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HEALTHCARE PROVIDERS' PERCEPTIONS OF DIVERSITY AND CULTURAL COMPETENCE

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“Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status”

ICN forward to the code of ethics for nurses

ABSTRACT

Swedish society is ethnically diverse and since the early 1960s immigrants have made significant contributions to the labour market in healthcare. Today many Swedes, including first- and second-generation immigrants, work together in a healthcare setting that serves an increasingly diverse population. Cultural competence is required of nurses, healthcare providers and healthcare organisations in order for them to provide quality service to culturally and ethnically diverse populations. The overall aim of the studies included in this licentiate thesis was to assess healthcare providers' perceptions of diversity and cultural competence.

The specific aim of Study I was to compare native Swedish and first- and second -generation immigrant healthcare providers' perceptions of diversity in relation to equality and communication in elder care settings. Data used in this cross-sectional study on healthcare providers (n=643) were obtained using a Swedish questionnaire; Assessing Awareness and Acceptance of Diversity in Healthcare Institutions (AAAD). Factor analysis revealed five subscales within the areas of communication and equality. These subscales were tested for reliability before being used for data analysis. ANOVA testing compared differences between native Swedes and first- and second-generation immigrants. The results show that there are more similarities in the perceptions of communication and equality between native Swedes and second-generation immigrants than between first- and second-generation immigrants.

The specific aim of Study II was to describe the translation, adaptation, and psychometric evaluation of a non-Swedish questionnaire, the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). This instrument assesses five subscales: Cultural Desire, Cultural Awareness, Cultural Knowledge, Cultural Skill and Cultural Encounter. The evaluation process was guided by Gessinger´s structure for translation, validation, and reliability. After translation and adaptation with the help of a group of experts, validity tests were conducted by response test (n=15) and on the content (n=7) and internal structure and internal reliability (n=334). The tests revealed weak validity and reliability for the instrument, and additional item and factor analysis did not confirm the proposed structure. These problems might be related to the translation and adaptation or the structure of the instrument. The IAPCC-R was found to not be appropriate for use in a Swedish context.

Key words: ANOVA, communication, cultural competence, diversity, equality, healthcare provider, healthcare workforce, psychometric evaluation.

LIST OF PUBLICATIONS

This thesis is based on the following two papers referred to in the text by Roman numerals. Study I compares groups of first- and second-generation immigrants and native Swedish healthcare providers' perceptions of working with co-workers who have different ethnic backgrounds and encounters with patients and significant others on communication and equality. Study II describes the translation, adaptation, and evaluation of an instrument measuring cultural competence among nurses, nursing students, and academic staff.

I. Olt, H., Jirwe, M., Gerrish, K., Saboonchi, F., & Emami, A. Communication and equality in elderly care setting: perceptions of first- and second-generation immigrant and native Swedish healthcare providers. *Diversity and Equality in Health and Care.* (Submitted)

II. Olt, H., Jirwe, M., Gustavsson, P., & Emami, A. (2010)**.** Psychometric Evaluation of the Swedish Adaptation of the Inventory for Assessing the Process of Cultural competence among Healthcare Professionals-Revised, (IAPCC-R). *Journal of Transcultural Nursing, 21*(1), 55-64.

LIST OF ABBREVIATIONS

AAAD	Assessing Awareness and Acceptance of Diversity in Healthcare Institutions
ANOVA	Analysis of variance between groups
CA	Cultural Awareness
CD	Cultural Desire
CE	Cultural Encounter
CK	Cultural Knowledge
CS	Cultural Skill
CFA	Confirmatory Factor Analysis
CFI	Comparative fit index
EF	Exploratory Factor analysis
IAPCC-R	Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised
RMSEA	Root mean square error of approximation (parsimonious fit)
SRMR	Standardized root mean square residual

CONTENTS

1 INTRODUCTION

As a nurse in the field of elder care and advanced care in patients' homes, I have experienced many encounters with patients and families of culturally and ethnically diverse backgrounds. Those encounters were sometimes challenging, and increased my awareness of different behaviours and values that are culture-based. It made me aware of different ways patients and their families communicate and cope with severe diseases, and in some cases, death.

One such example was a meeting with a woman from the countryside of a Middle Eastern country. By the time she arrived and joined her family in Sweden, her cancer had progressed. She suffered from cancer-related pain and had an infusion pump with which she could self-administer extra doses of morphine when needed. While changing her dressings, I asked her if she needed help getting an extra dose. She nodded her head up and down, which I interpreted as a "yes," and looked at me. I was about to give her additional morphine via her infusion pump when I asked specifically *where* she had pain. She again nodded her head up and down. At that moment, her daughter came into the room. She helped me ask her mother about the pain, and I noticed the mother's difficulties with the Swedish language. They had a conversation, and the daughter said her mother had *no* pain. She also explained to me that nodding up and down was, for her mother, negation rather than affirmation.

This was a powerful introduction for me to cross-cultural communication, and with it came the realization that misunderstandings can lead to serious and even life-threatening medical mistakes. This was one of many experiences that sparked my interest in diversity among the people we care for and work with in healthcare. As a lecturer at Karolinska Institutet, I have had the opportunity to pursue my inquiry into healthcare providers' awareness and knowledge of caring for people with backgrounds different from their own, as well as their perceptions about the impact of cultural diversity in the workforce environment.

2 BACKGROUND

2.1 Diversity of culture and ethnicity

Currently in Sweden, diverse healthcare providers with different cultural and ethnic backgrounds work together when caring for ethnically and culturally diverse patients and their significant others. This overall aim of this thesis was to assess healthcare providers' perception of diversity and cultural competence in order to gain a broader understanding of experiences of working in a diverse workgroup and with patients. The thesis will start with a description of the main concepts that the two studies have embraced as established and defined in the literature.

2.1.1 Defining diversity and cultural competence

Simply defining the term "diversity" is a challenge. Schölin (2008) found that management in Swedish healthcare settings had difficulties understanding what to include in considering diversity and were doubtful about the impact diversity had on their facilities. The term "diversity" is often used when discussing different groups in the population in terms of differences in ethnic and cultural background. "Cultural diversity" and "ethnic diversity" are often used interchangeably (Hamde, 2008). There is no common or uniform description of culture and ethnicity. *Diversity* is a concept that most people think they understand. Yet when questioned in detail, a wide range definitions are offered. Cultural diversity is often a description of all people in a society and their own individual cultures (Hamde, 2008). According to Campinha-Bacote (2003a) cultural diversity is also a function of people's age, sexual orientation, gender, socioeconomic status, religious affiliation, language, physical size, physical and mental disability, political orientation, occupational status and geographical location.

Leininger's defines *culture* as "learned, shared and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways (Leininger & McFarland, 2006). Culture is changeable and forms the person's values and norms and is related to the traditions of the group. Culture is a presumption for construction of ethnicity (Spector, 2004). Within a culture there are different ethnicities (Gregg & Saha, 2006).

All people are cultural beings with an *ethnicity.* Ethnicity is a social construct created by oneself and the categorization of oneself by others. Ethnicity could be related to national borders, language, colour or an identity that people give to themselves related to a group of people. Ethnicity is a process and is created in relation to others (Lill, 2007; Torres, 2010; Mullholland & Dyson, 2001). Ethnicity is in turn often used interchangeably with race. Until the mid-1800s, race was used to distinguish groups of people by biological differences. The validity of this was later disputed by anthropologists and sociologists. That, plus the movement of immigrants between countries, has led to the concept of *ethnicity* replacing that of race (O´Dell, 2002). Ethnicity is complex and described as a process that is a sociocultural construct, defined by oneself and one's categorization by others (Mullholland & Dyson, 2001).

Cultural competence is an ongoing process (Campinha-Bacote, 2002) in which one takes diversity into consideration in all encounters with an awareness of oneself and the other and with a cultural sensitivity including respect and willingness to understand and meet the other (Jirwe, Gerrish, & Emami, 2006; Kim-Godwin, Clark, & Barton, 2001).

There is a risk when categorising people that it can lead to stereotypes instead acknowledging of the complexity of a humans. An assumption underpinning cultural competence is that differences exist both within a group of people and between different groups. Although categorization of people is complicated, it is sometimes necessary to use it e.g. in research and for statistical representation. In this thesis is the categorization of the groups of first- and second-generation immigrants based on an earlier definition that was used when this project was designed. First generation immigrants are those born outside Sweden and second generation immigrants are those born in Sweden with one or two parents born in other countries (Statistics Sweden, 2002).

2.1.2 Diversity addressed in society and in caring research

Today, about 15% of the 9.5 million people in Sweden were born in other countries than Sweden (Statistics Sweden, 2012). The diverse backgrounds of people in our society are reflected in healthcare settings, where we now see considerable diversity among healthcare staff, patients, and significant others.

There has been considerable research on diversity in healthcare, focusing on culture and ethnic groups, race differences and education levels (Gates & Mark, 2012; Guerrero, 2012), generational differences (Hendricks & Cope, 2012) and age differences (Lehmann-Willenbrock, Lei, & Kauffeld, 2012). Diversity can be seen as different layers or dimensions that have relevance *within a particular context.* Diversity within groups could, for example, include gender, sexual orientation, or generation cohort (Culley & Dyson, 2001; van Knippenberg & Schippers, 2007). A group's culture is an important component and foundation of a person's ethnic identity (Spector, 2004). All people are ethnic and have an ethnicity that should not be solely linked with an immigration experience (Mullholland & Dyson, 2001). However ethnic diversity in Sweden is more often used to refer specifically to people with an immigrant background and to the groups' own cultures and organizations within those groups (Hamde, 2008).

Elder care institutions are the healthcare settings with the most diverse staffs with an immigrant background (Swedish Association of Local Authority and Regions, 2007). Studies and models on workforce organisation of diverse workforces have pointed out the importance of responding to the non-majority ethnic and cultural groups in society (Dreachslin, Hunt, & Sprainer, 2000; Purnell et al., 2010). A study on diversity in a community health centre in the US found it difficult to meet the ethnic and cultural requirements due to difficulties hiring bilingual and bicultural staff with competencies for the work (Bond, Haynes, Toof, Holmberg, Reyes, & Quinteros, 2013).

