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Cultural competence in primary child health care services – interaction between primary child health care nurses, parents of foreign origin and their children

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If one is truly to succeed in leading a person to a specific place, one must first and foremost take care to find him where he is and begin there.

Søren Aabye Kierkegaard (1813–1855).

*With love to my mother Lisen, my father Gunnar
and my sons Hannes and David*

ABSTRACT

Background and aim: Every third child assigned to the Primary Child Health Care services in Stockholm County is of foreign origin. The aim of this thesis was to explore aspects that might risk an optimal and high quality interaction between the nurses and parents of foreign origin and their children in the clinical child health services. An additional aim was to use this knowledge to create a specific training in cultural competence directed to nurses and evaluate the effectiveness of this.

Material and methods: Both quantitative (Study I and IV) and qualitative (Study II and III) research methods were selected. Study I: quantitative data collection among nurses (n=270) through a questionnaire and data analysis using logistic regression. Study II: qualitative data collection among nurses (n=19) through interviews utilising Grounded Theory Methodology (GTM). Study III: qualitative data collection among parents (n=21) through interviews utilising GTM. Study IV: quantitative data collection through questionnaires in pre- and post-study design among the intervention group (n=24) and a control group (n=27) of nurses. Data analysed using the Wilcoxon signed-rank and Wilcoxon rank-sum tests and variance analysis.

Results: The nurses reported insufficient working conditions and cultural competence. They experienced difficulties in their interaction with this group of children and their parents, and the difficulties were particularly associated with long professional experience, full-time work and a high proportion of children of foreign origin. The nurses' main concern turned out to be their anxiety about missing children being exposed to risks of ill-health due to various conditions in their home environments. Unfamiliar and not understandable psychosocial conditions created difficulties for the nurses when trying to assess health risks for the child's health and development. A theoretical model was created that explains the process of assessing risks for the child's health and various elucidating strategies used by the nurses. The parents' main concern turned out to be their feelings of exposure and anxiety about being misjudged as parents due to their origin. Hence they were watchfully checking rapport i.e. if they could perceive sympathy and understanding from the nurses. A theoretical model was created that illustrates the interactive process between parents and nurses and factors determining whether parents believed that rapport was possible to be established. After specific training, the intervention group of nurses rated their cultural competence to be somewhat improved, especially their cultural skills.

Conclusions: Deficient working conditions, lack of cultural competence and experiences of difficulties were found among nurses. Assessing risk factors in a child's home environment seems to be a difficult task for nurses in need of certain competence, skills and elucidating strategies. These strategies could further be developed and frame the nurses' cultural skills when performing their assessment of health risks for the child.

The possibility to establish rapport with the nurse can prevent parents from feeling hesitant and unwilling to bring the child in for check-ups. Thus, it is crucial for nurses to become aware of their own demeanour and way of interacting with parents and children of foreign origin. The concept of establishing rapport frames and elaborates the concerns of cultural encounters and cultural competence in the context of child health services.

Short, specific training programmes in cultural competence are helpful for nurses, who rate them as having an impact on their ability to cope with the demands of working with parents and children of foreign origin. Findings and theoretical models in this thesis are important tools for professional reflection, as a means for teaching cultural competence and as a basis for further exploration and conceptualisation.

Keywords: cultural competence, specific training, primary child health care services, interaction, nurse, parent, child

LIST OF PUBLICATIONS

This thesis is based on the following original articles, which will be referred to in the text by their Roman numbers.

- I Berlin, A., Johansson, S-E., Törnkvist, L.
Working conditions and cultural competence when interacting with children and parents of foreign origin – Primary Child Health Nurses’ opinions.
Scandinavian Journal of Caring Sciences 2006; 20(2): pp 160–168.

- II Berlin, A., Hylander, I., Törnkvist, L.
Primary child health care nurses assessment of health risks in children of foreign origin and their parents – a theoretical model.
Scandinavian Journal of Caring Sciences 2008; 22: 118–127.

- III Berlin, A., Törnkvist, L., Hylander, I.
Watchfully checking rapport with the Primary Child Health Care Nurses – a theoretical model from the perspective of parents of foreign origin.
Submitted.

- IV Berlin, A., Nilsson, G., Törnkvist, L.
Cultural competence among Swedish child health nurses after specific training – a randomized trial.
Submitted.

LIST OF ABBREVIATIONS AND DEFINITIONS

GTM	Grounded Theory Methodology
PCHC	Primary Child Health Care Centre
SC	Stockholm County Council

Definitions used

Primary Child Health Care Services: referred to as PCHCservices in study I, II, PCHCservices in study III, health services in study IV and child health services in this thesis.

Primary Child Health Care Centre: PCHC centre in study I, PCHC in study II and III, health centres in study IV and in this thesis.

Primary Child Health Care nurses: referred to as PCHNurses in study I and II, PCHCnurses in study III and simply as *nurses* in study IV and this thesis.

Child of foreign origin: the child itself and/or one parent were born outside the Nordic countries, i.e. Sweden, Norway, Denmark, Finland and Iceland.

Parents of foreign born: parents born outside the Nordic Countries i.e. Sweden, Norway, Denmark, Finland and Iceland. Referred to simply as parents in study III

CONTENTS

List of publications	7
List of abbreviations and definitions	8
1 INTRODUCTION	11
2 BACKGROUND	12
2.1 Swedish Child Health Services	12
2.1.1 History	12
2.1.2 Guidelines and organisation.....	13
2.1.3 Content	13
2.2 The Primary Child Health Care Nurse.....	16
2.2.1 Competence and obligations	17
2.2.2 Interaction with parents and their children.....	17
2.3 Migration	18
2.3.1 The history of immigration to Sweden.....	19
2.3.2 Today's perspective	19
2.3.3 Consequences of migration.....	19
2.3.4 Living conditions of immigrant families in Sweden.....	20
2.4 Migration from the perspective of child health services in Stockholm County.....	21
2.5 Caring for culturally diverse clients.....	22
2.5.1 Culture	22
2.5.2 Culture in nursing.....	22
2.5.3 Consequences of having different perspectives	23
2.5.4 What can be done?	23
2.6 Cultural competence.....	24
2.7 The cultural competence model	24
2.8 Summary.....	25
3 AIMS.....	26
3.1 General aim.....	26
3.2 Specific aims.....	26
4 MATERIALS AND METHODS.....	27
4.1 Ethical approvals	27
4.2 Overall study design.....	27
4.3 Participants and data collection.....	28
4.3.1 Research setting.....	28
4.3.2 Study I.....	28
4.3.3 Study II and study III	31
4.3.4 Study II	31
4.3.5 Study III.....	32
4.3.6 Study IV.....	34
4.4 Data analysis	35
4.4.1 Study I.....	35
4.4.2 Study II–III.....	35
4.4.3 Study IV.....	37
5 MAIN RESULTS	38
5.1 Study I.....	38

5.1.1 Working conditions.....	38
5.1.2 The nurses' opinions regarding cultural competence	39
5.2 Study II	39
5.3 Study III.....	41
5.4 Study IV.....	43
6 DISCUSSION.....	45
6.1 Main findings	45
6.2 Cultural competence.....	45
6.3 Method.....	50
6.3.1 Strengths and limitations	50
6.4 Clinical implications	51
7 CONCLUSIONS.....	53
8 ACKNOWLEDGEMENTS.....	54
Summary in Swedish / Sammanfattning på svenska.....	56
Bakgrund	56
Målsättning	56
Material och Metod	56
Resultat	56
Slutsatser.....	57
References.....	58
Article I	67
Article II.....	77
Article III	87
Article IV	107

1 INTRODUCTION

In countries with a long history of immigration resulting in a population with culturally diverse backgrounds, such as the United States and the United Kingdom, literature has reported evidence of unequal health care linked to race and ethnicity [1-3]. Moreover, evidence has been found that health care providers have difficulties meeting the needs of an ethnically diverse population [3, 4]. These difficulties have been highlighted for several years and methods for overcoming these problems have been discussed.

