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Enabling nursing students to become culturally competent – a documentary analysis of curricula in all Swedish nursing programs

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Research has shown that majority of nurses feel that they lack relevant knowledge about immigrant's cultural backgrounds, and therefore, feel incompetent in providing these patients with good care. Last year alone, 4520 nursing students graduated from nursing schools throughout Sweden. Later on, they will meet and treat people from diverse cultural backgrounds and consequently, it is crucial that their educational training prepares them for their future work in a multiethnic society. The aim of this study was to investigate whether the nursing curricula in Sweden's nursing schools provide students with the necessary tools for becoming culturally competent. The present study was based on two main questions: (i) Do the present educational plans and courses provide nursing students with the opportunity to become culturally competent? (ii) How do the contents of the educational plans match the contents of the course plans? The study was conducted using a quantitative documentary analysis, where the authors analysed the curricula of 26 nursing schools in Sweden and then compared them to the theoretical frame of reference 'The Process of Cultural Competence in the Delivery of Healthcare Services', a model written by Campinha-Bacote. The results showed that 69% (18/26) had included the concept of culture in their educational plans, whereas 77% (20/26) had included this in their courses. In all, 15% (78) from a total of 504 curricula had included the concept of culture in some way or another. However, the analysis found that only three schools provided students with specific training on the topic. Conclusively, the results showed that nursing students were not prepared for their work in a multiethnic society and nursing education in Sweden has failed to implement existing research into the nursing curricula.

Keywords: documentary analysis, cultural competence, curriculum.

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Introduction

Research shows that healthcare services have failed to contribute to satisfactory care for people from other cultural and socio-economic backgrounds (1). According to Barbosa da Silva (2), a mutual understanding between patients and healthcare workers is needed in order to prevent misunderstandings. Nurses require more knowledge about other cultural values and lifestyles, so that they can provide adequate care to patients from diverse cultural backgrounds. They must have a good level of competence in this area, so that they are able to consider the patient's cultural background during the caring process and therefore, deliver culturally competent care (3). The nurses' inability to provide culturally competent care or even standard care to minority groups was mainly related to their lack of knowledge about communicating with these culturally diverse patients (4–6). Some studies have shown how nurses face many difficulties during these encounters. They also found that the nurses failed to provide satisfactory care to these patients due to language barriers and a lack of knowledge about cultural variations. The patients also felt a strong sense of insecurity during their meetings with healthcare staff, and this was also linked to language barriers and a fear of being misinterpreted (7–10). Sweden

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is a relatively small country. During the last 40 years, the country has undergone changes, and although it was once a homogenous country, today, 25% of the total population has one parent originating from another country. The number of nurses with non-Swedish backgrounds is also high. In 2003, members of the nursing union consisted of almost 10% of nurses from non-Swedish cultural backgrounds when compared with the year 1998 when the number was 7.5%. In the Capital of Stockholm, this number was twice as high and still is (12). In 2005, 4520 nurses graduated throughout Sweden, and during the past 10 years, 33 000 nursing students have graduated from universities in Sweden (11).

Curriculum

The curriculum represents the collected documents where the goal, the content and the distribution of an education are written. The first question in the curriculum is therefore: How can we organize our knowledge so that we can teach it, and the answer to this question is coherent to what we can know and what is worth knowing (12). All curricula are descriptions of competency. They describe what the education should give to the student and what the student is supposed to learn and perform after graduation (13). Therefore, a curriculum has three key elements: goal, content and teaching methods. Without a doubt, this process should result in a definite level of learning (12). Each educational programme should have an educational plan stating the included subjects, together with a main outline of the contents and pre-requirements (14). The university law states that university programs in Sweden should work towards an education based on scientific, evidence-based work. In their educational programs, the universities should aim to promote and encourage international awareness and an understanding of other countries. Each course within the programme should have a written course plan containing substantial information on the number of points awarded for each course, the level of advancement, the aim of the course, the main content, the required literature, the type of examination and the requirements for passing the course (15).