Furthermore, a study including older adults from different ethnic minority groups in the US did not find any concordance between ethnic or cultural healthcare providers and patients and the patients' satisfaction with their care (Phillips, Chiriboga & Jang, 2012). Another study

found that patients had positive feelings about staff from the same ethnic background. They felt safe in their encounter and could communicate better and open themselves to the other person, and they experienced a closer relationship with the healthcare providers and felt more involved in their own care (Delphin-Rittmon et al., 2013). Similar data is not available for the Swedish population. Nor is patient satisfaction the sole criterion by which to measure the desirability of or necessity for a healthcare workforce that mirrors the diversity of the population it serves.

The Swedish population is increasingly diverse in ethnicity, language skills, and religion (SOU 2007:37). In 2011, 12% of the elderly had a background other than Swedish, a percentage that will increase in coming years as the population ages (Statistic Sweden, 2011). It is evident that being fully responsive to future needs will require improving our knowledge about and understanding of the impact of diversity in Swedish healthcare service institutions. Failure to do so runs the risk of miscommunication, which could lead to increasing medical and care errors and grievances because patients do not feel safe in the care of diverse teams.

2.1.3 Ethnicity, "we" and "them"

Culture can be seen as the foundation or base for the construction of ethnicity (Culley, 2001). One way to identify ethnicity is from a person's description of their identity or identities; it is how they view themselves. The alternative is to consider how others define and categorize a person's ethnicity.

The ethnic identities people give themselves or are given by others are often chosen and based on their language, nationality, religion, culture, or skin colour when these differ from others (particularly the dominant population) in a society. Ethnicity can also be seen as something that is constructed in a social context in relationship to others. For the individual, this could become a source of identity of oneself, and for others it could be used as a source for categorization of people (Lill, 2007; Mullholland & Dyson, 2001).

The creation of what defines the "ethnicity" of the others and of oneself is the foundation for our perceptions of each other (Lill, 2007). Immigration background could be a part of the perception of ethnic differences. An immigrant status itself is often assigned to a social position in which the immigrant is seen as the "other" in the society. One way of creating and showing social position is the construction of "them" in relation to patients with an immigrant background and of "we" in relation to healthcare providers with a native Swedish background. This way of dividing and generalizing people is carried out by all groups, independent of what group or ethnicity one belongs to in society. The "we" and "them" social construction provides a framework for people to decide what is acceptable and what norms they should relate to. The agreed-upon social construction becomes visible when people are discussing and comparing their thoughts in relation to the norm that has been unconsciously set up in society (Torres, 2010).

The social position to which healthcare providers often assign patients with immigrant backgrounds has been found to not be congruent with the immigrant patients' own views. In earlier reports, documents, and studies of patients with an immigrant background, "them" have been described as the ones who are problematic in care situations. These same people,

however, are often described as good caretakers for the elderly compared to those born in Sweden with a non-immigrant background (Torres, 2010). The view of "them" as skilled in taking care of the elderly is attributed to it being a part of their culture. This trait is ascribed to both relatives of the patients and co-workers with immigrant backgrounds.

Social positions can be divided into a "we" and a "them" and could have an impact on the relationships in healthcare encounters with patients and between co-workers (Torres, 2010). It is not enough to learn and understand different cultures in a diverse healthcare environment. There has to be an understanding that ethnicity is as much about "you" as "them," because we create each other in the relationship (Lill, 2007).

2.1.4 Otherness–the experience of being "them"

Another perspective is the immigrant's point of view. "Otherness" is described as the feeling of being different in relation to other healthcare providers and in relation to the patient. It could be that physical differences such as skin color give rise to the feelings of "otherness." Otherness is seen as being outside the dominant group that holds power and voice in society. This otherness is a sense of wanting to be included and adapted to the majority group, yet experiencing the perception of not belonging and being pushed aside. These feeling have been described as emotional nakedness and shame (Ryan, 2012; Xu, Gutierrez, & Kim, 2008). Feelings of loneliness and being marginalized and segregated and not belonging to social groups in society or at work were explained by people as resulting from their differences in ethnicity, language, and culture (Omeri & Atkins, 2002; Xu et al., 2008).

The feeling of being different and "other" is not always negative. Not being involved in the group can lead to a feeling of pride that one is not like the others. The otherness could be a free choice that one makes. Those who feel or experience that they are the "other" can choose to be involved with those who share the same feelings. People of different backgrounds who might not have much else in common can thus be united by these common experiences in a relationship where neither is dominant over the other (Ryan, 2012).

An interview study conducted on first- and second-generation Mexican immigrants showed that the second generation experienced the "othering" of themselves and their parents more than the first generation of immigrants did. These experiences were related to people's involvement in society (Viruell-Fuentes, 2007). There is a lack of research studies on the perception of "otherness" among first- and second-generation immigrants working in healthcare.

2.2 Cultural and ethnic diversity in healthcare institutions

2.2.1 Working in a diverse workforce

The shortage of nurses among countries in Europe (WHO, 2013) and in Australia, U.S. and U.K. has led to registered nurses have been recruited from abroad. Several studies has been conducted to learn more about the experience of these itinerant nurses as they take up positions in foreign countries and go from being part of the dominant culture in their homelands to becoming the "other".

Nurses trained in other countries often hold different views of work and work-related tasks. Expatriate nurses differ in their expectations of the clinical and other tasks they are to undertake. Nurses from China, for example, were found to not be accustomed to taking an active role in patients' daily care, which was expected in the U.S. (Xu et al., 2008). In a small-scale study from Australia that interviewed 13 immigrant nurses whose native language was not English, the nurses felt they had not been allowed to use all the clinical skills for which they had training. Other skills were expected, such as the communication skills required to organize and be involved in the care of patients. The relationship with co-workers was experienced differently when there was a more casual relationship between nurses than the immigrant nurses were used to. The immigrant nurses felt they were more included as a member of the team and that they were expected to work independent of the more immediate physician oversight and presence to which they were accustomed (Smith, Fisher, & Mercer, 2011). Furthermore, an interview studies from the U.K. overseas nurses from China, Philippines India and sub-Saharan Africa found that they experienced differences in medical management and use of equipment. They felt that their clinical technical competencies were not taken into consideration at work and that the care emphasized a holistic approach with broader work responsibility than they were used to. The work included collaboration with other professionals and organizing care around the patient, which differed from their previous task-oriented work approach (Gerrish & Griffith, 2004).

Communication is one challenge in work. A survey study compared differences between immigrant and non-immigrant healthcare assistants' work experience in elder care in the US. Immigrants more frequently reported difficulties in communication with co-workers compared with non-immigrants. The findings could be explained by language difficulties (Khatutsky, Wiener & Anderson, 2010). An interview study with nine educated nurses from China working in a US healthcare setting found communication to be the most challenging issue both in understanding and expressing themselves. Communication difficulties arose from a deficiency in language skills that resulted in difficulty interpreting words, understanding medical terminology, and comprehending the cultural content of conversations. Lack of communication skills led to negative feelings and stress for the nurses and also posed a risk to patient safety (Xu et al., 2008). Another study from the U.S. found that communication and interaction with co-workers from other ethnic and cultural backgrounds was more likely to involve misunderstandings based on culturally different views and perceptions (Bond et al., 2013).

There are few studies from Sweden that have asked healthcare providers from ethnic different backgrounds about their experiences working in diverse workgroups. Lill (2007) tried to understand how ethnicity is created in a diverse workgroup. Focus groups were conducted with healthcare providers in elder care, and the issue of language was found to be central. A lot of discussion centered on the use of languages other than Swedish at work**.** Those discussions resulted in ethnic frictions within the workgroup. It was also found that immigrant groups felt more supervised by the majority group at work and expressed concern that they could be blamed for things at work because of their immigrant-based "otherness." Management was found to be important to the workgroup. A manager was expected to be supportive and open to differences and not conflict averse. It was important that the manager listen to all ethnic groups at work if there were conflicts. The manager's approach to the workgroup was related to the work atmosphere (Lill, 2007).

Another study using focus group interviews found that staff on the work team created different perceptions and realities of the situation based on their race, which in turn led to stereotypes, social isolation at work and misperceptions of the other. Leadership that is well schooled in diversity issues and with a solid understanding of different perspectives was found to be a mitigating factor that created more effective communication (Dreachslin et al., 2000). This study focused on Blacks and Caucasians in the U.S. While the historical context makes the case unique, there are elements that seem to apply to Swedish minority groups.

Supportive and approachable senior nurses were a factor in facilitating the integration of the U.K. overseas nurses in the ward. Resistance from co-workers, and their refusal to be helpful and approachable had effects on the nurses' self-esteem and confidence. Immigrant nurses had difficulties raising issues about co-workers when the manager was of the same ethnic group as the co-worker (Gerrish & Griffith, 2004). Another study found that co-workers were hesitant to communicate with each other in diverse workgroups, due to the risk of offending other co-workers of other ethnicities in the workgroup. Healthcare providers often experienced working with a manager from another ethnic background as involving less trust and a lack of respect. This creates a setting in which conflict and miscommunication can flourish. Managers found it challenging to be the leader of a diverse workforce. Unique skills and strong leadership were needed in order to successfully manage a diverse work force (Dreachslin, Sprainer & Jimpson, 2002).

Ethnic diversity and job satisfaction are related to each other. Gates & Mark (2012) found that ethnic diversity in a workforce has an increased effect on older nurses' job satisfaction. An opposite view was found in a study where nurses' job satisfaction was a factor for appreciation of differences at work and for building trusting relationships in a diverse workforce. This study was based on a large sample of nurses older than 50 (Beheri, 2009).