Theories and theoretical models on cultural competence mainly originate from the USA, UK, Australia and New Zealand [5].

As a nurse working in Primary Child Health Care services (hereafter referred to as child health services) in one of the immigrant-dense suburbs of Stockholm, I worked with a group of parents from Somalia and their children. During the 1½ years of project work I repeatedly had the opportunity to consider my Swedish culture, values and beliefs as both a private person and a professional child health services nurse. This project work sparked an interest in health, illness and health care systems in other parts of the world. Thus, I attended a master course in international public health and gained new knowledge regarding cultural diversity in health care. My master thesis analysed the child health services guidelines to determine how they directed the nurses when interacting with children and parents of foreign origin. I used the sunrise model by Madeleine Leininger [6] as a theoretical framework. She is known as a pioneer in helping nurses develop an awareness regarding culture and its affects on health care. Conclusions from this analysis were that there was a need to explicate and concretise guidelines if they were to guide the nurses. These insights extended to a curiosity as to how cultural interaction in health care could be explicated, concretised and understood. When looking into nursing literature mainly from the USA and UK, I found that these thoughts had already been considered. Finding Campinha-Bacote's [7] cultural competence model was like putting the process into words. I could understand what was going on inside me. This was the impetus for this thesis since I wanted to know what nursing colleagues experienced, as they are the key people in child health services. I also wanted to contribute knowledge in order to explicate and illuminate the mutual interaction between the nurses and parents of foreign origin. Moreover, the nurses' cultural competence needed improvement in order for them to provide high-quality child health services on equal terms to all parents and children using them.

2 BACKGROUND

2.1 SWEDISH CHILD HEALTH SERVICES

2.1.1 History

Child health services has a long history and tradition in Swedish society. Its roots can be traced back to the 19th century and to the problems Sweden faced during urbanisation, confined living and urban poverty led to a high infant mortality rate.

As a result of this, and inspired by the “Goutte de Lait” in France, medical doctor Gustaf Moritz Blumenthal started Mjölkdroppen (the Milk Drop) in one of the poorest areas in Stockholm, the capital of Sweden. The Milk Drop was a forerunner to Primary Child Health Care Centres (further defined health centres) and aimed to improve the infants’ health by preventing life-threatening diarrhoea and infections. This was achieved by providing medical advice and information to the mothers. Furthermore, infant medical examinations were done on a regular basis and sterilised cow milk was distributed to non-breastfed infants. The Milk Drop spread all over the country and by 1910 there were 25 similar activities financed by contributions from wealthy people and the church. The medical activity was carried out by paediatricians or general practitioners working with a superintendent, in most cases unmarried women with no education or, in best cases, trained nurses. These women’s task was to ensure that mothers complied with health care advice, perform home visits and distribute milk to the infants. In 1921 the Milk Drop activity was prescribed to deal with all infants’ health and mothers in general were requested to contact a Milk Drop centre with their newborn babies [8, 9].

2.1.1.1 From philanthropic to government granted

The years 1930–1940 were a period of transition for the Milk Drop. It changed from a philanthropic activity to a professional one. By 1931 approximately 75% of newborn babies were enrolled in the Milk Drop centre activity. There was much discussion of the negative consequences for the child when parents used old traditions and childcare practices. The importance of medical science was stressed and medical doctors were seen as experts to lean on [9]. Consequently, activities were concentrated on educating mothers and monitoring the health of the children [10].

In 1937 the Swedish Government decided that children’s health should be a societal concern and decided to give government grants to maternal and child health care services. In 1938 it was determined that these health care services should be supervised by the national medical board, include education for the health care providers, and that there should be standard equipment for every health care centre. In addition, the preventive activities at these centres should be free. By 1940 a majority of infants in Sweden’s big cities participated in the preventive health care services, while only one-third of children in the countryside did.

From 1950 to 1960 health care services were further improved with a general vaccination programme and a programme for preventing childhood accidents. Health

guidance became a word of honour with a goal of identifying health risks and detecting unfavourable development in the child [10].

2.1.1.2 Identifications of risk groups

The years 1970–1980 saw child health services focus on identification of health-related and social risk groups [10]. In early 1970 general health check-ups were added for children at age four. This contributed to an extension of professional posts involved in the child health care services: nurses, paediatricians, psychologists and senior physicians. In the 1980s child health services became part of the primary health care system, which became responsible for the medical and administrative management of paediatric care. The National Board of Health and Welfare stressed preventive and health care supervision [11].

Since 1990 the focus has been on the child's ambient environment and the family as a whole, with the primary aim of supporting the parents' competence and self-esteem. As the physical health of Swedish children has improved there has been a gradual shift of focus in the child health services from an overall somatic perspective to a public health and psychosocial perspective [10, 12].

2.1.2 Guidelines and organisation

Child health service activities are regulated by a number of international, national and local conventions, laws, constitutions and guidelines [13], such as the international convention on the rights of the child [14] and national legislation, e.g., the Health and Medical Services Act [15], the Patient Records Act [16] and the Social Services Act [17].

The Department of Child Health Care Services in the Stockholm County Council consists of chief physicians and health care developers with responsibility for the content of and guidelines for health centre activities, quality assurance through further training, supervision, and collecting and processing statistics. Additionally it contributes help and support to the staff at the health centres, superintend and ensures that the convention on the rights of the child [14] are followed, as well as co-operating with the National Department of Child Health Care Services in order to ensure that child health care services are delivered on equal terms [12]

2.1.3 Content

2.1.3.1 Knowledge base and theoretical frame

The child health services knowledge base and theoretical frame are based on paediatric medicine. Social paediatrics is another of the service's main topics, including epidemiology, preventive strategies and specific methods for treatment [11].

Social paediatrics has been defined by Gustafsson [18] as:

Seeing the child as a part of a larger family unit and a larger social context, and observing how children's health and illness depend on environmental factors. (p 242).

Health care work can be divided into three fields: prevention, tracking and treatment. The main focus is on prevention and tracking various diseases and disabilities. Child health care can also treat minor ailments [12].

2.1.3.2 Core programme and overall aim

From the very beginning, child health services has had two main focuses: *primary prevention* with information and vaccinations and *secondary prevention* with regular health check-ups, at certain key ages based on a core programme (Table 1). These health check-ups are mainly based on clinical identifications, and the core programme's framework and content were developed and regulated by the National Board of Health and Welfare [19].

The overall aim of the health services is to promote children's health, security and by:

- giving support and parenting advice
- detecting and preventing physical and mental ill health in children
- paying attention to and preventing risks for children in ambient environment and society
- giving all pre-school children access to and actively offering to register them with child health services [12].

Child health services are still free of charge and even though participation is voluntary almost 100% of the pre-school children and their parents use the services.

By the end of 2008, 158,680 children aged 0–6 years were assigned to one of the 128 health centres in the county with a staff of 449 nurses. At these health centres 646,101 health consultations were performed. Fourteen per cent of these were to see a doctor as the main part of health consultations involve the Primary Child Health Care Nurse [20].

Table 1. Core programme of health check-ups of the pre-school child aged 0–5 years in Primary Child Health Care Services.