In Sweden, nursing education was reformed in July 1993, and today, a degree in nursing is awarded after the student has completed a total of 120 points (180 ECT, 3 years of full-time studies). This education is provided in 26 universities throughout Sweden. To qualify for a nursing degree, the nurses must have acquired the necessary knowledge and ability to work independently in the healthcare sector. Nursing also requires skills in general nursing, self-awareness, and the ability to understand and develop relationships with patients and their spouses. It is also important that nurses participate in preventive work and healthcare promotions (16). Apart from these directions, it is up to each University to set its own goals for each separate educational program and decide upon the content and outline. Therefore, nursing education can be different, depending on which part of the country you study in, although they all lead to one degree and all follow the social board's competency requirements (16). Those working with the nursing curricula should now consider the changes that have taken place in society and healthcare and work on implementing these changes into the current curricula. In order to make these kinds of changes, new routines will not be enough and schools must constantly evaluate, analyse, change and improve their nursing curricula (17). The change of social structure in the Swedish society means a shift towards a more multiethnic society, which should be reflected in the contents of nursing education (9).

Cultural competence in nursing education and the healthcare system

Competence is a process, not a particular event, and its key element is the desire to become involved in the process. There is a direct link between caregivers' level of cultural competence and the ability to contribute to satisfactory care for people from other cultures. Cultural competence is not the same as colour blindness; it is the ability to respect and value cultural resemblances and differences (18).

The aim of nursing education must be to produce culturally competent nurses who can understand and help people from different parts of the world. The first step in enabling nurses to become culturally competent is to introduce this subject to students at the start of their nursing education. Students' cultural experiences should be shared in the classroom, with the help of seminars and open discussions. An innovation is much needed in our universities in the sense that the teachers themselves need to first undergo education in culturally sensitive care before they begin to teach the subject (19).

In general, when we seek to attain a new professional competency, it starts on the educational level. In the context of education, when we speak of the term competence, we are referring to a student's right to reach a certain standard of knowledge during their education. Hopefully, the student then becomes the owner of a specific type of competence. The students then become active creators of the competence they have gained, and are then asked to use this competence in their future practice (13).

According to recommendations from the Swedish National Board of Health and Welfare, nurses today must have multi-cultural knowledge and take professional responsibility. A nurse must have the competence to meet patients' physical, psychological, social, spiritual, cultural and religious needs (20). Therefore, the aim of this study was to describe whether or not the nursing curricula in Sweden's nursing schools equip the students with the necessary tools for becoming culturally competent. This

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study was based on two main questions: (i) Do the present educational plans and courses provide nursing students with the opportunity to become culturally competent? and (ii) How well do the contents of the educational plans match the contents of the courses?

Design and methodology

A quantitative approach was used in this study and documentary analysis was used to deal with the material. Documentary analysis is a method used for analysing documents of varying types, such as health improvement programmes, clinical practical guidelines (21), health policy implementation (22) and e-mail conversation (23). This method has also been used to analyse nursing curricula (24). With the increase of the Internet usage as a tool, it has become quicker and easier to obtain access to documents. It is also more cost-efficient and the researchers do not have to be present at the data gathering (23).

Also, other advantages of conducting a documentary analysis are linked to the fact that data is already available and ethical issues are usually not a problem, since most of the materials are public documents. In addition, the documents are 'non-reactive' since they already exist and there is less risk that the author might influence them. One disadvantage with this method is the fact that data is taken out of its original context, and that the researcher can extract the parts of data that best supports his/her interpretation of the data (21, 22). There can also be errors in the original documents (22). The strengths and weaknesses of the method were carefully weighed against each other to see whether the method was appropriate for the data and aim of the study, and the authors believed that documentary analyses was an adequate and fully viable method for this study.

Sample and data collection

The sample consisted of the educational plans and courses from all of Sweden's 26 nursing schools. Data collection consisted of two different types of documents: the educational plans and the courses, with the help of Internet searches on the University homepages. The total data consisted of 26 educational plans and 504 courses, which came to a total of 1300 pages. The withdrawal rate from this study was not high, as most of the material was available online. University number four lacked three descriptions of courses, since these courses were undergoing changes and the new material was not yet available.