Diversity is often considered a positive for the workforce when it is seen as a way of increasing effectiveness and creativity among diverse workers and in the organization (Schölin, 2008). A diverse workforce has been seen as a factor that could reduce disparities and inequality in healthcare (Bond et al., 2013; Dreachslin et al., 2000). However,

descriptions by healthcare staff themselves of working in a diverse environment are often marked by stories of inequality and discrimination.

2.2.2 Equality and discrimination at work

Equality is as an important issue related to health care providers' experiences in a diverse workplace environment (Alexis & Vydelingum, 2004; Shutes & Walsh, 2012; Smith, Allan, Henry, Larsen, & Mackintosh, 2006).

Ethical codes and acts for equality and discrimination in society should be seen as a guide for all healthcare providers on what is acceptable and what should be strived for at work. The ethical codes for nurses stress the importance of the healthcare environment. ***"****In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected"* (ICN, 2012). In Sweden, the Discrimination Act is intended to be a guide for the workplace and society on how to protect people who need extra attention and are vulnerable to discrimination. The purpose of the Act is, *"to combat discrimination and in other ways promote equal rights and opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age"* (SFS 2008:567).

However, inequality and discrimination is a problem that has been identified in earlier research studies against educated immigrant nurses working with co-workers from the majority population Staff with backgrounds other than that of the dominant population often describe experiencing discrimination by both patients and co-workers (Berdes & Eckert, 2001; Neysmith & Aronson, 1997). Nurses have been questioned regarding their competence despite their education, and they have been treated unequally in terms of receiving less help at work (Alexis, 2009; Larsen, 2007) and being assigned more menial tasks (Alexis, & Vydelingum, 2004; Larsen, 2007).

Discrimination based on racism in encounters with the elderly and their families has been described in home-based care by healthcare providers (Neysmith, & Aronson, 1997), along with a feeling of being respected less than their co-workers by the families of the patients (Sloane, Williams, & Zimmerman, 2010). Self- reported workplace discrimination related to race or ethnicity was three times greater among immigrants compared to non-immigrant care assistants (Khatutsky et al., 2010). The feeling of being different has also been experienced even within a group of black people. Healthcare providers who were recent immigrants reported feeling inequality and discrimination from black co-workers who were not recent immigrants (Berdes & Eckert, 2001). Though not conducted in a Swedish context, this phenomenon is likely to exist cross-culturally. A Swedish study on healthcare providers in elder care found that staff with darker skin colour were more exposed to discriminatory acts from the elderly. Staff were, in general, tolerant of such behaviour from the elderly (Lill, 2007)**.**

2.2.3 Cultural competence to meet diversity in healthcare institutions

Healthcare staff who are culturally competent are essential in a diverse society. The goal is to provide culturally adapted care, which is defined as, "*the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural*

context of a client, individual, family or community" (p. 54). Cultural competence is an ongoing process (Campinha-Bacote, 2002). Cultural competence involves attributes that include a nurse's cultural caring, sensitivity, knowledge, skills within the community and its intersection with the healthcare system. This competence is associated with improved health-related behaviors by the patient and increased work satisfaction for the nurses (Kim-Godwin et al., 2001).

Leininger's model of "cultural care" is the first description for nurses of how to address diversity. During the early 21st century, the concept of cultural competence evolved from the transcultural nursing perspective (Leininger & MacFarland, 2002). Cultural competence is a part of transcultural nursing, and is a process for developing the competence needed to meet cultural needs in encounters with patients from diverse cultural and ethnic backgrounds (Campinha-Bacote, 2002; Jirwe, 2008; Papadopoulos, 2006).

The concept of cultural competence is complex and multidimensional, which makes it difficult to define what it involves and how to teach it. Cultural competence in Sweden was investigated using the Delphi technique by Jirwe, Gerrish, Keeney, & Emami (2009). A group of nurses and researchers ranked statements about the skills needed by nurses when encountering patients from culturally diverse backgrounds. Five areas were agreed upon. From highest to lowest ranking they were cultural sensitivity, cultural understanding, cultural encounter, understanding of the health and illness beliefs, and social and cultural context. "Cultural sensitivity" is regarded as the most important skill for nurses. It involves being aware of one's own background and using one's personal attributes, such as being flexible, in encounters with people from other backgrounds. It is also necessary to have "cultural understanding," which relates to awareness of similarities and differences and risks of discrimination as well as knowledge of the patient's native country. Next in rank was "cultural encounter," which is an awareness of responses and reactions in each encounter with the patient in order to identify linguistic shortcomings and use the skills that one is aware of along with communications skills. "Understand the health and illness beliefs" means recognizing beliefs that differ from one's own experiences and preferences in healthcare and treatment strategies. The trait about which there was the least agreement was a need to identify and respect the patient's "social and cultural context," which includes each person's religion and spirituality, gender, family structure, nutrition and dietary choices, education background, and occupation and economic preferences (Jirwe et al., 2009).

Cultural competence focuses primarily on the needs of healthcare providers in meeting the needs of their patients. It does not include dealing with diversity among co-workers. The definition needs to be extended so it includes an "ability to work effectively with co-workers" on an individual and organizational level (Allensworth-Davies et al., 2007). There are models describing cultural competence in which diversity in the work environment and the organization itself are included (Frusti, Niesen, & Campion, 2003; Purnell et al., 2011).

Purnell has described four components in the organization and administration that should be taken into account when attempting to create a culturally competent work environment. These components include evaluating whether the staff fully reflects the community's composition

in terms of cultural background and linguistic skills; introducing new co-workers into a culturally diverse workgroup; orienting new co-workers in regard to language shortcomings in the workforce and among patients; and developing a better understanding of how to overcome these issues and improve the staff's competence in this area (Purnell et al., 2011). Equality can be promoted and disparity reduced in healthcare by improving the cultural competence of healthcare staff and the organization, and having staff leadership that is knowledgeable about the culture and values of the community (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013; Dreachslin,Weech-Maldonado, & Dansky, 2004).

Hospital-based research studies on cultural competence and its effects on the perception of care among ethnic groups find that a high level of cultural competence correlates strongly with patient satisfaction with cross-cultural communication, the staff's responsiveness to them, and pain control. Overall, hospitals with a higher degree of cultural competence provide better experiences for their patients (Weech-Maldonado et al., 2012). Nurse assistants also experience increased job satisfaction when there is a high level of cultural competence in the organization. A comfortable work environment including good cross-cultural communication with co-workers and strategies for responding to and acting on unfairness at work was important for staff (Allensworth-Davies et al., 2007).

The concept of cultural competence is used frequently in research focused on a wide variety of questions, including those concerning healthcare providers and their encounters with culturally diverse patient populations (Lundberg, Bäckström, & Widén, 2005; Mold, Fitzpatrick, & Roberts, 2005), and assessment of educational interventions (Benkert,Templin, Schim, Doorenbos, & Bell, 2011; Reyes, Hadley, & Davenport, 2013). Previous research studies recommended education and training for healthcare staff and students to better deal with diversity in patient healthcare (O´Hagan, 2001) and in the workforce (Allensworth-Davies et al., 2007). It is, however, difficult to find consistent advice on implemetation of education about cultural awareness, including the specific knowledge and skills that are recommended (Delgado et al., 2013). Cultural competence education has also been criticized for not taking into consideration the complexity of the patient's life or sociocultural context, thus creating a risk of promulgating racial and ethnic biases and stereotypes. Economic, educational, linguistic and other disparities are often attributed to cultural traits rather than being viewed as general problems resulting from social disadvantage. Culture is commonly related to race and ethnicity, but culture and ethnicity should not been seen as identical. In other words, it should not be taken for granted that a particular ethnic group shares the same culture (Gregg & Saha, 2006)

2.3 Immigration

This section provides an understanding and clarification of concepts related to people living in Sweden with from different cultural and ethnic backgrounds who are commonly described as immigrants.

2.3.1 History of immigration to Sweden

People have always migrated within Europe. The reasons and numbers have varied widely, based on a number of factors including economics, world events including wars, political changes, and ethnic strife. The immigrant phenomenon in Europe, however, is different from that of countries such as Australia, Canada, and the USA, which were built by immigration (Penninx, Kraal, Martiniello, & Vertovec, 2005).

Since the Second World War, Sweden has a history as an immigrant country. Finnish children and Baltic refugees arrived in substantial numbers. Work-related immigration from outside the Nordic countries began in the early 1950s (Hultén, 2007; Migrationsverket, 2010a) but since then the reasons for immigration and government policies have changed. As a result, more immigrants today are refugees and families from outside the EU (Hultén, 2007; Statistic Sweden, 2006).

People are moving for different reasons such as education, work, living with a partner in the country, or joining their families and relatives (Migrationsverket, 2013a). For European citizens it requiring only a registration for right of residence after three months in the country (Migrationsverket, 2012). There are separate regulations for people who come from countries outside of Europe, so called third-country citizenship. A visa is required, and it permits a maximum stay of only three months (Migrations verket, 2010b).

Some people's movements are not of their free choice. Some are in need of protection due to their race, nationality, social group, religious or political beliefs, sex, or sexual orientation. These people are refugees. According to the UN Geneva Convention, which Sweden signed in 1951, every person should be assessed to determine if they meet the criteria for protection (Migrationsverket, 2013b). If the person is situated in a country outside their native country and are in need of protection, they could be transferred to Sweden or one of 25 other countries in the EU through a program of resettlement. This is conducted in collaboration with the UN refugee agency, UNCHR. All residents who stay for their own protection are considered to have been granted asylum (Migrationsverket, 2012).

During 2012, asylum seeking increased in Sweden, reflecting an increased need for protection due to ongoing armed conflicts in many places throughout the world. The biggest groups of refugees came to Sweden from Syria, Somalia, Afghanistan, and Eritrea. There are, in addition, many undocumented citizens. In 2012, 1900 people transferred to Sweden as its quota of immigrants and resettlements. Sweden is the country within the EU that takes the most people within this group (Migrationsverket, 2013c). The EU is working toward emphasizing solutions that develop strategies to deal with the requirements for development and labor markets that result from an increasing population (Migrationsverket, 2012).