The child's age	Health care provider	Information/Health dialogue/Examination/Assessment/Planning/Measure
0–14 days	nurse*	Offer contact with the health centre within one week after discharge from maternity hospital Home visit by nurse within one month after discharge from maternity hospital Information concerning the child's health, pregnancy, delivery, breastfeeding, care, equipment, parent's role, smoking, alcohol, child's safety. Information and offer of participation in a parent group Follow-up on discharge report information from delivery ward Somatic examination of the child Health care planning Risk assessment for Hepatitis B and tuberculosis (TBC)
2–8 weeks	nurse	Visits to the health centre approximately 2–4 times per month Support and assessment of the child's health, growth, breastfeeding/feeding, development, parent–child contact, child's safety
2–5 months	MD** nurse	Assessment of psychosomatic development at 4 weeks of age Addition of AD vitamins Parent groups start (6 times during the child's first year) Somatic examination of the child by an MD at 6–8 weeks of age Visits to the health centre approximately once a month (somatic examination by an MD if needed)
3 months	nurse	Information concerning the child's health, growth, development and mobility, breastfeeding, psychosomatic stimulus, parent–child contact, child's safety.
5 month	nurse	Assessment of the mother's mood according to Edinburgh Postnatal Depression Scale (EPDS) or other evidence based method
6–12 months	nurse	Vaccination I Vaccination II Visits to the health centre approximately every second month Information on the child's health, growth, development, teeth, food and food habits, psychosomatic stimulus, parent–child contact, child's safety, kindergarten/childcare Information regarding dental health
6 months	Dentist or dentist assistant nurse/MD	Addition of AD vitamin Somatic examination of the child Vaccination against TBC if child at risk
8 months	MD nurse/MD nurse	Assessment of psychosomatic development and health Questions concerning life style (smoking, alcohol)
10 months	nurse/MD MD	Assessment of psychosomatic development Somatic examination of the child
12 months	MD nurse	Somatic examination of the child (if not done at 10 months) Visits to the health centre Information concerning the child's health, growth, development, teeth, food and food habits, physical activity, psychosomatic stimulus, parent/child contact, child's safety, kindergarten/childcare Questions concerning life style (smoking, alcohol) Vaccination III

The child's age	Health care provider	Information/Health dialogue/Examination/Assessment/Planning/Measure
18 months	nurse	Visits to the health centre (Somatic examination by a MD if needed) Assessment of psychosomatic development Information concerning the child's health, growth, development, teeth, food and food habits, physical activity, psychosomatic stimulus, TV/media habits, child's safety. Parents role/setting limits Addition of AD vitamin Vaccination
3 years	nurse	Visits to the health centre (Somatic examination by a MD if needed) Information concerning the child's health, growth, development, teeth, food and food habits, physical activity, psychosomatic stimulus, TV/media habits, speech development. Assessment of language development and comprehension Questions concerning life style (smoking, alcohol) Assessment of psychosomatic development if needed
4 years	nurse	Visits to the health centre (Somatic examination by an MD if needed) Information/health dialogue concerning family situation, the child's health, growth, development, motor activity, behaviour, food and food habits, physical activity, questions concerning life style (smoking, alcohol), TV/media habits, child's safety Assessment of psychosomatic development Vision screening Audition test Assessment of language development
5 years	nurse	Visits to the health centre (Somatic examination by an MD if needed) Information/health dialogue concerning: the child's health, growth, development Vision screening Vaccination IV Decision to need for formal assessment before school starts. Cooperation with and epicrisis to the School Health Services

* nurse = Primary Child Health Care nurse

** MD = general practitioner and/or paediatrician

2.2 THE PRIMARY CHILD HEALTH CARE NURSE

The clinical part of child health services in Sweden is carried out at the health centres, where Primary Child Health Care nurses (hereafter referred to as nurses) are the key providers [12]. The nurses' clinical work at the child health services in Stockholm County is regulated by international and national laws, constitutions and guidelines as well as by local guidelines for the Stockholm County Council [13] such as: *Regelbok för barnavårdscentraler/BVC* [Rule Book for Child Health Centres] and *The Method Book*. The Department of Child Health Services, which is responsible for developing a plan of operations for the county's health centres, has set down its rules and methods in *The Method Book*. This is a frequently used reference and help list for the nurses and is easily accessible on a website [12]. A full-time nurse (working 40 hours a week) sees approximately 60 newborn babies a year. The number of children per nurse is reduced

in areas with a heavy workload, such as areas with a high percentage of children of foreign origin, first-time-parents, single parents, high rates of unemployment, and low degree of education among parents [12].

2.2.1 Competence and obligations

The nursing task in the child health services requires specialist competence in paediatric and/or district nursing. Moreover, the nurses should have training in health and illness in children and adolescents and social medicine with the aim of observing and assessing the families' overall living conditions. Further education is important for nurses in order to guarantee high quality. Furthermore, supervision on a regular basis is required when new tasks or methods are implemented. These nurses work from a health educational, psychosocial and overall perspective based on the families' needs [12, 13].

The nurses have a medical responsibility for caring efforts and are professionally independent regarding the majority of child-health activities, e.g., preventive health care, such as health education, psychosocial support and advice, vaccinations and health surveillance [12, 19, 21-25]. According to the core programme they assess children's motor and linguistic development and their physical, mental and psychosocial health (including the family's social situation), and then decide what kind of intervention or individual support a child and family may need for optimal health development. The nurses generally encounter the children and their parents at the health centre, although home visits are pointed out as a quality indicator in the first contact between the nurse and parent [19, 25]. It is mandatory for the nurses to report to the social service authorities if they have doubts about unfavourable conditions in which a child may need protection [26].

The nurses cooperate with general practitioners and paediatricians, who come on a regular basis to give the children medical check-ups. Other professions include dentists/dental assistants (informing parents about dental care) and speech therapists attending team conferences at the health centre as consultants. Each health centre has access to a psychologist, who provides supervision and consultation to nurses in psychological matters regarding the child and its family. The nurses are instructed to cooperate with, e.g., the maternal health care services, social authorities, kindergarten and pre-school [12, 26]. The core programme provides repeated opportunities for the nurses to interact and build a relationship with the child and its parents (Table 1), especially during the child's first year [12, 25].

2.2.2 Interaction with parents and their children

The word interaction can be defined as the action and influence people have on each other (Chambers reference on line). In the clinical work at the health centre the interaction among nurse, parent and child is substantial and regarded as a key element of child health care [24]. The contextual arena in which the interaction among the nurse, parents and child takes place is mainly framed by the content of the core programme aiming to provide health care surveillance and health information [12, 21, 24, 27].

Health care surveillance is rooted in the paradigm of surveillance medicine and deals with the problematisation of normal variation within a population, especially in relation to the development of children [28, 29]. Foucault [30] states that the provision

of information about health care is based on expertise, professionalism and power. From this perspective, nurses in the child health services can be regarded as experts with a power position in relation to the parents [24]. Beattie [31] states that health information can be provided in an authoritative way, telling the client what to do or what to change, or in a negotiating, patient-centred or empowering way, where the client is involved in the decision with the goal of empowering the client to make his/her own decisions.

In child health services, the nurses cooperate with and work through the parents to promote the child's physical, mental and psychosocial health. The exchange of ideas and information is an important tool, in which non-verbal communication has been shown to be a significant feature of the interaction [24].

The guidelines exhort the nurses to see the parents as experts on their own children, because they are the first people who can detect changes in the child's health. Moreover, they should base their interaction on the needs of the child and parents, and actively support and strengthen parents' beliefs in their own competence and problem-solving capacity [12].

Previous studies on the interaction between nurses and Swedish parents in child health services have found that the parents in general are satisfied, especially with home visits, accessibility, friendly treatment [21] and receiving valuable support in troublesome situations [27]. A two-way perspective was investigated, in which the parents' expectations were compared to what nurses thought parents expected from them, revealing similarities in how both parties viewed the mutual interaction. The authors discuss these findings as the result of the deeply rooted Swedish tradition of visiting the child health services as a first-time mother [27].