Data analyses

We began by coding all the documents from 1–26, so that the results would be presented anonymously and this also allowed us to trace misplaced documents to their original place. Then the material was read thoroughly so that the researchers could become familiar with the data. Although the process was time consuming, this was necessary, as it helped the researchers to get an overall picture of the contents of the documents (21, 22). After this, the data reduction process began. All parts of the document that illuminated the subject in any way were included. Key words like ethnicity, culture, cultural competence, religion, transcultural, multicultural, internationalisation and intercultural helped us to extract the relevant text for our analysis and all other parts of the curricula were thereby excluded (21). Figure 1 shows the process of analyses of data. The results of the information retrieval are presented in Tables 1 and 2. Thereafter, all the documents were read through once again for confirming that no relevant text was missed from the first extraction. The three involving authors of this article repeatedly reviewed the text thoroughly for number of times to insure that agreement was achieved on the different topics. Therefore, the documents underwent a careful analysis. All courses where the sample words were identified were presented in alphabetical order. For example, 17c represents university number 17's third identified course. The selected courses constituted

Table 1 Outline of Sweden's 26 nursing schools' course plans analyzed upon Campinha-Bacote's five concepts

University	*CD*	*CA*	*CK*	*CS*	*CE*
1	–	–	2/12	–	2/12
2	–	–	1/26	–	2/26
3	–	2/12	5/12	1/12	1/12
4	–	–	3/16	–	–
5	–	–	–	–	–
6	–	1/17	2/17	–	1/17
7	–	1/14	1/14	–	1/14
8	–	–	–	–	–
9	–	–	3/21	–	2/21
10	–	1/18	2/18	–	1/18
11	–	–	1/27	–	–
12	–	–	1/15	–	–
13	–	–	1/20	–	–
14	–	–	–	–	–
15	–	–	1/12	1/12	1/12
16	–	–	1/14	–	–
17	–	–	3/17	–	1/17
18	–	–	1/21	–	1/21
19	–	–	–	–	–
20	–	–	1/20	–	–
21	–	1/15	1/15	–	–
22	–	–	–	–	–
23	–	–	1/25	–	–
24	–	–	1/29	–	–
25	–	3/24	8/24	3/24	2/24
26	–	–	6/24	2/24	1/24

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Table 2 Cultural competence – different levels of classifications in the course plans

University	*CD*	*CA*	*CK*	*CS*	*CE*
1	–	–	B, B	–	B,C
2	–	–	C	–	C,C
3	–	B,C	A,A,A,B,B	C	B
4	–	–	A,A,B	–	–
5	–	–	–	–	–
6	–	A	A,B	–	A
7	–	B	A	–	B
8	–	–	–	–	–
9	–	–	B,B,C	–	A,B
10	–	A	A,A	–	A
11	–	–	A	–	–
12	–	–	A	–	–
13	–	–	B	–	–
14	–	–			–
15	–	–	B	A	A
16	–	–	A	–	–
17	–	–	A,A,B	–	A
18	–	–	C	–	C
19	–	–	–	–	–
20	–	–	A	–	–
21	–	A	B	–	–
22	–	–	–	–	–
23	–	–	A	–	–
24	–	–	A	–	–
25	–	A,A,C	A,A,A,A,A,B,C,C	C,C,C	A,A
26		–	A,B,B,B,B,B	A,C	A

our research material and these were compared to Campinha-Bacote's five concepts.

Theoretical framework of cultural competence

Campinha-Bacote's model, 'The Process of Cultural Competence in the Delivery of Health Care Services' (25), was used as a theoretical framework. The theory is built upon five concepts that is described here: Cultural Desire (CD), Cultural Awareness (CA), Cultural Knowledge (CK), Cultural Skill (CS) and Cultural Encounters (CE). To facilitate the analysis of the documents using the theoretical framework, each of the five concepts were summarized in order to capture the main message of each concept.

Cultural Desire is described as the motivation of the healthcare professional to 'want to' engage in the process of developing cultural competence, which is based on respect, openness and caring for others. Cultural Awareness is the examining of one's identity and the realization of ones prejudgements, prejudiced thoughts, biases and values about other individuals from other cultures. Cultural Knowledge is to seek knowledge about other cultural groups, their health-related beliefs, practices and cultural values. In order to achieve this, one must first understand a patient's worldview. Cultural Skill is the ability to collect relevant data regarding the patient's current problem and also the ability to perform a culturally based assessment. A Cultural Encounter is the process that encourages healthcare professionals to engage in direct close interaction with people from other cultures, this is an important step in preventing stereotyping (25). The model, 'The Process of Cultural Competence in the Delivery of Health Care Services' (25) was regarded appropriate as theoretical framework for the analysis since it has been used by others for planning structuring and evaluating nursing programs world wide (26–29).

