderly according to different cultures	2004-2013	2520000 including citations and patterns	1
	Dr. Campinha Becote model of cultural competence	2004-2013	4370	1
	Deductive content analysis	2004-2011	1150000	1
			Total	37

Appendix 3: An illustration of Data collected

Author and year of article publication	Title of Article	Objective of the study	Result of the study
Nera Komeric, Suzanne Bedford &	Two sides of the coin: Patient & provider per-	Explore experiences, attitudes, & opinions of im-	Positive responds in quality and accessibility of health ser-

Mieke L. Van Driel, 2012, Australia	ception of health care delivery to patients from culturally and linguistically diverse background	migrants from different cultural and linguistic backgrounds & their health care providers with regards chronic disease care.	vices. Barriers in health care cost and waiting time to receive treatment. Need for greater access to interpreters, culturally education and communication. Racism and discriminatory practices were experienced.
Kristiina Heikkilä, Anneli Sarvimäki & Sirkka-Liisa Ekman, 2007, Sweden	Culturally congruent care for older people: Finnish care in Sweden	To describe how cultural congruency is used in care of older Finnish immigrants to promote their wellbeing.	Cultural congruency based on shared ethnic background of clients and caregivers created common ground for communication, solidarity, ease care situations leading to improvement of client wellbeing.
Andrew E. Scharlach, Roxanne Kellan, Natasha Ona, Aeran Baskin, Cara Goldstein & Patrick J. Fox 2006, U.S.A	Cultural Attitudes and Caregiver Service use: lessons from focus groups with racially and ethnically diverse family caregivers	To examine cultural variations in caregiving experiences, care related values, beliefs and practices & factors contributing to the use of caregiver support services.	Caregiving experiences, care-related values and beliefs as well as care practices differ across racial and ethnic groups.
Elaine P. Congress 2004, USA	Cultural and ethical issues in working with culturally diverse patients and their families: The use of Culturagram to promote cultural competence practice in healthcare settings	To introduce an assessment tool for health care professionals to advance understanding of culturally diverse patients and their families.	Social workers were able to work more effectively with families from different cultures after using the assessment tool. Evaluation of the tool was positive & plans were made to assess the effectiveness of the tool to promote cultural competent practices.

Stina Johansson & Katarina Anderson 2008, Sweden	Diversity – A challenge to the Scandinavian care regime?	To find out about rights mentained and dilemmas issues in the intersection of gender and ethnicity in care.	Clients maintaining control in everyday life makes both gender & multicultural care in private sector more complex. Clients feel less threatened with female workers and there is homogeneity in practices within elderly care.
Azita Emani & Jamal Safipour, 2013, Sweden	Constructing a questionnaire for assessment of awareness and acceptance of diversity in healthcare institutions	To assess caregivers cultural awareness and acceptance of diversity in healthcare institutions.	Attitudes towards discrimination, working with clients of different backgrounds, communication with people of different background and interaction within staff, and between client and staff were recognized as the dimensions and proved to be usable in Swedish context to measure cultural awareness.
Jane Warburton, Helen Bartlett & Visala Rao 2009, Australia	Ageing and cultural diversity: Policy and practical issues	To present a multimethod study that explores challenges and identify practical responses in cultural and linguistic diverse background issues in care	Challenges associated with service provision were recognized, need for developing appropriate models for aged care and the addressing of social isolation.
Frances Badger, Laura Clarks, Rachel Pumphrey & Collette Clifford 2012, United Kingdom	A survey issues of ethnicity and culture in nursing homes in an English region: nurse managers' perspectives	To explore issues of ethnicity and culture in nursing homes in an English region	Clients were to be treated individually and not by category, individual care plans resulted to needs being met appropriately and cultural sensitive care delivery varied. Care managers

			must consider delivery of culturally sensitive services.
Truus Spijker, Joy Notter & Koss Stomp 2004, Netherlands	Taking the community into the home: Health and social health in the community.	To explore the concept of cultural safety and its importance in planning and providing care for older adults.	Care could be merged into the community, thus community into the home. Traditional approach to healthcare moved to one that valued individuals, understanding comes with acceptance and respect of individuals. There is no one way in providing culturally safe care.
Lisen Dellenborg, Carola Skott & Eva Jakobsson 2012, Sweden	Transcultural encounters in a medical ward in Sweden: Experiences of healthcare practitioners.	To explore the approach adapted by health care practitioners when handling transcultural encounters.	Diversity presented by patients and complexity of individual and collective levels left practitioners confused as to what kind of knowledge they needed to increase cultural competence. Need for discussion and guidance in attitudes regarding clients from different cultural backgrounds, and critical self-reflection of caregivers.
Moody Harry 1998, USA	Cross cultural geriatric ethics: Negotiating our differences	To determine the differences of solutions to ethical problems in geriatric care in a cross cultural perspective.	There should be respect of clients' dignity and position in their family, life and death interventions invoke ongoing responsibility that cannot be lightly disregarded, adoption of posture to negotiate differences should be endorsed.