Nevertheless, problematic interactions have also been found. First-time mothers with low socioeconomic status have been identified as a less-satisfied group of parents [21]. In addition, some mothers went to the health centre expecting support but instead felt they were treated insultingly. Nurses were found to have difficulties dealing with the problems of motherhood and hidden social problems that affected their interaction [27].

Baggens [24] studied the communication between nurses and families during visits to the health centres and home visits. The results revealed that the nurses took the initiative as to what topics to discuss, often with reference to the core programme (Table 1). Moreover, nurses did not work with empowerment because they took the expert role and offered standard solutions, seldom asking for the parents' viewpoints or encouraging parents to find their own solutions.

2.3 MIGRATION

The word migration means the movement of people, leaving one place and settling in another, especially another country. The concept includes both emigration and immigration [32].

2.3.1 The history of immigration to Sweden

International migration has changed Sweden from an emigrant country in the 19th century to an immigrant country. A historical overview of immigration to Sweden can be divided into four phases:

First phase, 1939–49: As a consequence of World War II, refugees came from Sweden's neighbouring countries, the Baltic States and Eastern Europe countries.

Second phase, 1948–1972: Labour migrants came from Finland and Southern Europe to work in Swedish industry.

Third phase, 1950–1989: Conflicts and political persecution contributed to migrants from Eastern Europe, South America, Middle East, Africa and Asia.

Fourth phase, 1990 to today: Migrants from the Baltic States, the Middle East and Africa. The most common reasons for coming to Sweden have been war, politics and family [33, 34].

2.3.2 Today's perspective

The migrants have a global character with a spectrum of different cultures, languages and social origins. The Swedish national statistics use different classifications of migrants, such as country of birth, foreign-born, country of citizenship, foreign citizenship [34]. According to these reports, Swedish society today has more than one million foreign-born inhabitants [35, 36] originating from about 209 different countries: 19% from the Nordic countries, 34% from Europe and 47% from non-European countries [33]. These individuals constitute approximately 14% of the total population, and another 10% of the total population is second generation, i.e., born in Sweden with at least one foreign-born parent [35, 36].

In 2009, 101,230 new inhabitants were granted residence permits on various grounds (e.g., family ties 29%, refugees 13%) and 24,194 new people came to Sweden seeking asylum with a majority from Somalia [32]. In Stockholm, the capital of Sweden, immigrants make up about 20% of the total population [35, 36].

2.3.3 Consequences of migration

When people migrate it does not only mean that they are crossing a border, it also means that a life process is starting that affects all aspects of the migrant's existence: non-migrants, communities in both the sending and the receiving countries and the second generation.

Migration as a process can be viewed as an open journey where aspects like the thoughts, plans and cultural identity of an individual transform as a result of influences from the new environment [37]. Immigrants enter the new country and its environment with the richness of their own cultural identities intact. This will affect how they learn, relate to and adapt to the new culture [38].

Acculturation refers to the complex process that occurs when an individual is required to adjust his/her own cultural identity and adapt to the cultural views, traditions, customs and language of the majority society. In this process a new way of culture is being created; old ways do not work and new ones are not yet clear [38]. This may lead to feelings of confusion and disorientation and, in severe cases, to acculturation stress [39]. Caplan [40] states that this type of stress and its mechanisms

are not fully understood, but that it seems to affect both the physical and mental health of immigrants even though little information is available regarding how it is manifested in health outcomes.

2.3.3.1 The family

Earlier studies have shown that migration influences families' health, i.e., family wellness and family function with a weakened parent role [41]. Many immigrant families are exposed to heavy psychosocial stress related to experiences in their home country (war and persecution), migration [42-47] and segregation in the new country [46]. Literature points out some acculturation difficulties for immigrant families, such as coping with differences if coming from an agrarian life to an urban life in the new country, separation from the extended family and becoming isolated in order to cope with all new elements in the new country [48].

Morrison & James [49] talk about immigration and acculturation acting as stressors on the family unit and describe this as a process of change in family relationships. These changes include loss of self-image in parents, bringing out a threat of incompetence, isolation and annihilation [50] changed role function especially of the male [51] and an increased risk for divorce [52]. Moreover, children tend to adopt characteristics of the new country, e.g., language and values, more rapidly than their parents, leading to parents and children being in different processes. These factors are known to have a negative effect on the health and well-being on the whole family [42, 48].

2.3.3.2 The child

Worldwide, the negative consequences of migration on the child's health have been emphasised for many years. As stated by Schor [53] the child's health is influenced by such factors as the parent's physical, emotional and social health, social circumstances, and child rearing practices. Moreover, children's problems are linked to their parents [54, 55].

In a study from the Netherlands, Reijneveld et al. [56] found that immigrant parents more frequently reported problems in their children and the authors concluded that psychosocial problems occur more frequently among certain immigrant groups, especially children whose families migrated for economic reasons. Hjern et al. [44] reported that the first 18 months of exile are a risk factor for poor mental health in refugee children and presumed to be linked to stress within the family. A public health survey in the USA [57, 58] reported that children of immigrant families lived in overcrowded housing and in households with lower annual income than non-immigrant families. Moreover, these children were twice as likely as other children to be in "fair" or "poor" health. Cederblad et al. [59] found it to be a risk factor for the child's psychosocial health if both parents were refugees from a non-European war zone.

When it comes to physical health, studies have revealed that immigrant children generally have poor physical health as well as poor dental health with an increased risk for dental caries [43-45, 47].

2.3.4 Living conditions of immigrant families in Sweden

Segregation of foreign-born families has been highlighted by Swedish authorities [60] and the daily press have discussed the consequences of segregation, i.e.,

unemployment, grant dependence, poverty and the negative effect they have on children [61, 62].

It is also well-known in Sweden that many families visiting child health services are exposed to psychosocial burden [42-45, 47].

2.4 MIGRATION FROM THE PERSPECTIVE OF CHILD HEALTH SERVICES IN STOCKHOLM COUNTY

All parents and their pre-school children, including asylum-seeking and refugee families, are invited to child health services. Today one-third of children assigned to the services are of foreign origin, i.e., the child or at least one parent was born outside the Nordic countries (Sweden, Norway, Denmark, Finland and Iceland). Within the county this group of children varies from 8.7 to 93.4 per cent per municipality [20].

The nurses' Method Book has a main chapter named *Foreign origin* giving guidance to the nurses in the following areas:

Different definitions are used by Swedish authorities regarding refugee and immigrant families, the asylum-seeking process and the child's right to Swedish health care. This includes information regarding general health care surveillance of adoptive children; asylum-seeking and/or recently migrated children; the basic health care programme at the health centre, which stresses the need to consider the somatic health status of the whole family; psychosocial support and/or a preventive health care plan. The guidelines emphasise that the immigrant families' social and educational backgrounds vary and the medical world view might differ from that of the nurses, thus contributing to difficulties and misunderstandings. Hence, this demands flexibility and sensitivity to the families' specific needs and wishes to effectively avoid uncertainty and misunderstandings. It also emphasises the importance of a mutual dialogue. Furthermore, the importance of getting support and help to cope with strong feelings through teamwork and supervision is mentioned [12].

Olin Lauritzen [63] studied encounters between immigrant families and nurses in the maternal and child health services and described the core programme as structurally ethnocentric. Furthermore, she states that the programme contributes to a social frame and routine, with a repeated structure in a given order and pattern with different sequences: collection and assessment of information, followed by counselling and interventions. According to the investigator, this was a hidden agenda not visible to the immigrant families. Topics such as family relations, child rearing practices, health risks and precautions were not as routinely discussed as health information framed by the core programme. In the light of this, the core programme seems to cause interactional dilemmas and tension between the preventive health care routines and the relation between nurses and parents. Finally, Olin Lauritzen [63] discusses how the Swedish child health services' health surveillance, health information and counselling to parents are affected by cultural ideas about normal childhood and development.