Results

The result which is presented in Table 3 showed that only three universities in Sweden provided students with more specific education on this topic. The majority of courses that included the components of cultural competence were those focused on elderly and terminal care. The results also showed the importance of geographical structures, which means that depending on where one studies in Sweden, one is provided with different opportunities to develop cultural competence. Universities located in larger cities,

Table 3 Outline of Sweden's 26 nursing schools' educational plans analyzed upon Campinha-Bacote's five concepts

University	*CD*	*CA*	*CK*	*CS*	*CE*
1			X		
2					
3		X			
4			X	X	
5					
6					
7					
8			X		
9					
10					
11					
12					
13		X			
14					
15					
16		X			
17					
18		X			
19					
20		X			X
21					
22			X		X
23					
24					
25		X		X	X
26			X		

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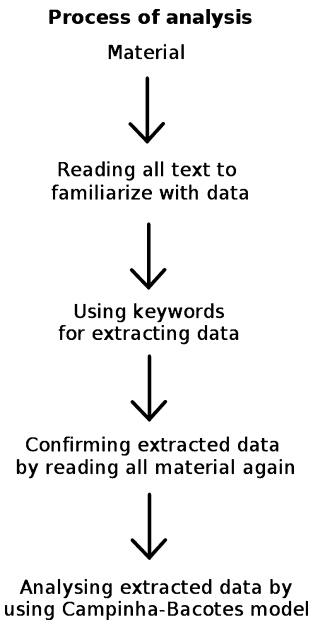

Figure 1 Process of analysis.

where more immigrants live, show more variety of content regarding cultural knowledge in their curricula. Despite this, the results were poor, indicating that only 69% (18/26) of universities had included the subject in their educational plans and only 15% (78/504) in the actual courses.

The analysis of the educational plans showed that 11 of 26 Universities had included the cultural perspective, varying from single words, to larger pieces of text. The following extracts are examples from the educational plans:

In the analysis, Campinha-Bacote's concept of 'cultural desire' could not be identified in the educational plans.

Cultural Awareness was identified in 6/26 of the educational plans, and these universities pointed out the importance of promoting international collaboration between different countries. They also encouraged discussions, which focused on respect for cultural diversity '*Students with different cultural backgrounds should be given the opportunity to share their knowledge and experience. Internationalisation should contribute to an increased understanding of the importance of culture in care'* (University, 13).

Cultural Knowledge was identified in 5/26 of the educational plans. This focused mainly on the medical aspects of health and illness. '*While medical care focuses mainly on diagnosis and treatment, nursing focuses mainly on the patients' reactions to illness and the influence of physical, social, psychological, spiritual and cultural aspects'* (University, 25).

Cultural Skill was identified in 2/26 of the educational plans. One of these universities stated the following: '*The students are gradually trained in independent planning and conducting and evaluating care in complex situations, as well as understanding the influence of culture on women and men's health'* (University, 4).

Cultural Encounter was identified in 3/26 of the educational plans and the focus was placed on the importance of being able to communicate with people from diverse cultural backgrounds during the care meeting. '*Through an educational program, the students learn different forms of communication strategies which focus on gender and a transcultural perspective'* (University, 22).

Courses

In Table 1, the column on the far left represents the codes given for each university. The remaining columns describe results from the analyses process. The figures referring to percentages represent a total number of courses that included a specific theme. For example, Cultural Awareness (CA) was included in 2/12 courses, which meant a total of 17%. The documentary analyses showed that Campinha-Bacote's concepts were identified in 20/26 university courses (78/504).

Also here, the amount of text varied from single words to larger pieces of text depending on the university. The concept of Cultural Desire was, once again, not identified.

Cultural Awareness is described as an understanding of other cultures and respect for the fact that all humans are different, but also an awareness of the similarities amongst us. The concept was identified in 2% of the courses. *'During the course, the student's own cultural understanding will be compared to other cultures, to be able to see how one's own view affects the care of others'* (University, 25).

Cultural Knowledge is described as an understanding that illness and health can be expressed differently, depending on one's cultural background. A total of 9% of all the courses had included this concept. '*The course includes cultural aspects on the grieving process and the meaning of rituals. The course includes closeness and distance, ethical issues and cultural competence'* (University, 1).

Cultural Skill is emphasized first and foremost as the ability to assess the patient's needs in relation to their cultural background. This concept was found in 1% of the courses *'Further studies involve the ability to assess patients' needs from an entirety perspective, including: cultural, gender and environmental aspects'* (University, 3).