2.3.2 The concept of immigrant

The concept of *immigrant* as used by most people relates to those with backgrounds that differ from the majority population and who are *"persons who have moved from their country to another country to live"* (Nationalencyklopedin, 2013a). The Swedish government definition of immigrants is, *people who have moved because they are in need of protection and those*

who have been registered in Sweden for at least a year (Government offices of Sweden, 2011).

The term "immigrant" was implemented in Sweden during the 1960s to avoid the negative impact that was related to the earlier concept of 'aliens' or 'foreigners' (Nationalencyklopedin, 2013b). Today, the concept of immigration has taken on the connotation of something negative, and immigrants are often associated with unemployment and criminal acts (SOU 2006:59).

2.3.3 First- and second- generation of immigrants

Approximately 18% of all healthcare providers have a background other than that of the majority of the population. This group includes those who were born outside of Sweden and immigrated "first generation immigrants" and those born in Sweden to parents from other countries "second generation immigrants" (A.Isacsson. Swedish Association of Local Authority and Regions, personal communication, January 30, 2013).

Before 2002, government statistics divided the population into groups born outside the country and those born in the country with one and/or two parents from other countries. Since 2004, it is more common to use categorization guidelines established by the Culture Ministry. This definition is broader. Foreign-born are described as people born outside of Sweden. Swedish-born are divided into those with one, two or neither of the parents born outside Sweden (Statistics Sweden, 2002).

First- and second- generation immigrants have been studied mainly in relation to specific health attributes and outcomes. For example, data collected from a university hospital in Germany, on depression symptoms among staff found that symptoms were more frequent in first- and second-generation immigrants than among non-immigrants. This result has to be interpreted with caution due to the varying sample size among the study groups (Sieberer et al., 2012). Other studies have investigated the risk of suffering from diseases such as rheumatic diseases at an increased frequency among first- and second-generation immigrants (Li, Sundquist, & Sundquist, 2009) and cancer risk (Myrup et al., 2008).

2.4 Studying the impact of cultural and ethnic diversity in healthcare

2.4.1 Methodology of assessing cultural and ethnical diversity

Assessment of healthcare staff's perception of working in a diverse environment, and comparing the impact of diversity and the staff's cultural competence in diverse healthcare setting could provide a basis for improvement in healthcare. A questionnaire to assess the perception of diversity in Swedish workgroups was difficult to find. This led to a project in Sweden to develop of a specific Swedish tool, the Assessing Awareness and Acceptance of Diversity in Healthcare Institutions (AAAD) (Emami & Safipour, 2013).

One of the first published papers on assessment of cultural competence is from 1993, "Influences on the cultural self-efficacy of community nurses." The questionnaire assessed nurses' cultural care for three different cultures: African Americans, Latinos and Southeast Asians. Nurses were assessed on their self-efficacy on knowledge of the groups' cultural patterns and health beliefs, skills in clinic and cultural sensitivity (Bernal & Froman, 1993). Since that time, more questionnaires have been developed. Four of 11 instruments in a review on cultural competence by Loftin Hartin, Branson and Reyes (2013) were based on Campinha-Bacotes' model, "The Process of Cultural Competence in the Delivery of Healthcare Services" (2003a).

2.4.2 Studying the perception of diversity among care providers working in healthcare institutions

The AAAD was specifically developed to assess diversity within healthcare institutions (Emami & Safipour, 2013). The instrument's items are based on a comprehensive literature review and participation during development by a team of experts in transcultural care including an anthropologist and a sociologist, and with input from the social welfare officer at the Swedish Integration Board as well as the Swedish Centre Against Racism.

The AAAD is a self-administrated questionnaire, intended for use among all staff working in healthcare institutions. The questionnaire is divided into two sections, in addition to a section that collects basic demographic information about the respondent. The items in Section One ask about the workforce and collaboration at work. Section Two asks about care encounters with patients and significant others.

Section One is intended for both healthcare providers and non-healthcare staff; Section Two is intended only for healthcare providers. Sections One and Two have 26 items assessing communication, attitudes and discrimination. Each item is scored on a four-point Likert scale in which the choices are: strongly agree (4), agree to some extent (3), disagree to some extent (2), strongly disagree (1).

The questionnaire has six dimensions:

1. Attitudes toward discrimination
2. Interaction between staff
3. Stereotypic attitude toward working with a person with a Swedish background
4. Attitude toward working with a patient with a different background
5. Attitude toward communication with persons with different backgrounds
6. Attitude toward interaction between patients and staff.

The AAD questionnaire was tested during 2006 on 841 people working in healthcare settings for the elderly. Its internal consistency and reliability was established with the Chronbach alpha, Spearman rank correlation and Guttman split-half statistical tests. Its content and construct validity were evaluated (Emami & Safipour, 2013).

2.4.3 Studying cultural competence among healthcare providers

The instrument Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals–Revised (IAPCC-R) is frequently used in studies of cultural competence. It is an American-language instrument of U.S. origin, developed by Campinha-Bacote (Campinha-Bacote, 2003a). The IAPCC-R scales are Cultural Desire, Cultural Awareness, Cultural Knowledge, Cultural Skill, and Cultural encounter. The instrument is based on the Campinha-Bacote's model, "The Process of Cultural Competence in the Delivery of Healthcare Services".

The assumptions of the model are that cultural competence is a process, and that more similarities will be found within cultural groups than between cultural groups. The model also assumes that there is a relationship between healthcare providers' cultural competence and their ability to provide culturally adapted care. The model contains the following five subscales: Cultural Desire (CD), Cultural Awareness (CA), Cultural Knowledge (CK), Cultural Skill (CS), and Cultural Encounter (CE).

The pivotal subscale in the model is Cultural Desire, which describes a genuine interest in "wanting" to develop cultural competence. Cultural Awareness is the awareness of "oneself" and the "other" when it concerns prejudices and cultural behaviour. Cultural Knowledge is the knowledge of how patients and their families experience and explain their health problems and the treatments they obtain as well as knowledge about culture-specific issues for the group. Cultural Skills are the healthcare provider's cultural assessments and methods of obtaining information when taking care of ethnically diverse people. Cultural Encounter is the experience the care provider obtains in his or her encounter with patients and families who are culturally different from the healthcare provider. Communication and language assessment are important for an effective encounter.

The IAPCC-R instrument is a self-administrated tool and intended for use with vocational nurses, nursing students, nurses and nurse faculty, among other healthcare professions. IAPCC-R assesses five subscales with five items each, for a total of 25 items. Each item is scored with a four-point Likert scale ranging from strongly disagree, disagree, agree, and strongly agree. Each option is assigned 1 to 4 points. Five of the items are inverted and score the opposite. The total score is then summarized and categorized to a level of cultural competence. Higher scores demonstrate a higher level of competence. The ranges are culturally incompetent (25–50 points), culturally aware (51–74 points), culturally competent (75–90 points), and culturally proficient (91–100 points).

The questionnaire was evaluated and cited in Campinha-Bacotes' description of the instrument in 2003 by Koemple on 275 nurse practitioners. Spencer and Cooper-Brathwaite evaluated the instrument on 50 public health nurses and established a Chronbach alpha. Validity has been evaluated with construct- and content validity (2003a).

2.4.4 Development or translation and adaptation of an existing questionnaire

If there is no instrument that fits the purpose and context of a research study, then there is a need to develop one. The first step in development of items for a new questionnaire is to obtain thorough knowledge about the subject being assessed. Information can be obtained

from experts in focus groups, individual in-depth interviews, observations in clinical areas or from theory, models and previous research (Streiner & Norman, 2008).

Items are then constructed and evaluated and selected for the questionnaire from an item pool larger than that required for the final version of the questionnaire. The criteria for elimination of items include demonstrated ambiguity caused by unclear, overly short, or poorly worded questions. Other difficulties with words are related to value-laden words, jargon, negative words such as *not* and *never*, or difficult words in general. Items are considered for elimination if two questions are asked about the same item, or an item is overly lengthy. Before selecting a response scale, it is helpful to discuss what kind of responses the items might elicit. The Likert scale is an example of a widely-used response scale. This scale is used for statements of agreement, probability, or similarities, which are ranked from greatest level of agreement to greatest level of disagreement. The response scale that is chosen determines in large part the analysis that can later be performed (Spector, 1992; Streiner & Norman, 2008). The instrument is ultimately evaluated on its validity and reliability.

When using an instrument or questionnaire in a new cultural context and/or in another language, it must be independently evaluated, since there are multiple factors at work that were not part of the original assessment of validity and reliability. Geisinger (1994) describes different steps to ensure good psychometric quality of a survey instrument being proposed for use in a new context. One step is to use a translator and adapt the questions. What has to be considered during this step is if the question's content is culturally relevant in the new context. This requires of the translator competence in the culture and language of both contexts. After this is done, the questions are back translated and compared with the original instrument. Instead of using a back translator, a review of the translated and adapted version of the instrument can be performed using a group of subject matter experts. The questionnaire can then be adapted and rewritten based on comments from the group. Then the questionnaire is evaluated for validity and reliability.

One way to validate items in a questionnaire is by using a cognitive method known as the "think aloud method" (Sudman, Bradburn, & Schwarz, 1996). Respondents are asked to "think out loud" and are recorded as they complete the questionnaire. The researcher asks for more information, when needed, in order to understand how the respondent is interpreting the question. The Conrad and Blaire taxonomy (Conrad & Blair, 1996) is well suited for analysis of interviews that use the "think aloud" method. The taxonomy involves five classes of problems that could be found. These are lexical/vocabulary problems, inclusion/exclusion problems, temporal problems, logical problems, and computational problems.