Other authors have considered multicultural concerns regarding the Swedish child health services: Hjern [45, 46] raised questions as to whether parents of foreign origin might consider the preventive and public health teaching activities as unfamiliar and alien. This group of parents has been found to be non-compliant with, for example, precautions given at the child health services [64]. Additionally, Lagerberg et al. [65]

have reported that parents of foreign origin fail to come to the various check-ups to a greater extent than Swedish families.

2.5 CARING FOR CULTURALLY DIVERSE CLIENTS

In the United States, caring for people from diverse cultures has been in focus since the early 1950s, starting with nurse and anthropologist Madeleine Leininger [6].

The need for transcultural nursing began as a result of immigration and the challenges and difficulties nurses faced when caring for clients with culturally diverse backgrounds [66]. Applying an anthropological, and thereby a cultural, perspective to nursing theories allows us to reflect on the similarities and differences in caring within one culture and between clients from different cultural backgrounds [66].

2.5.1 Culture

Historically the concept of culture has numerous different meanings and definitions. One such definition is a set of guidelines in a society that symbolise lifestyle, behaviour, specific traditions, norms and values. These include attitudes, beliefs and ideology [6, 67-69]. The culture concept has been problematised as contributing to stigmatising [70] and maintaining differences [68].

Dunn [38] claims that culture can be described as dynamic, shared, symbolic, learned and integrated.

Culture is dynamic: culture is nothing that is at once fixed and stated. It is constantly created, produced, changing, evolving, and functioning in human interaction and in relation to an individual's psychological, physical and social environment. Thus, individuals constantly learn new ways of being, thinking and acting. With this in mind it is impossible to make generalisations applying characteristics to all members of a group. To do so would be to stereotype individuals (p 106).

Culture is shared: within a cultural context, values and beliefs are shared, identified and articulated. Individuals are said to agree on what is normal, right, appropriate, wrong, or incorrect, and expected behaviours and roles among individuals emerge.

Culture is symbolic: Language, nonverbal gestures, music and dress are examples of symbols within a culture. These are observable symbols and are what individuals in interaction initially identify as culturally common or different.

Culture is learned: members of a culture learn what the rules are through interaction with their environment. This learning is influenced by the individual's developmental stage, abilities and temperament.

Culture is integrated: learning about one's culture takes place within a multidimensional context – families, schools, friendships and occupations – that makes culture an integrated entity and includes an individual's total life span. Within this span there are different arenas that may expect different behaviours, e.g., language used at home differs from what is used in the occupational context.

2.5.2 Culture in nursing

The medical profession can be seen as a sub-culture with its own particular world view, explanations, beliefs and values [69]. Nursing care is said to be dominated by the

western value system [2, 3, 71] as regards concepts such as normal versus abnormal, health versus disease [29] based on scientific rationality [69]. The nursing culture has its own features, which are exemplified by a specific language, values, rules, rituals and clothing [72]. Consequently, this could widely differ from and sometimes also be controversial in the client's culture, religion, beliefs, values, and language [2, 3, 69, 71].

2.5.3 Consequences of having different perspectives

When nurses lack the understanding that culture affects care and fail to recognise significant cultural differences between themselves and the client, there is a risk of an ethnocentric practice [3]. This phenomenon is also called medicocentrism, a bias caused by viewing health through the lens of medicine or a biomedically-oriented perspective [73, 74]. Consequently, this contributes to misunderstandings and inadequate care [75, 76]. Thus, there could be a double bias with a general cultural ethnocentrism and a medicocentrism. This might be a reason why international studies over several years reported problematic situations between health care providers and clients with different cultures, such as noncompliance [77], refusal of medical treatment [78], language barriers and misunderstandings [79-81].

These circumstances may result in a risk of undermining and avoidance behaviour among health care providers in care services, greater risk for failure and nursing turnover [82], inadequate care delivery [81], misdiagnoses and complications [83], poor health outcomes [84] or health status [38], low satisfaction among clients [81] and lack of equality in care [85].

When it comes to parents and their children interacting with health care providers, the following negative consequences have been reported: language barriers leading to increased diagnostic testing and long stays for the parents and child at health care clinics [86] correlated with increased costs and misuse of health care resources [87], parents being negligent in seeking help for their children when experiencing a lack of understanding of their culture [88], not discussing home remedies due to fear of offending the health care provider and hesitancy to ask questions [89], withholding information, non-adherence to recommended treatments, missed follow-up appointments and dissatisfaction with the health care provided to the child [90].

2.5.4 What can be done?

As a result of these reports, attention has been given to health care services, stressing that health care requires cultural humility [91] and should be culturally relevant [82], culturally responsive [7] and culturally sensitive and appropriate [92]. These concepts have gradually been replaced by the concept of cultural competence, which is argued to subsume the competence of humility and sensitivity [38].

It has been argued that this competence is one way to reduce some of the difficulties stressed in literature when providing health care to a culturally diverse population [93, 94].

2.6 CULTURAL COMPETENCE

Cultural competence seems to have a broader definition than just having competence about different cultures. It includes a fundamental change of an individual's thinking, understanding and interacting with the world around them [38]. It requires a deep and conscious understanding of personal values, an empathy for and curiosity about others and a willingness to ask questions to gain a better understanding [95]. The importance of cultural competence for health care providers has been stressed to develop a trusting relationship, since the clients will feel more valued and better understood and will have an increased willingness to carry out the health plan [93, 94].

Literature on cultural competence and its theoretical framework has been developed primarily in North America, Europe and Oceania. Over the years several definitions were found in the literature. The core components of these frameworks have four general main themes: "an awareness of diversity among human beings; an ability to care for all individuals; non-judgemental openness for individuals and enhancing cultural competence as a long-term continuous process" [5]. In this thesis the cultural competence model of care developed by psychiatric nurse Campinha-Bacote [7] from the USA was chosen to illustrate the process of culture competence. It was chosen because it is known to provide guidance when teaching and implementing cultural competence [94]. In addition, the model comprises both a theoretical perspective and guidance on how to apply awareness and knowledge in clinical practice.

2.7 THE CULTURAL COMPETENCE MODEL

According to Campinha-Bacote [7], "there is a direct relation between the level of competence of health care providers and their ability to provide culturally responsive health care services" (p.181). Campinha-Bacote stresses that cultural competence is an individual process in which health care providers continually "strive to achieve the ability and availability to work effectively within the cultural context of a client" (p. 181). To become culturally competent, the individual has to proceed through a process of five different constructs or levels: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.

Cultural awareness is the process whereby a provider starts to examine his or her own biases and tries to explore his or her culture and professional background. The cultural competence process starts at the cultural awareness level but to become culturally competent the provider has to "move beyond" this level and continue the process to its end. The second level, cultural knowledge, is the process in which a provider obtains knowledge of different cultures and ethnic groups – their worldview, traditions, religion and differences in health-seeking behaviour. The third level, cultural skill, is the ability to conduct cultural assessment, i.e., collect relevant data about the client's present problem as well as making a physical assessment. The fourth level, cultural encounter, is the process in which a provider directly "engages in face-to-face cultural interactions" with clients from different cultural backgrounds in an attempt to modify existing beliefs or to prevent possible stereotyping of these individuals. Finally, the fifth construct, cultural desire, means the provider's motivation and willingness to go into the process of becoming culturally aware, knowledgeable, skilful and wanting to seek cultural encounters has been stimulated.

Educational intervention is one way for health care providers to start the journey towards cultural competence. Most training programmes in cultural competence have mainly been arranged in the USA, UK and Europe [96]. Varying curricular content and teaching strategies have been used and it has been concluded that cultural competence training improves knowledge, attitudes and skills among health care providers [97].