Cultural Encounter is characterized as the meeting between healthcare personnel and patients. The concept was identified in 3% of all the courses. '*To be able to establish trustworthy relationships with different people regardless of age, social class, and ethnic background'* (University, 1).

Nursing schools in Sweden classify different courses in different advancement levels ranging from A to C. Level A represents the first level of achievement within the area of study. These courses usually consist of 1–20 points. After passing A level, the student will begin a continuation course at level B (21–40 points). Finally, students can

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deepen their knowledge by continuing on to the C level, which is equivalent to 41–60 points. The levels of advancement should follow each other so that studies on the basic level A are followed by studies on level B and completed with deepened studies on level C. To be eligible for studies on B or C level, the A-level points must have been passed first.

The result presented in Table 2 clearly shows that there is a missing structure in the existing courses, which obviously complicates the learning process for students tremendously. According to Campinha-Bacote, in order for students to have the opportunity to develop cultural competence, the learning process must start with Cultural Desire followed by Cultural Awareness. Although her model does not function as a step-by-step process, many researchers agree with Campinha-Bacote stating that in order to achieve culture competence, you must first be aware of your own culture, values and prejudgements before you start discovering others (9, 18, 30–32).

Discussion

Are concepts such as culture, ethnicity, transcultural nursing, and cultural competence fashionable words? and, in our documents, do they function as politically correct word constructions? Obviously, the review of the documents in this study cannot show us precisely what the students have learned, since they do not provide sufficient information on the content of the courses. We found that directives were unclear and there were no clear guidelines regarding the actual contents of the courses. This means that there is a great risk that what is being taught will be dependent on the teacher and his/her knowledge regarding cultural issues in caring and/or his/her level of engagement in cultural issues. The problem of priority was raised by the board of health in the report 'Immigrant knowledge in universities', when surveys were sent to different programs in universities throughout Sweden, including the nursing program. One of the questions requested information on the obstacles that teachers face when teaching students about 'immigration knowledge' as they called it. One out of four teachers reported that they experienced difficulties, when it came to prioritising topics that they believed the students should be tutored in (33). In occupations such as the nursing profession, where one is working closely with people, one must make priorities regarding the type of knowledge that is to be taught, as this is important in helping students to develop cultural competence. This is especially important when one considers that caring is supposed to be delivered equally, regardless of cultural background. Although, at the present time, there is external pressure to focus on the development of professional competence, interpreting and converting social changes into the curriculum can be a difficult task for the educational units. If political guidelines for educational content were more comprehensively designed, this would enable the educational units to have more influence on what is being taught and the level of competency can be improved (13). In other words, the politicians have let the individual school units choose the main contents of the educational programmes and therefore, those responsible at each unit must also consider the changes in social structure and the implications of current research.

Our results show that courses focusing on cultural aspects mostly included courses on elderly care. However, it is also imperative that other groups within the nursing profession improve and include the cultural perspective. This shifting focus on cultural issues ends out the wrong signal to nursing students which can result in confusion and therefore mean that they may not even consider the cultural aspects in their overall caring perspective.

To be able to contribute to effective health care in a multicultural society, nurses need to understand how minority groups have been influenced by cultural, political, historical, social and economic factors, which in turn have an effect on their health and illness. Each training course should begin by exploring the students' own cultural values, beliefs and actions which includes prejudiced thoughts. This contributes to a better understanding of how the students' own values affect their view of other cultures (34). Another important aspect that needs to be raised is the inequality that exists among minority groups regarding both health status and care. This might well be a result of discrimination and marginalization within the healthcare sector (35). Nurses must be encouraged to avoid discrimination and/or special treatment at all costs, and becoming more aware of culturally diverse groups will help them to achieve this goal.

In this study, we have been looking at nursing education in Sweden from a cultural standpoint, and similar studies have been conducted in many parts of the world. In the USA, researchers found that most of the universities teaching the subject could not manage to avoid creating a 'we and them' feeling (1). In Canada, a similar study indicated the same results as our study that students had very limited opportunities to develop cultural competence during their basic nursing education. Specialized training courses on transcultural nursing care were offered at only a small number of Canadian universities. At these specific universities, the courses were optional, not mandatory, and therefore, students could choose not to attend. An empirical study followed 76 nurses who had received 5-week education in cultural competence. The findings showed that this intervention had been effective, since these nurses felt less insecure in their meetings with patients from other cultural backgrounds (36). In Australia, the results were in line with our study, since cultural content was only identified in 23 of 28 nursing educations, with three of these schools focusing more specifically on the topic. These researchers recommended that the focus

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should be placed on implementing changes in the nursing curricula, so that all schools can educate nurses in becoming culturally competent (37).