"Lexical or vocabulary problems" occur when words or groups of words are not understood in the question. "Inclusion/exclusion problems" occur when the respondent doesn't know how or what to include or exclude when reading a word or concept. "Temporal problems" occur when it is unclear to the respondent how often, how many, or in the point in time to which the question is referring. "Logical problems" can be divided into three types. The first is when the question is asking for a different focus or is asked with negation. The second type is when the question is irrelevant to the respondent. The third type consists of contradictions and

tautologies, if the questions are experienced as similar by the respondent, or if the respondent has difficulties answering on the required response scale. “Computational problems” consist of all other problems that are identified during the response process. The identified problems are once more a guide for changes and adaptation or elimination of the items (Conrad & Blair, 1996).

Different methods for evaluation of validity can be used to identify whether items in fact measure what a particular question seeks to measure (Spector, 1992). Methods can be based on judgment from experts on the items and the subject when reading it or on statistical tests (Streiner & Norman, 2008). An item analysis identifies weaknesses in items and permits consideration of whether an item should be kept as is, modified and kept, or deleted. A sample of about 100 to 200 respondents is recommended. The recommended and most frequently used item analysis is “internal consistency”. This is a reliability test that evaluates the shared underlying constructs, derived from the variance of the items (Spector, 1992).

Reliability assesses whether the item in the instrument is reproducing the assessment on the items by different people or at different times (Streiner & Norman, 2008). One measure of internal consistency is the item correlation of each item to the sum of the other items in the questionnaire. A coefficient is set that guides the decision for retained items, e.g 0.40.

Chronbach’s alpha determines internal consistency by evaluating and comparing the sum of the items with the items’ variance. The test is not evaluating the stability over time where the test-retest or split-half could be more useful (Spector, 1992). Cronbach’s alpha coefficient should have a minimum value of 0.7, and the higher the value of the coefficient the better (Brace, Kemp, & Snelgar, 2006; Spector, 1992). The normal range for Cronbach’s alpha is between 0 and 1, but it can have a negative value under some circumstances (Polit & Beck, 2010). If there is a negative value, this can signal that something is wrong and the item should have been deleted at an earlier phase in the development of the instrument (DeVellis, 1999). One explanation for such an outcome is that items scored were not reversed in a proper way (Spector, 1992). An item correlation test can reveal items with poor correlation that could go undetected by a reliability test (Brace et al., 2006). This justifies the use of both analyses.

An evaluation of the internal structure can be conducted using factor analysis, confirmatory factor analysis (CFA) or/and exploratory factor (EF). The two analyses are used for different purposes. When the CFA is used, the purpose is to examine a previously determined component structure, subscales of the questionnaire, or to investigate whether the structure is supported (Tabachnick & Fidell, 2001). If the questionnaire assesses multidimensional components, then it is important that the component constructs with their items differ from other constructs (Spector, 1992). When EF is used, the purpose is to find out if there are any items that correlate with each other and reveal a subscale (Spector, 1992). A sample size of at least 300 is considered sufficient to provide a reliable estimate of correlation when conducting factor analysis (Tabachnick & Fidell, 2001). The level of 0.40 for factor loading is considered a medium loading value (Brace et al., 2006).

3 RATIONALE AND AIM

This licentiate work is a part of a research programme started in 2003 and conducted at the Division of Nursing Karolinska Institutet studying cultural competence and diversity among healthcare staff.

Sweden has an ethnically and culturally diverse population and there is a need for diverse healthcare providers in the healthcare workforce. The Swedish requirement is in line with countries within and outside the EU with a diverse population (SOU 2007:37; Dreachslin et al., 2000; Purnell et al., 2010). Previous research has found that working in a diverse healthcare setting can lead to communications problems (Dreachslin et al., 2002; Khatutsky et al., 2010), decreased respect and trust toward each other (Dreachslin et al., 2002) and experiences of equality problems within the staff group and in work tasks (Alexis & Vydelingum, 2004; Shutes & Walsh, 2012; Smith et al., 2006).

Previous studies on ethnic minority groups' perceptions about working in a diverse workforce have for the most part been conducted in other countries outside Sweden. Studies on diversity in healthcare are inherently culture-centric because they relate to matters of healthcare policy, workforce organization, and management styles as well as a large number of culture-specific factors. There is substantial gap in our knowledge of these perceptions within the Swedish context, which makes the data presented here all the more significant.

A culturally competent workforce and organization that includes a comfortable work environment is described as a way to improve job satisfaction, increase equality and reduce disparity in healthcare institutions (Dreachslin et al., 2004). Comprehensive information about cultural competence among first- and second-generation immigrants and native Swedes is lacking and is important for improving our understanding of how healthcare staff can work more effectively in a diverse workforce for safe care of our elderly patients. If we are to provide relevant education and cultural competent care for all the elderly, there is a pressing need for a better understanding of the broader context of healthcare providers' perceptions of working with co-workers from different backgrounds and in a diverse work environment.

3.1 Overall aim

The overall aim of the studies included in this licentiate thesis was to assess healthcare providers' perception of diversity and cultural competence.

3.2 Specific aims

Study I. To compare native Swedish and first- and second-generation immigrant healthcare providers' perceptions of diversity in relation to equality and communication in elder care settings.

Study II. To describe the translation, adaptation, and psychometric evaluation process in relation to the validity and reliability of the Swedish version of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) instrument.

4 THE STUDIES

4.1 STUDY I

Data used in the following study is drawn from a project within the overarching research program conducted from 2005 to 2008. The specific project's purpose was to increase cultural competency among healthcare staff and to prevent the negative treatment of healthcare staff and patient having backgrounds from different countries.

The aim of Study I was to compare native Swedish and first- and second-generation immigrant healthcare providers' perceptions of diversity in relation to equality and communication in elder care settings.

4.1.1 Design

A cross-sectional survey design was used. Data were collected on one occasion using a self-assessment questionnaire.

4.1.2 Sample

Data were collected on all employees in several elder care settings. The response rate was high, with 841 (83%) of the 1016 questionnaires handed out completed and returned.

For the purpose of this study only data from healthcare providers was used. Respondents from administration, financial departments, IT support, dietetics, and food administration in the café and canteen were not included. Of the 678 healthcare providers who responded, 35 did not complete the survey. Data from 643 respondents who submitted completed questionnaires formed the basis for this analysis (see Table 1).

The respondents were classified into one of three groups: first-generation immigrants, second-generation immigrants, or native Swedes. This was done based on two self-reported items in the questionnaire's demographic section. Item 1 was *"Were you born in a country other than Sweden?"* with responses of "yes" or "no" and item 2, *"Were one or both of your parents born in a country other than Sweden?"* with responses of "yes, one", "yes, both", or "no".

Table 1. The sample of healthcare providers for the study

Healthcare providers n=643		
First generation of immigrants	Second generation of immigrants	Native Swedish
47% (n=302)	12% (n=78)	41% (n=263)

4.1.3 Data collection and procedure

Data collection using the AAAD was conducted during two weeks in 2006 in nine nursing homes and six home-based elder care settings. The questionnaires were distributed to the employees at work. After completion, they were left in a box at each setting. To inspire and motivate completion, a webpage was established where the number of completed questionnaires from each setting could be followed every day.

Items in the AAAD that focused on equality and communication were chosen, in line with the aim of the study. The selected items from the AAAD were used for factor analysis to determine the underlying patterns or dimensions of correlation on the variance of the items. The five subscales that emerged for use in the current study were "Care for elderly patients from different backgrounds", "Equality in the workplace", "Communication between co-workers from different backgrounds", "Self-awareness in collaboration with co-workers from different backgrounds" and "Treatment from patients and significant others from different backgrounds".

4.1.4 Data analysis

One-way ANOVA was used to compare the differences between the first- and second-generation of immigrants and native Swedes for each of the subscales. A follow-up post hoc test (Fisher's least significant difference) was conducted to examine the pair-wise differences, and Cohen's d on the effect size was calculated from the pooled standard deviations (Coe, 2002).

4.1.5 Findings

Significant differences were seen in the distribution of gender and age in the three groups. In general there were more females than males in the three groups, and the first generation immigrants were the group with the most males (21.3%) and the native Swedes with most female (90.5%). The average age of the native Swedes was greater than 45 years and the average age of the second generation immigrants was younger than 35 years. First generation immigrants had the average age between 35 and 45 years. Second generation immigrants had least permanent employment, and native Swedes had the longest durations of employment at more than 10 years. First-generation immigrants had the longest duration of employment at their current workplace between three and ten years and worked full time more than the other two groups (see Table 2). Almost all immigrant respondents rated their language proficiency in Swedish to be good or very good (first generation immigrants (91%), second generation immigrants (92%).

Table 2. Description of the characteristics of native Swedes (n=256–263), first generation immigrants (n = 295–302), and second generation immigrants (n=78)

		Native Swedish *(%) n*	*First generation immigrants* *(%) n*	*Second generation immigrants* *(%) n*	*P*
Gender	Female	90.5 (237)	78.7 (237)	88.5 (69)	<0.001
	Male	9.5 (25)	21.3 (64)	11.5 (9)	
Age	20-25	12.6 (33)	7.6 (23)	25.6 (20)	<0.001
	>25-35	19.2 (50)	20.5 (62)	28.2 (22)	
	>35-45	22.6 (59)	33.4 (101)	16.7 (13)	
	>45-55	22.6 (59)	26.5 (80)	19.2 (15)	

	Native Swedish *(%) n*	*First generation immigrants* *(%) n*	*Second generation immigrants* *(%) n*	*P*
Age >55	23.0 (60)	11.9 (36)	10.3 (8)	
Current employment duration < 1 year	16.0 (42)	12.4 (37)	23.1 (18)	0.095
From 1 to 3 years	25.2 (66)	27.5 (82)	24.3 (19)	
From 3 to 10 years	37.8 (99)	45.3 (135)	37.2 (29)	
>10 years	21.0 (55)	14.8 (44)	15.4 (12)	
Permanent employment Yes	76.2 (198)	71.4 (215)	66.7 (52)	0.198
No	23.8 (62)	28.6 (86)	33.3 (26)	
Employment Full time	47.7 (122)	56.3 (166)	52.5 (41)	0.130
Part time	52.3 (134)	43.7 (129)	47.5 (37)	

The result revealed more similarities between second generation immigrants and native Swedes than between second- and first-generation immigrants when asking for perceptions at work with co-workers and elderly patients/significant others. ANOVA identified significant differences between first generation immigrants and native Swedes in four of the five subscales. Compared to first generation immigrants, native Swedes perceived it more difficult to "care for elderly patients from different backgrounds"; more "equality in the workplace"; more difficult to engage in "communication with co-workers from different backgrounds" and perceived worse "treatments by co-workers, patients and significant others from different backgrounds" (see Table 3).