2.8 SUMMARY

With a long tradition in Swedish society, child health services were developed over a long period of time in a country characterised by ethnic homogeneity. In recent years the Swedish population has grown increasingly diverse, posing new challenges to child health services. The core programme for child health services has been described as structurally ethnocentric and questions have also been raised about whether parents of foreign origin might consider the preventive and public health teaching activities unfamiliar and alien. This group of parents has been found to be a non-compliant group, cautious about child health services and having a higher degree of failure to come to appointments.

All parents and their pre-school children, including asylum-seeking families, are invited to take advantage of the services. Today every third child assigned to child health services in Stockholm County is of foreign origin. Hence, the interaction between the nurses and this group of children and their parents seems to be an everyday event. These parents come from a variety of countries, speak a multitude of languages, and bring a host of cultural traditions and child rearing practices to their new homeland, Sweden. They may also carry a psychosocial burden. Consequently, the nurses must be skilful in interacting with parents from diverse cultures and with different types of problems and burdens. Additionally, they have a responsibility to provide quality health care on equal terms to all children and parents, including those of foreign origin. Little is known of the nurses' opinions of their abilities when responding to the demographic changes and their effects on the clinical work in child health services. It is also important to study how parents view the nurses working in child health services.

3 AIMS

3.1 GENERAL AIM

The general aim of this thesis was to explore aspects that might risk an optimal and high quality interaction between the nurses and parents of foreign origin and their children in the clinical child health services. An additional aim was to use this knowledge to create a specific training in cultural competence directed to nurses and evaluate the effectiveness of this.

3.2 SPECIFIC AIMS

To investigate the nurses' working conditions and cultural competence when interacting with children and parents of foreign origin (study I).

To theoretically explain the nurses' core problem regarding their interaction with children and parents of foreign origin (study II).

To construct a theoretical model that could explain and promote further understanding of the variety of experiences of parents of foreign origin regarding their interaction with the nurses in the child health services (study III).

To evaluate the extent to which specific training effected how nurses rate their own cultural competence, difficulties and concerns, and to study how the nurses evaluate the training (study IV).

4 MATERIALS AND METHODS

4.1 ETHICAL APPROVALS

In compliance with the Helsinki Declaration, ethical approvals for the four studies included in this thesis were obtained from the Ethical Committee at Huddinge University Hospital, Karolinska Institute, Sweden: (registration number 373/02, Study I; registration number 418/03, Study II–III; registration number 2008/1743–31/2, Study IV).

For study I, written informed consent was obtained from the heads of the nurses; the nurses themselves were given written information. In studies II–III, verbal informed consent was obtained from the participants. In study IV, verbal informed consent was obtained before the intervention started. Participation was voluntary. Nurses and parents included in the studies were informed that they had the option to terminate participation at any time. When postal questionnaires were used (study I and study IV), a form was attached to the questionnaire giving information about the purpose of the study, confidentiality and voluntary, anonymous participation. The questionnaires were returned in closed envelopes directly to a secretary who had no connection to the project. The list of names of all participants, including codes, was kept by a secretary who had no connection to the project.

4.2 OVERALL STUDY DESIGN

The thesis includes four studies carried out between November 2002 and March 2009 (Table 2). To supplement and validate the findings, both quantitative and qualitative research methods were selected for the problems under study. Study I was a survey and a prelude to the three following studies. A quantitative and deductive approach was used to illustrate the problem under study with numerical data, tables and scales. The quantitative results from study I needed to be understood in-depth, which required the use of qualitative interviews in study II. In study III qualitative interviews were conducted with parents of foreign origin; a variety of parents from different cultures and nationalities participated. The first three studies describe the exploration of aspects that might put an optimal and high-quality interaction at risk from two perspectives, from the nurses (studies I–II) and from parents of foreign origin attending the child health services with their child/children (study III). Study IV describes an intervention of specific training in cultural competence based on Campinha-Bacote's [7] definition and cultural competence model and study specific knowledge derived from findings in studies I–III.

Table 2. Overview of the general design and studies included in the thesis.

Studies	Design	Data collection	Analysis	Participants	What was studied?
I	Quantitative	Questionnaire	Logistic Regression Thematic-content analysis	270 nurses	Working conditions, experiences and cultural competence
II	Qualitative	Interviews Validating interviews	Grounded Theory Methodology (GTM)	15 nurses 8 (4* nurses) Total study sample: 19	Main concern, core of problems
III	Qualitative	Interviews Validating interviews	GTM	11 parents 10** parents Total study sample: 21	Main concern, Experiences
IV	Intervention – Randomised Control Trial (RCT)	Questionnaire pre- and post-training	Wilcoxon signed-rank test Wilcoxon rank-sum test Variance analysis (ANOVA)	Intervention group (IG): 24 nurses Control group (CG): 27 nurses Total study sample: 51	Effects of specific training in culture competence

* four new nurses who only participated in validating interviews, along with four of those nurses who were previously interviewed in-depth.

**ten new parents that participated in validating interviews

4.3 PARTICIPANTS AND DATA COLLECTION

4.3.1 Research setting

The material in studies I–III was gathered from child health services and the health centres in Stockholm County, i.e., among nurses (studies I–II) and foreign-born parents attending child health services with their children (study III). In addition, in study IV among child health services nurses in both Stockholm and Sörmland Counties.

4.3.2 Study I

This study aimed to investigate the nurses' working conditions and cultural competence when interacting with children and parents of foreign origin. For this purpose a quantitative approach was used. In November 2002, child health services in Stockholm County had 430 employed nurses. A decision was made to include all these nurses in the study. The decision was based on the fact that the children of foreign origin assigned to the services differed widely from municipality to municipality, and even

among health centres within the municipalities. Hence, it was difficult to make a relevant selection of participants. Table 3 illustrates a number of factors that affected the final number of participating nurses.

Table 3. Participants – the study group of nurses in study I.

	Number of nurses
Full-time post, part-time post	430
Excluded nurses due to:	
– head declined participation	– 30
– head did not send in written consent	– 13
Questionnaire sent to remaining study group	387
Vacant post	– 13
On long-term sick-leave	– 1
Empty questionnaire sent in with annotations:	– 13
– too busy (4)	
– no interest in participating (5)	
– newly employed in child health services (3)	
– lack experiences interacting with children and parents of foreign origin (1)	
Non-respondents, i.e., no questionnaire was sent in	– 90
Participants – final study group	270

4.3.2.1 Instrument

No suitable questionnaire could be found for the intended survey in study I, so there was a need to design a study-specific one based on results from previous studies regarding health care providers' experiences with caring for culturally diverse clients [80, 98-101] and the author's knowledge and experiences. The study-specific questionnaire was sent to an expert at Statistics Sweden who assessed the questionnaire's answering scales and measurability. The Department of child health services constituted an expert panel and pilot tested, assessed and considered the content, the intelligibility, and the relevance of each question in the questionnaire.

After modifications, the final questionnaire consisted of 30 questions, shown in table 4. Twenty-six questions were included in study I, and described four main areas:

1. The nurses' backgrounds and formal competence (12 questions).
2. The nurses' working conditions (7 questions)
3. The nurses' opinions on cultural competence (4 questions).
4. The nurses' overall opinions in open-ended questions (2 questions).

The following definition of cultural competence was provided in the questionnaire: Cultural competence refers here to knowledge of other cultures acquired through training or professional experience.

4.3.2.2 Data collection

Data were collected among child health services nurses using the study-specific questionnaire. The optimal time for sending out the questionnaire was discussed with the expert panel – the Department of Child Health Services. We decided to send out the questionnaire in mid-November. This decision was based on the knowledge that the nurses would be engaged in putting together the annual statistical report from mid-December through the end of February. Mailing of the questionnaires was preceded by an article published in the local papers by the Department of Child Health Services in Stockholm County Council. That article was intended to prepare and inform the nurses on the coming study and its purpose. The questionnaires were sent by post to the nurses' workplaces. A written reminder was sent to a maximum of two to those nurses who did not reply by the specified date.