Our results show the different advancement levels of all courses where Campinha-Bacote's concepts were identified (see, Table 2) and with the help of this table, you can clearly understand why the learning process is incoherent in its present form. Teachers often tell their students to follow 'the main theme or thread' when writing reports or papers. You cannot help but wonder how the student is supposed to fully grasp a subject if the material does not follow in a logical order. What is the point of teaching cultural knowledge in the advanced level if we fail to lay a solid foundation on the basic level? This only complicates the students learning abilities. The responsible units at each university must be able to determine an educational program that links cultural competence to all of the courses. This would provide nursing students with an education that equips them with the necessary tools to start the process of cultural competence.

In our analysis, Campinha-Bacote provided us with a clear definition and the core fundamental elements of becoming culturally competent. The model also functions as a good introduction to the area of cultural competence. Whether or not the student actually develops cultural competence after being educated on the subject can never be guaranteed, but the fact that deeper education increases their awareness leads, without a doubt, to students feeling more secure when meeting patients from diverse cultural backgrounds. Our results clearly indicated that the most frequent concept that was identified from Campinha-Bacote's five concepts for developing cultural competence was Cultural Knowledge, while the other concepts were not emphasized quite as much. This brings forward questions as to how and when students are supposed to develop cultural competence, when no clear or methodical process is available. One concept that was never identified in any of the documents was Cultural Desire. For many people, cultural desire surfaces after they begin to learn about other cultures and this usually leads to a hunger for more knowledge. We are unsure whether one person can actually teach another about cultural desire, as it probably emerges spontaneously after the actual process of learning begins. We believe that desire is a strong word and the words' interest or curiosity seem to be more appropriate for describing this particular process.

Conclusion

The analysis clearly showed that the curricula were lacking a rich content within the field of transcultural nursing, in order to enable the student in becoming culturally competent. There were also no congruence between educational plans and course plans. Further research could help to clear some questions about the contents of nursing education and what exactly is being taught to students. It would also be valuable to study both the teachers' and the nurses' experiences regarding this important topic.

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Author contributions

Azita Emami and Maria Jirwe were responsible for the study design, the conceptual idea, and the critical revision. Pardis Momeni wrote the paper and was also responsible for the data collection and analysis.

References

1 Duffy EM. A critique of cultural education in nursing. *J Adv Nurs* 2001; 36(4): 487–95.
2 Barbosa DS, Andersson M. *Vetenskap och människosyn i sjukvården: en introduktion till vetenskapsfilosofi och vårdetik (Science and human outlook in health care: an introduction to science philosophy and care ethics)*. 1993, Svenska hälso-och sjukvårdens tjänstemannaförbund, Stockholm.
3 Meleis A. Between two cultures: identity, roles and health. *Health Care Women Int* 1999; 12: 365–77.
4 Murphy K, Clark JM. Nurses' experiences of caring for ethnic-minority clients. *J Adv Nurs* 1993; 18(3): 442–50.
5 Gerrish K. The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *J Adv Nurs* 2001; 33(5): 566–74.
6 Cioffi RN. Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. *Int J Nurs Stud* 2003; 40(3): 299–306.
7 Songur W. *Att åldras I ett främmande land: om mellanöstern pensionärer i det svenska samhället [To age in a foreign country: about retired middle eastern in the Swedish society]*. Rapport nr 15. 1992, Stockholms socialtjänsts Forsknings-och utvecklingsbyrå/Tryckgruppen AB, Stockholm.
8 Emami A, Ekman S-L. Living in foreign country in old age: life in Sweden as experienced by elderly Iranian immigrants. *Health Care Later Life* 1998; 3(3): 183–98.
9 Gerrish K. Researching ethnic diversity in British NHS: methodological and practical concerns. *J Adv Nurs* 2000; 31(4): 918–25.
10 Gelfand D. *Aging and Ethnicity*. 1994, Springer Publishing Co., New York.
11 SCB. *Utbildning och forskning (Education and Research, Online)*. 2006, http://www.scb.se.