Table 3. Native Swedes, first- and second- generation immigrants, mean (M) and standard deviation (SD)

	Native Swedes		*First generation immigrants*		*Second generation immigrants*	
	M	(SD)	M	(SD)	M	(SD)
1. Care for elderly patients from different backgrounds.	2.39	(0.67)	2.07	(0.71)	2.25	(0.65)
2. Equality in the workplace.	3.46	(0.58)	3.11	(0.73)	3.37	(0.57)
3. Communication between co-workers from different backgrounds.	2.51	(0.64)	2.17	(0.64)	2.45	(0.68)
4. Self-awareness in collaborations with co-workers from different backgrounds	2.92	(0.61)	3.01	(0.75)	2.86	(0.73)
5. Treatment from patients and significant others from different backgrounds.	2.66	(0.49)	2.54	(0.61)	2.56	(0.53)

Two of the five subscales demonstrated significant difference between first- and second-generation immigrants. Second generation immigrants perceived more "equality in the workplace" and more difficulties in "communication with co-workers from different backgrounds". There were no significant differences between the three groups for the subscale "self-awareness in collaboration with co-workers from different backgrounds" (see Table 4).

Table 4. Comparison between first generation immigrants (*n* = 302), second generation immigrants (*n* = 78) and native Swedes (*n* = 263)

			Native Swedes vs. first generation immigrants	*Native Swedes vs. second generation immigrants*	*First generation immigrants vs. second generation immigrants*
Subscales	F	Sig.		Cohen´s d	
1. Care for elderly patients from different backgrounds.	14.70	<.001*	0.46		
2. Equality in the workplace.	20.70	<.001*	0.53		0.38
3. Communication with co-workers from different backgrounds.	21.02	<.001*	0.53		0.43
4. Self-awareness in collaborations with co-workers from different backgrounds	2.15	.118			
5. Treatment from patients and significant others from different backgrounds.	3.76	.024*	0.21		

*The mean differences are significant at the 0.05 level

4.2 STUDY II

The aim of Study II was to describe the translation, adaptation, and psychometric evaluation process in relation to the validity and reliability of the Swedish version of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) instrument.

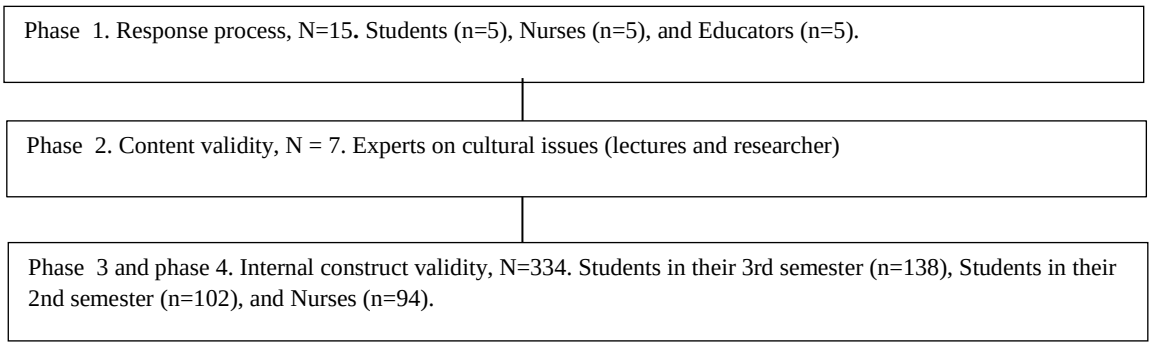
4.2.1 Design

The study used a cross-section design. After translation, a psychometric evaluation of the IAPCC-R instrument was conducted in four phases. Phase 1, evaluation of the response process. Phase 2, evaluation of the content validity. Phase 3, evaluation of the internal validity and Phase 4**,** evaluation of the internal consistency.

4.2.2 Sample

The translation and adaptation process involved three of the authors and a team of three other people with different expertise in the translation and adaptation of instruments, language skills for both of the cultural contexts, and cultural knowledge. A total of six people were involved in the first translation and adaptation process. Convenience samples of respondents were conducted for the study. Figure 1 below describes the samples in the four phases of the psychometric evaluation.

Figure 1. Respondents in the psychometric evaluation process



4.2.3 Data collection and procedure

The translation and psychometric evaluation process was followed by the initial steps described by Geisinger involving translation and adaptation of questions, reviewing the questionnaire, adapting the translation draft, and pilot testing the adapted and translated questionnaire (Geisinger, 1994).

The translated document agreed upon by the authors was sent to the team with instructions on how they should evaluate the items in the instrument. A meeting was held to discuss the content and specific wording of each item until final agreement was reached. The revised document was sent to the team after the meeting for additional comments, and some minor revisions were made.

Phase 1. The interviews conducted in the response process on the questions were inspired by the think aloud method. All interviews were conducted in the building of Campus Huddinge, Karolinska Institutet.

Phase 2. The translated instrument was sent to the experts, lecturers and a researcher on transcultural knowledge together with an article by Campinha-Bacote describing the model of cultural competence in more detail (Campinha-Bacote, 2003b). The experts were asked to assign each item to the model's five subscales after reading the article, in order to validate the content in the specific question.

Phase 3 and 4**.** Data for internal construct validity and internal consistency were gathered in association with teaching session´s for students at the division of nursing at Karolinska Institutet.

4.2.4 Data analysis

Phase 1. The analysis of the response process described earlier was conducted following the Conrad and Blaire taxonomy (Conrad & Blair, 1996) for "think aloud" methods. The data were sorted into the five classes of problems, which were described in detail earlier: lexical/vocabulary problems, inclusion/exclusion problems, temporal problems, logical problems, and computational problems.

Phase 2. The analysis of the content validity involved a comparison of each respondent's categorization of the items to the subscales with the correct key for the subscale provided by Campinha-Bacote. A summary of the corrected answers to the model's subscales was

compiled from the seven experts on transcultural nursing that related the five items to each subscale with a maximum of 35 corrected assignments to each item.

Phase 3. The statistics program SPSS (v. 14) was used for the analysis of internal construct. The level of correlation for the analysis was set at 0.40. Item analyses were conducted testing each item's association with the total summary measure, each item's association with the subscale it belonged to, and each item's association to the other subscales. An item analysis on the internal structure was also conducted. Internal construct was also analyzed with confirmatory factor analysis (CFA) and exploratory factor (EF) analysis was performed to identify the suggested factors for the instrument. Model fit was tested with the standardized root mean square residual (SRMR). Parsimonious fit was assessed by the root mean square error of approximation (RMSEA) and incremental fit was assessed by the comparative fit index (CFI).

Phase 4. Reliability test, Cronbach's alpha was conducted to evaluate internal consistency.

4.2.5 Findings

The evaluation of the translated instrument showed difficulties with validity and reliability of the instrument on all subscales. The subscale Cultural Awareness showed the greatest number of problems, followed by Cultural Skills and Cultural Encounter. The number of problems and findings for each subscale are described for each phase of the evaluation in Table 5.

Table 5. Summary of the results for the subscales from the four phases of the psychometric evaluation of the IAPCC-R instrument.

Subscales	***Cultural Desire***	***Cultural Awareness***	***Cultural Skill***	***Cultural Knowledge***	***Cultural Encounter***
Phase 1. Response process Problems identified in the five subscales out of the five (5) classes in the taxonomy.	4 (5)	5 (5)	3 (5)	4 (5)	2 (5)
Phase 2. Content validity Correctly assigned items to the five subscales with five items each. The maximum number of identified items was 7x5=35.	30 (35)	14 (35)	18 (35)	23 (35)	12 (35)
Phase 3. Internal validity Items associated to the total summary measured above 0.40.	3				2
The numbers of the five items (5) association to the subscale to which it belongs, above 0.40.	4(5)	0(5)	0(5)	2(5)	0(5)
Each item's (5) association to the other subscales to which it belongs.	1	4	4	1	5
Phase 4. Internal consistency, reliability test Cronbach's alpha for each subscale.	.65	.12	-.01	.56	.31

Phase 1. The response process showed difficulties in all five of the classes used for the analysis. Examples of lexical problems were words such as "culture" and "cultural

competence" being used in the items in a way that the respondents were not comfortable with. This led to difficulties in interpreting the items and knowing what to include in the concepts. Inclusion/exclusion problems with the items were found when respondents had trouble with not knowing who to include under the term "the others." Temporal problems were identified as difficulties understanding a specific quantity in the proposed response category. Logical problems were found in the negations that were confusing the respondents. Computational problems were found with some of the items asking for experiences that nursing students had not yet had.

Phase 2. The content validity showed that CD was the subscale the experts could most correctly relate the items to. The weakest, with 40% or less correctly-related items were identified as belonging to CA and CE.