Table 4. Summary of time of data collection, participants, data sources in study I.

Data collection	November 2002–February 2003
Participants	270 nurses (response rate 70%)
Data source	Study-specific questionnaire Total number: 30 questions
Data source regarding:	
<i>Background and formal competence</i>	15 questions
workplace	1 (question no. 1*)
sex	1 (question 27*)
year of birth	1 (question no. 28)
country of origin (if other than Sweden)	1 (question no. 29)
year of arrival in Sweden	1 (question no. 30*)
professional experience with child health services	2 (question no. 7–8)
formal and higher education	5 (question no. 2–6)
formal training in cultural competence	3 (question no. 9–11)
<i>Working conditions</i>	7 questions
proportion of children of foreign origin	1 (question no. 12)
available guidelines	1 (question no. 13)
available support and help	1 (question no. 14)
satisfaction with the quality of health care work	1 (question no. 17)
difficulties experienced	3 (question no. 18, 19, 20)
<i>Opinions regarding cultural competence</i>	5 questions
their own theoretical competence	1 (question no. 15)
their own competence according to clinical experiences	1 (question no. 16)
whether training might result in fewer difficulties	1 (question no. 21)
whether training might result in improvements in health care work	1 (question no. 22)
whether available training exists	1 (question no. 23*)
<i>Overall opinions and open-ended questions</i>	3 questions
suggestions on improvements	2 (question no. 24, 25)
general viewpoints	1 (question no. 26)

* topics not described in article I

4.3.3 Study II and study III

Study II attempted to explore the core problem and theoretically explain the variances in the nurses' experiences and in their interactions with parents of foreign origin. Study III attempted to explore the experience of parents of foreign origin regarding their interaction with child health services nurses. For these purposes a qualitative approach was selected and data collection was based on qualitative interviews.

4.3.3.1 Grounded theory methodology

Considering the aim to theoretically explain the mutual interaction, Grounded Theory Methodology (GTM) was considered to be the most appropriate, since it focuses on interactions and social events [102]. The selection of methodology was also based on the fact that there was a shortage of studies exploring the mutual interaction between child health services nurses and parents of foreign origin. Furthermore, a theory or a theoretical model was deemed to be useful during the specific cultural competence training for reflection on clinical practice.

The central processes of GTM were used when collecting and analysing data; i.e., theoretical sampling and the constant comparative method. Data were jointly collected, transcribed, coded and analysed [103]. Charmaz [104] explained the theoretical sampling as aiming to fill the gaps in data and holes in a theory. Therefore, after each interview a decision was made on what type of data to collect next and where to find the data needed to generate theory as it emerged. Hence, sampling in studies II–III was refined from open, to strategic, to variation, and finally to selective sampling [105, 106].

4.3.3.2 Data sources

The main data sources in studies II and III were transcriptions from the face-to-face explorative interviews. The purpose of the in-depth and exploring interviews was to try to get the nurses and parents to talk as openly and freely as possible about the topic under study to gain insights into their thoughts, feelings and experiences. Therefore, the in-depth interviewer avoided leading questions. The interviews were tape recorded to make it possible, if necessary, to analyse and expand the interviews with information about attitudinal and perceptual expressions. This type of data collection was considered to broaden and deepen the understanding of the research topic [107]. Another important data source was memos containing observations and reflections, written down directly after each interview. This was done in order to remain open-minded about the researchers' interviewing style, role and behaviour in the research process [108].

4.3.4 Study II

Nineteen nurses were included, all of whom had participated in study I: 15 were interviewed in depth. Of these, four were selected along with four new nurses to give validating interviews. The 15 nurses were selected for a variety of characteristics from the data set in study I (Table 5).

Table 5. Description of data collection, data source, participant characteristics in Study II.

Data collection	February to May 2004
	Validating interviewing 2006
Data source	Face to face interviews.
	Transcriptions and memos
	Validating interviews
Participants	15+4*
	Total study sample: 19 nurses
Characteristics of nurses being interviewed in-depth	
country of origin	Sweden, Nordic countries, outside Nordic countries
the proportion of children of foreign origin	
<25	5 nurses
25–<50	1 nurse
50–100	9 nurses

*new nurses who only participated in validating interviews along with four of those nurses earlier interviewed in-depth.

4.3.4.1 Interviews

The individual face-to-face exploratory interviews were conducted in the nurses' own workplace, chosen by the nurses themselves to avoid losing too many work hours. The interviews lasted 40–95 minutes and were tape-recorded with the nurses' permission.

The first sample of five nurses was selected to ensure breadth in data in relation to age, country of origin, professional experience and number of children of foreign origin within the nurses' area of responsibility. Subsequent sampling was determined by the emerging conceptual framework, which resulted in a focus on areas with a large proportion of children of foreign origin.

4.3.4.2 Question guide

A semi-structured interview guide was devised based on findings in study I that included a list of the following broad themes: scenarios (episodes/incidents) of interactions, feelings and thoughts in these situations, actions taken in different situations, how the nurses resolved difficulties that arose and what the nurses considered to be important factors in the interaction. At the end of each interview a summary was done and the nurses verified or added more information. Directly after each interview memos were written and shortly afterwards the entire interview was transcribed verbatim. The interview guide with themes was gradually developed as new themes and information emerged from the former interviews. For example, after the tenth interview the themes *unclear* and *anxiety* appeared and the following interviews focused on what strategies nurses used in these situations. Thus the analysis and interviews were based on the principles of the constant comparative method.

4.3.5 Study III

Twenty-one foreign born parents were included; 11 were interviewed in-depth and 10 new parents participated in validating interviews.

Before sampling these participants, two parents (of foreign origin) gave pilot interviews. They were also asked to provide views on interview questions, selection procedure and how oral information should be given to prospective participants. Their advice was to be honest about the fact that previous studies (study I and II) had revealed that nurses experience difficulties in their interaction with this group of children and their parents and that the aim now was to get the parents' viewpoints. After these discussions, parents were selected through visits to six different health centres. On seven occasions the lead author spent time in waiting rooms talking to parents. Parents were given written and oral information about the aim of the study. The parents decided themselves whether they wanted to be interviewed and where.

Table 6. Description of data collection, data source, participant characteristics in Study III.

Data collection	June 2006–March 2007
Data source	Validating interviewing July 2008. Face to face interviews. Transcriptions and memos Validating interviews
Participants	11+10* parents of foreign origin Total study sample: 21 parents of foreign origin
Characteristics of parents being interviewed	
Parents	9 mothers, 2 fathers
Country of origin	
Africa	4 parents
Middle East	4 parents
Southern Europe	3 parents
Number of years in Sweden (range)	3–22
Number of children per parent (range)	1–5
Ages of children (range)	3 weeks–8 years
Place for interview	
<i>The health centre</i>	3 parents
<i>Parents' home</i>	7 parents
<i>Other place</i>	1 parent

* participated in validating interviews

4.3.5.1 Interviews

The majority of the individual, face-to-face, exploratory interviews were conducted in the parents' homes (Table 6). Interviews ranged in length from 30 to 65 minutes and were tape recorded with the parents' permission. One parent needed an interpreter because of poor Swedish. To ensure breadth in data collection, parents were selected from a variety of characteristics as shown in table 6.

4.3.5.2 Interview guide

A semi-structured interview guide was devised and initially included a list of the following broad themes: scenarios (episodes/incidents) of interactions, actions taken/feelings/thoughts in different situations, how the parents handled/felt/thought in

different episodes/incidents and what the parents considered to be important factors in the interaction.