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12 Lundgren U. *Att organisera omvärlden; En introduktion till läroplansteori (To Organize the World Around One: An Introduction to Curriculum Plan Theory)*. 1983, Liber, Stockholm.
13 Johansson B. *Från allmänmänsklig kompetens till omvårdnadskompetens. (From General Human Competence to Nursing Competence)*. 1996, Göteborgsuniversitet, Vårdpedagogik-Omvårdnad.
14 Svensk författarsamling. *Utbildnings-och kulturdepartementet (Högskolelag 1993:100) (Education and Cultural Department, Parlament)*. 2004, 289.
15 Svensk författarsamling. *Utbildnings-och kulturdepartementet (Högskolelag 1992:1434) (Education and Cultural Department, Parlament)*. 2005, 1208.
16 SFS. *Förordning om ändring I högskoleförordningen (1993:10). Svensk författningssamling (Regulation of Change in University Law)*. 1995, Liber Allmänna förlaget, Stockholm, 337.
17 Johansson B. *Vårdutbildning: Synpunkter på läroplansarbete. Rapport nr 1993:1 (Nursing Education: Viewpoints on Curricula Work)*. 1993, Göteborgsuniversitet, Vårdpedagogik-Omvårdnad.
18 Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. *J Transcult Nurs* 2002; 13(3): 181–84.
19 Josipovic P. Recommendations for culturally sensitive nursing care. *Int J Nurs Pract* 2000; 6: 146–52.
20 Socialstyrelsen. *Kompetensbeskrivning för legitimerad sjuksköterska (Description of Competency for a Registered Nurse)*. 2005, Stockholm.
21 Appelton VJ, Cowley S. Analysing clinical practice guidlines. A method of documentary analysis. *J Adv Nurs* 1997; 25: 1008–17.
22 Abbot S, Shaw S, Eltson J. Comparative analysis of health policy implementation: the use of documentary analysis. *Policy Stud* 2004; 25(4): 259–266.
23 Murray CD, Sixsmith J. Qualitative health research via the Internet: practical and methodological issues. *Health Informatics J* 2002; 8: 47–53.
24 Gerrish K, McManus M, Ashworth P. *Levels of Achievement: A Review of the Assessment of Practice*. 1997, The English National Board for Nursing, Midwifert and Health Visiting, London, England.
25 Campinha-Bacote J. *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care* (4th edn). Transcultural C.A.R.E Associates, Cincinnati.
26 Marcinkiw LK. A goal for nursing education. *Nurse Edu Today* 2002; 23: 174–82.
27 Fahrenwald N, Boysen R, Fischer C, Maurer R. Developing cultural competence in the baccalaureate nursing student: a population-based project with the Hutterites. *J Transcult Nurs* 2001; 12(1): 48–55.
28 Koskinen L, Tossavainen K. Benefits/problems of enhancing student's intercultural competence. *Br J Nurs* 2003; 12(6): 369–77.
29 Sargent ES, Sedlak CA, Martsolf DS. Cultural competence among nursing students and faculty. *Nurse Educ Today* 2004; 25: 214–21.
30 Cortis JD. Culture, values and racism: application to nursing. *Int Nurs Rev* 2003; 50: 55–64.
31 Galanti GA. *Caring for Patients from Different Cultures: Case Studies from American Hospitals*. 1991, University of Pennsylvania Press, Philadelphia.
32 Lister P. A taxonomy for developing cultural competence. *Nurse Educ Today* 1998; 19: 313–18.
33 Socialstyrelsen. *Invandrarkunskap i högskoleutbildningen*. Rapport nr 1997:1 (*The National Board of Health and Welfare, Immigration Knowledge in University Educations*). 1997.
34 Gerrish K, Papadopoulos I. Transcultural competence: the challenge for nurse education. *Br J Nurs* 1999; 8(21): 1453–57.
35 Ahmad WIU*Making Black People Sick: 'Race' and Health in Contemporary Britain*. 1993, Open University Press, Buckingham, 11–33.
36 Brathwaite AC, Majumdar B. *Evaluation of a Cultural Competence Education Programme*. *J Adv Nurs* 2006; 53(4): 470–79.
37 Pinikahana J, Manias E, Hapell B. Transcultural nursing in Australian nursing curricula. *Nurs Health Sci* 2003; 5: 149–54.

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