Phase 3.The internal structure revealed that the association of each item to the total summary varied between –0.09 and 0.50. Only five of the 25 items correlated at or above the 0.40 level that was set in advance. In line with the findings in Phase 2, the item's association to the subscale to which it belonged was strongest in CD with four items. The weakest subscales were CA, CE, CS with none of the items reaching the level of 0.40 in their own subscale. The weakest subscale association to the other subscales was found to be CE, where only one item in the scale even reached a level of 0.40 with other subscales. The model fit test in a one-dimensional model and a five-dimensional model showed poor model fit with RMSEA=0.121, CFI=0.595, and SRMR=0.106. The variance for more than half of the factors showed less than 50% variance. The exploratory factor analysis, extracted eight factors instead of the five, which was difficult to interpret.

Phase 4. Reliability testing on the instrument's internal consistency for the subscales resulted in a Cronbach's alpha of 0.65. Cronbach's alpha in the five subscales ranged between -0.01 and 0.65, which strengthened the finding about the items' association with their own subscales.

The findings showed weak correlation of the items to the five subscales. As a result, this instrument was not considered suitable for use in a Swedish context. The evaluation in Study I of the IAPCC-R instrument for measuring cultural competence identified problems in translation, adaptation, and psychometric tests that indicated difficulties in using the instrument in healthcare settings in a Swedish context.

5 ETHICAL CONSIDERATIONS

These two studies were approved by the Research Ethics Committee at the Karolinska Institutet.

Study I (reference 2009/463-31). When the project began in 2005, an ethical commission decided that no ethical approval was needed when doing research on staff. An ethical approach was taken consistent with the Helsinki Declaration. Before starting work on the analysis of the data for the current study, an application was submitted for documentation of ethical approval. That approval was obtained in 2009. In the initial phase of the study, the managers and staff who were invited to participate were orally informed about the project and time was allowed to discuss any questions that arose.

The AAAD questionnaires were distributed by their managers or a contact person connected to the study to all staff at the nursing homes and home-based care settings. A cover page was added to the questionnaire describing the project and providing notice that participation was voluntary. Questionnaires were completed and handed in anonymously in a box in each setting. Consent from the respondents in the study was assumed on the basis of the completed questionnaires. Even though the questionnaires were counted and reported at the workplace Web page for staff, we considered that pressure to hand in the questionnaire had been minimized by providing the opportunity to hand in the questionnaire without answering the items.

Study II (reference, 668/03-550). All respondents were given written and verbal information about the study and oral consent was obtained from the respondents. The respondents were told that they could withdraw from the study whenever they wanted without providing a reason or explanation. Permission was obtained from the developer of the instrument, Campinha- Bacote. It was limited to a one-time-only use, and the instrument should not be distributed in any way than handing it out to the respondents in this study. Campinha-Bacote was involved in the process and contacted whenever the group had any questions about the instrument. Ethical consideration and statements were given to Campinha-Bacote, who wished to be regularly informed about the results. A separate permission would be needed for using the instrument in presentations or handouts. In addition, all findings of the project will be sent to Campinha-Bacote during the five-year permission period.

6 DISCUSSION

Excellent healthcare demands healthcare workers who are knowledgeable about far more than simply the mechanical techniques of care. Nurses, in particular, are responsible for the care of the whole person, psychologically as well as physically. Healthcare providers must manage *two* sets of complex relationships: colleague-to-colleague and nurse-to-patient (including significant others). The relationships are critical because healthcare staff must function as a cooperative team in order to deliver optimal care. The relationships involve factors that are strongly influenced by many aspects of one's culture, ethnicity, and other social attributes. If there is dysfunction in either set of relationships, care and possibly even safety will be unacceptably compromised. It is important to understand that quality care is a chain with many links; a break in any of these links results in failure of the chain.

Where there is an overlay of cultural or ethnic differences, it adds to the challenge of relationship management and creates additional risks. In a culturally and ethnically-diverse society such as Sweden, there are multiple points of potential failure in these relationships due to differences in culture and ethnicity. Understanding and mitigating these risks is an urgent necessity as the Swedish population becomes increasingly diverse. Yet relatively little research has been done in Sweden to create a comprehensive understanding of the issues of cultural diversity as they affect both collaboration in the healthcare team colleague-to-colleague and to-patient relationships. The studies reported in this thesis were initial steps down this road.

The primary goal was to better understand diversity and cultural competence in healthcare settings where the workforce and/or patients were ethnically diverse. The findings in Study I showed that perceptions of communication and equality as aspects of cultural competence at work differ between first-generation, second-generation, and native Swedes.

Study I provided valuable new insights into understanding the complexity associated with communication and diversity in the healthcare workforce. Whereas most existing studies have focused on immigrant groups as a single entity, this study is novel in that it has sought differentiate between first- and second- generation immigrants. The study identified similarities between native Swedes and second generation immigrants in contrast to first and second generation immigrants. This overall result could be explained with the acculturation process that differs between the groups. Acculturation refers to changes in the values and behaviours that can occur at an individual and group level when people from minority populations interact with the majority population and start to align their values and behaviours more closely with those of the majority population. The changes affect the identity and can lead to cognitive changes (Sam & Berry, 2006). Second generation immigrants who were born and raised in the Swedish society could be seen to have acculturated to the majority population, of native Swedes and its values and behaviours.

The findings identified that first-generation immigrants perceived more inequality in the workplace than their native Swede co-workers and second generation immigrants. This could be explained by the fact that first generation immigrant respondents may have experienced at work a perceived status as ”others”. Having experiences of being the “other” may have given

the first generation immigrants a greater awareness of and a sense of identifying inequality in the workplace than their co-workers from the native Swede population and second generation immigrants. Members of a diverse health care workforce may understand and reinforce their work environment based on their lived experiences and frames of reference that have been accumulated through their past encounters with people. This is in line with the findings of Dreachslin et al., (2002).

Although Study I identified statistically significant differences, between different groups, it does not provide any explanation of why these differences might exist. A qualitative study in a Swedish context would be useful to gain further insight on how communication and equality are perceived in the workplace and in care of the elderly settings.

Study II found that an attempt to transpose a well-validated American-language questionnaire assessing cultural competence into the Swedish context did not yield an instrument that met the minimum criteria for use based on consistency and validity.

When using an instrument or questionnaire from another country that is developed for a specific cultural context or system it is imperative to evaluate its appropriateness for use in the new context. Any such evaluation is particularly challenging if the instrument is made for assessing cultural competence. In translating the instrument to Swedish, there was a risk that a culturally congruent translation would change the content of the questions to a level that would jeopardize the validity and reliability of the original questions so that they would no longer measure what they were intended to measure. Even though great care was taken to carry out culturally congruent translation without changing the original content of the question, difficulties were reported by the respondents in understanding what the questions were actually were asking.

Health care workers require cultural competence for their encounters with people from a different ethnic background to their own. Cultural competence is described both as a goal and a process moreover, generic and specific ethnic and cultural dimensions are included. Cultural competence is multidimensional and complex. As Study II has identified trying to capture all dimension of cultural competence in an instrument is problematic. For example one of the difficulties was in understanding the questions related to the term "ethnicity," that was usually only attributed to immigrants rather than everyone irrespective of their background. That was in line with Hamde´s (2008) finding suggesting that Swedes often selectively attribute ethnicity to immigrants without acknowledging that native Swedes also have an ethnic background and therefore ethnicity can be attributed to them as well as to immigrant groups.

Some of the questions in IAPCC-R were formulated in a way that could create confusion among the respondents who participated in the validation phase of our study. For example, one question in the original instrument asked, "It is more important to conduct a cultural assessment on ethnically diverse clients than with other clients" (Campinha Bacote, 2003a, # 21, Page 110). It is unknown what group of clients is being referred to as "ethnically diverse clients" and what group is included in the term "other clients." The question itself immediately divides populations into two parts, and creates a presumption of “us” and “other” that may bias the results. Moreover by attributing the term "ethnicity" to only one of these

groups, there is room for conceptual confusion about what the term ethnicity stands for. Kumas-Tan, Beagan, Loppie, MacLeon and Frank (2007) state that this is a profound problem in a number of studies on minorities and the dominant population, where minorities are the only groups portrayed with their ethnic background while the dominant population is not.

It is not clear if it is the intention of the theoretical framework of IAPCC-R to designate immigrants or minority groups as the target group when responding to the items. The description of the assumption for the IAPCC-R model is that cultural competences are an "essential component in rendering effective and cultural responsive care to all clients" (Campinha-Bacote 2003a, p 14). This does not adequately describe if it is "the other" clients or your own ethnicity that is included in culturally-responsive care**.** Respondents' stereotypes could create an unconscious bias when the instrument asks about cultural and ethnic groups in general, or about the "other". Gregg and Saha (2006) highlighted the risk of repeating stereotypes in cultural competence education by not taking cultural context into account, but rather seeing it as something fixed and stable in groups.

The study also found that respondents were confused by and had difficulties understanding cultural competence and what to include in the concept. This confusion was also identified in a study on how cultural competence was used in healthcare policy directives. It revealed problems in defining cultural competence. This posed a hurdle to the use of policies related to cultural competence as a guide at work (Grant, Parry, & Guerin, 2013). Cultural competence, described earlier, is a concept that is multidimensional and defined in different ways. The intention to capture all dimensions of cultural competence in the instrument IAPCC-R could be the source to the problems found in the evaluation process. Spector (1992) recommended a written introduction of concepts that are used in an instrument, which could have helped the respondents better understand the concepts used in the questions, and thus increased the validity of the instrument.

Study II showed that there is a lack of awareness about other factors or categories of diversity than immigrants when caring for cultural and ethnic groups**.** The Cultural Awareness subscale of the IAPCC-R asked for factors such as gender, sexual orientation, religious affiliation, occupation, geographical location that should be taken into consideration when seeking cultural competence. The question opened the mind of at least one respondent, who became aware that diversity within culture and ethnic groups was important to consider in encounters with people having other backgrounds. The finding from Study II is in line with a previous Swedish study (Jirwe, Gerrish, Keeney, & Emami, 2009) where the responses from participants who were practicing nurses and nurse researchers were very similar to those of our study. Including aspects other than ethnicity and culture such as gender, age, immigration background, socioeconomic status, etc. in diversity among patients and/or healthcare providers will provide a more comprehensive view of the phenomena. It can allow for a more holistic view of individuals and can prevent stereotyping and biases in understating the source of differences and similarities among a diverse group align with (Hammer, Bennet, & Wiseman, 2003). There may need to be more focus on this in educating staff and students when it does not seem obvious for all healthcare respondents that diversity in other

categorizations has to be considered in all encounters in healthcare and in collaboration with co-workers from all ethnic and culture groups.

6.1 Methodological limitations and considerations

In Study I, items were chosen in line with the study aim from the AAAD questionnaire and analysed. A factor analysis was conducted on the chosen items before further analysis. By setting a high limit for values at Kaiser Meyer Olkin, KMO, the intention was to reduce the items and to get a strong correlation between the remaining items for the subscales. A comprehensive evaluation of the original questionnaire was done. However, a specific psychometric test on collected data for the specific subscales in Study I of the questionnaire was not conducted. This would be needed in order to make further use of the brief version of the questionnaire, AAAD.

In Study I, factor analysis on subscale 5 had a Cronbach's alpha of 0.65, slightly lower than the proposed acceptable level of 0.70 (Polit & Beck, 2010). However, it may be that rather than indicating inferior reliability, this is related to the small number of items in the subscale (Spector, 1992) as the value of Cronbach's alpha increases where subscales contain more items (Starkweather, 2012; Streiner & Norman, 2008).

Missing data ranged from 1-8% on the items selected in section one, and between 19 and 22% of the items in section two. The Expectation Maximization (EM) algorithm was used to handle the high missing rate for the items selected from AAAD. The items could be found in two subscales in the questionnaire, subscale 1 and subscale 5. The higher rate of missing data may introduce a potential risk for bias and a threat to generalization of the results concerning the subscales**.**

The demographic composite of healthcare employees reported gender and age differences among the three groups of respondents (first- and second-generation immigrants and native Swedes) in relation to information about employment conditions. More males in the cohort of first-generation immigrants is consistent with previous international studies (Bond, et al., 2013; Khatutsky et al., 2010; Ortega, Gomes Carneiro, & Flyvholm, 2010). The higher employment rate of first-generation immigrant males may be accounted for by the availability of the elder care niche to those without a Swedish education or extensive training or experience in the field.

The intention of categorizing people as native Swedes, or first- or second-generation immigrants in Study I was to understand if there were differences in perception between the groups without going into specific categories of ethnicity or cultural background. What is missing in this study is information about the education or occupations of the staff, which would provide a more in-depth understanding of the responding group. We did not ask for ethnicities or migration status or reasons for immigration from the employees. Those factors were not the focus of this study, but consideration must be given to the fact that those factors could have an impact on a wider understanding of diversity and perceptions at work.

The sample was gathered in nursing homes and home-based care for elder. It was not possible to ascertain if the difference in settings had an impact on the results. There was a slightly

higher response rate from nursing homes (n=346) compared with responses from home-based care (n=289, missing n=8).

Some of the respondents in the response process in Study II took more time and started to delve deeper in their thoughts, which gave more nuance in their understanding of the question and its answer and this may have made it more difficult for them. This has previously been noted as an outcome of the method used in this study, but the method is still highly recommended for use in the evaluation of questions to be used in an assessment instrument (Streiner & Norman, 2008).The study sample in the evaluation phases of the instrument's internal validity and reliability might be a limitation. A more equal sample size for the different groups involved might have yielded different results.

7 CONCLUSION

Study I showed that there were more similarities in perception between native Swedes and second generation immigrants with regard to communication and equality than compared with first generation immigrants in the workforce.

Differences in perceptions were reported on equality where second generation immigrants and native Swedes experienced more equality in the workplace than first generation immigrants. However, inequality experienced in encounters between healthcare providers from different background and elderly persons and their significant others was perceived to be worse by native Swedes than by first generation immigrant.

Communication with co-workers and caring for elderly persons with a different background is perceived to be more difficult for healthcare providers from a native Swede background than immigrant healthcare workers. Second generation immigrants held similar views to native Swedes compared with first generation immigrants in their communication with co-workers from other backgrounds.

The instrument IAPCC-R tested in Study II with the intention to assess cultural competence among healthcare providers and scholars did not reach an acceptable level of validity and reliability to be used in a Swedish context.

8 IMPLICATIONS FOR NURSING PRACTICE AND EDUCATION

In the education of nursing students and allied healthcare professions, training focused on cultural competence is highly important. Because of the complex chain of interactions that is involved, only close attention to creating cultural competence in healthcare interactions with both colleagues and patients will yield the best result.

Cultural competence is not just a matter of convenience or comfort, although it should lead to both. Ultimately, this is an issue of patient safety. Failures of cultural competence whether in colleague-to-colleague or nurse-to-patient encounters, create patient risks. We as nurses and healthcare providers, have a moral and professional obligation to mitigate and eliminate such risks to the best of our abilities. Critical reflection to extend the awareness of oneself and the other, and structures in the organization and at work, could create additional avenues for understanding of cultural and ethnic complexity in a diverse society (Mattson, 2010).

The perceptions of native Swedes and immigrants (both first- and second-generation) have to be taken into consideration in a diverse workgroup. There is a need to be aware that second generation immigrants may share the same language and culture as first generation immigrants, yet, as Study I found, they have a greater similarity to native Swedes in their perception of communication and equality.

Healthcare workers will deliver optimal healthcare only when they feel comfortable in their interactions with co-workers and patients whose backgrounds differ from their own. Support is needed for native Swedes in their work with the elderly from other countries. Attention to developing cultural competence among workers in healthcare facilities is a strategy that may also yield benefits by improving performance and job satisfaction among a diverse workforce. Managers need to be aware of organizational structures that can be leveraged to enhance equality and communication in a diverse workgroup. The results of this study can be used by the healthcare administrators and managers in planning, organization and the leadership of diverse healthcare services. The knowledge generated from this study can also be used to develop and improve leadership skills that promote openness to diversity in the healthcare services and facilitate effective communication between coworkers (Dreachslin et al., 2000).

When considering using instruments in a different context, it is important that the theoretical framework is carefully studied together with the specific questionnaire items. Translation in the new context involves cultural as well as linguistic considerations. A cognitive method such as the think-aloud method is recommended in the translation process. Further tests for validity are recommended. The tests can provide a broader view and understanding of the items or subscales content in a new context.

9 FUTURE RESEARCH

Suggestions for future research about diversity and cultural competence in the context of healthcare:

- Studying co-workers' perceptions on collaboration in a diverse workforce, by first- and second- generation immigrants and native Swedes addressing aspects such as gender, sex, education, economic situation and ethnicity.
- Development of methodological tools to measure dimensions of cultural competence in a diverse workforce and collaboration between co-workers in Swedish elder care.
- A qualitative study (for example using focus groups or interviews) to gain greater insight into communication and equality in a diverse workforce in Swedish elder care.

10 SVENSK SAMMANFATTNING

Svenska samhället består av en etnisk mångfald och sedan början av 1960-talet har invandrare bidragit med en betydande insats inom vårdens olika arbetsplatser. Idag arbetar svenskar, däribland första- och andra generationens invandrare tillsammans i en hälso-och sjukvård som vårdar en alltmer mångkulturell befolkning. Kulturell kompetens efterfrågas för sjuksköterskor, vårdgivare och hälso-och sjukvårdsorganisationen för att stärka möjligheten att ge god service och vård till alla. Det övergripande syftet för genomförda studier i denna licentiatavhandling var att utvärdera vårdgivares uppfattningar om mångfald och kulturell kompetens.

Den första studien avsåg att jämföra infödda svenskars och första- och andra generationen invandrares uppfattningar om mångfald angående jämlikhet och kommunikation inom äldrevården. Den här studien har varit en del av ett större projekt där ett frågeformulär utvecklats för datainsamling. Från projektets tvärsnittsstudie har data från vårdpersonal (n = 643) använts. I frågeformuläret identifierades frågor inom kommunikation och jämlikhet vilka användes i en faktoranalys som grupperade de utvalda frågorna till fem delskalor; ”vård av äldre”,” jämlikhet på arbetet”, ”kommunikation med medarbetare”, självmedvetenhet i samarbete med medarbetare”, ”behandling från patienter och närstående”. Delskalorna användes i en Anova analys för att jämföra gruppernas uppfattningar. Det övergripande resultat visade att det förekom fler likheter i uppfattningar om kommunikation och jämlikhet mellan infödda svenskar och andra generationens invandrare än i jämförelse med första generationens invandrare.

Den andra studien utvärderade instrumentet ”Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)”. Instrumentet är utvecklat i USA utifrån en modell som avsåg att mäta kulturell kompetens hos vårdgivare utifrån fem delskalor; ”kulturell önskan”,” kulturell medvetenhet”, ”kulturell kunskap”, ”kulturell skicklighet” och ”kulturella möten”. Utvärderingen av instrumentet genomfördes med stöd i litteraturen där riktlinjer för översättning, validering och reliabilitetsprövning beskrivits. Översättning och anpassning av frågorna genomfördes först av en grupp forskare och kliniker med språk- och ämneskompetens. Pilotstudier på det översatta instrumentet genomfördes med intervjuer för att undersöka hur frågorna uppfattades och genom bedömning om frågorna stämde överrens med det delområde de var avsedda att mäta. Slutligen genomfördes statistiska analyser om frågornas interna struktur och dess stabilitet. Resultatet visade på en svag validitet och reliabilitet för instrumentet. Problemen kan vara relaterade till översättningsprocessen och den kulturella anpassning som genomfördes men mer troligt är att problemen härrör från instrumentets egen struktur. Slutsatsen av denna studie är att instrumentet i sin nuvarande form inte är lämpligt för användning i ett svenskt sammanhang.

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