At the end of each interview a summary was done and parents verified or added more information. Memos were written directly after each interview as a basis for decisions concerning areas to cover in further interviews, including specific questions. The interview guide with themes was gradually developed and questions became increasingly focused as new themes and information emerged from the previous interviews. For example, after the seventh interview the themes *accepted*, *questioned* and *exposure* appeared and the following interviews focused on what/how the parents handled/felt/thought in different situations. Thus the interviewing and analysis were based on the principles of the constant comparative method.

4.3.6 Study IV

This study aimed to evaluate the extent to which specific training affected how nurses rated their own cultural competence and experiences of difficulties and concerns, and to study how the nurses evaluated the training. Before planning the training, the researchers contacted the expert panel from Department of Child Health Services for advice on the suitable point in time for the intervention and strategies regarding information to the responsible heads of department.

The intervention of specific training in cultural competence was conducted as a randomised control trial. Study participants comprised an intervention group (IG) and a control group (CG) of nurses working in health services in Stockholm and Sörmland Counties.

The effects of the specific training on the study sample of 51 nurses (table 7) were assessed through coded questionnaires in a pre- and post-study design.

Table 7. Time of data collection, data source, participant’s characteristics in study IV.

Data collection	February 2009 and March 2009
Participants	IG: 24 nurses* CG: 27 nurses Total study sample: 51 nurses
Country of origin in IG	Sweden, Nordic countries, outside Nordic countries
Country of origin in CG	Sweden, Nordic countries, outside Nordic countries
Data source	Questionnaires pre- and post-training

*20 nurses from Stockholm County, 4 nurses from Sörmland County)

4.3.6.1 The intervention

The specific training intervention in cultural competence included a specific content, process and performance. The content comprised Campinha-Bacote’s [7] definition and cultural competence model contributing a theoretical frame and study-specific knowledge derived from studies I–III. The process comprised four pedagogical approaches: a participatory learning approach focusing on the nurses’ clinical work; a theoretical and a clinical/practice section aimed at linking theory to clinical practice; and case methodology and reflective practice groups aimed at discussing and reflecting on cases with help of the theoretical models derived from studies II and III. The

training was carried out over three days, with the third day occurring after four weeks of clinical work at the health centres. The intervention is described more in detail in Article IV.

4.3.6.2 Instrument for outcome assessment

Three aspects were assessed as outcomes of the training intervention: *cultural competence, experiences of difficulties and concerns, and the nurses' evaluation of the training.*

Campinha-Bacote's instrument for assessing cultural competence was not selected, as a psychometric evaluation concluded the instrument was not valid and reliable for use on Swedish practicing nurses [109]. Instead the *Clinical Cultural Competence Training Questionnaire – pre-(CCCTQ-PRE)* and *Clinical Cultural Competency Training Evaluation Questionnaire – post-(CCCTEQ-POST)* were used. This instrument was selected because the questionnaires cover the levels in Campinha-Bacote's cultural competence model and because it had previously been used in a European study (including Sweden) and was already translated into Swedish[96].

To assess the nurses' *experiences of difficulties and concerns*, 14 questions with different statements of difficulties were used: 11 based on findings from international studies (earlier used in study I) and 3 based on findings from studies I–II. Seven questions in the *CCCTEQ-post questionnaire* evaluated the training.

4.4 DATA ANALYSIS

4.4.1 Study I

Logistic regression models were used to investigate the association between the nurses' *experiences of difficulties* (outcome variable) and a total of nine different *explaining variables* divided into *background and formal competence* and *working conditions*. Three models were calculated: a crude, an age-adjusted (including all the explanatory variables) and a main-effect model (variables selected when p-value <0.05. How well the entire model fit the data was assessed by Pearson's goodness of fit and judged to be good (p>0.8465). Analysis by *t*-test for independent samples found no significant difference between responders and non-responders. Qualitative thematic-content analysis was used to analyse individual comments in the open-ended questions [110].

4.4.2 Study II–III

As noted previously, when using GTM the analysis starts at the first data collection. Following this approach the tapes were listened to, transcribed and analysed before the next interview was carried out. In the first stage, *open coding*, transcripts were read line by line. Units of meaning were underlined and noted in the margin. These were grouped with similar code phrases and incidents emerged that captured the *substance of data*. Comparisons were made incident by incident, similarities and differences were identified, and new codes were condensed into concepts and categories such as: *clear* and *unclear* (Study II), *open*, *unclear* and *closed demeanour* (Study III). Events, connections, and hidden information appeared when data were summarised and sorted.

In the second stage, *axial coding*, patterns and connections emerged from empirical data in response to the question “how do the concepts relate to each other?” [111]. Data were coded through *selective coding* against the basic social process *assessment of health risks in children* (study II) and *watchfully checking for rapport* (study III) and the theoretical models were developed.

4.4.2.1 Credibility (studies II –III)

In studies II and III, various validity checking was integrated in the analytic process covering the criteria of *fit*, *work* and *relevance* [105]. First, the emerging theoretical model, findings and concepts were constantly compared with data in conformity with GTM. Second, fit (internal validity) was confirmed through quotations. Third, validating interviews were performed and participants were asked four specific questions covering the criteria of fit, work and relevance as follows: Do you recognise the experiences illustrated in this model? Is anything new? Is the model clear and easy to understand? Do you have use for the model?

Eight nurses participated in study II; their characteristics are shown in table 8. Four of these nurses had earlier been interviewed in-depth and the other four nurses participated solely in the validating interview. Three were individually interviewed at their workplace and five were invited to a group session. The interviews were tape-recorded with the nurses’ permission. When all interviews were conducted the material was transcribed verbatim.

Table 8. Characteristics of eight nurses participating in validating interviews.

Country of origin	Sweden, Nordic countries, outside Nordic countries
Proportion of children of foreign origin	
<25,	1*
25–<50	1*
50–100%	6 (of whom 2 were new nurses and only gave validating interviews)

*new nurses (four) that only participated in validating interviews together with four of those nurses earlier interviewed in-depth.

Ten new parents of foreign origin participated in the validating interviews in study III; their characteristics are shown in table 9. These parents were individually interviewed at one health centre. Notes were taken of the parents’ answers, and at the end of each interview a summary was done and parents verified or added more information.

Table 9. Characteristics of 10 parents of foreign origin participating in validating interviews.

Parents		8 mothers, 2 fathers
Country of origin		
Africa		3
Middle East		5
Southern Europe		2
Number of years in Sweden	(range)	1–20
Number of children per parent	(range)	1–4
Ages of children	(range)	5 weeks–7 years
Place for validating interviews	(no. of parents)	At one health centre (10)

Both nurses and parents confirmed that the results rang true and that the theoretical models explained their situations, were easy to understand, meaningful, coherent and applicable in practice.

4.4.3 Study IV

Data were analysed testing question-to-question differences in mean rank pre- and post-training within and between IG and CG nurses. Differences in mean rank between pre- and post-training within groups were tested using the Wilcoxon signed-rank test. Training differences between groups were tested using the Wilcoxon rank-sum test. Differences in distribution between groups were tested using the Pearson chi² test and Fischer's exact test [112]. Second, to determine if there was an interaction between training and the repeated factor (pre- and post-training), data were analysed using repeated measures analysis of variance (ANOVA). The total scale of answers pre- and post-training regarding *cultural competence* and *experiences of difficulties and concerns* were summarised by giving each answering alternative a score from 1 to 4 (5).

4.4.3.1 Statistical outcomes and software

The data in study I and study IV were analysed using the statistical package STATA version 10 (Stata Corporation, 4905 Lakeway Drive, College Station, Texas 77845 USA). The results in study I are presented as the odds ratio (OR) with 95% confidence intervals (CI).

In study IV the results are presented as mean ranks and in the question-to-question analysis p-values ≤ 0.01 are considered a statistically significant training difference. In the variance analysis (ANOVA), p-values < 0.05 are considered a statistically significant training difference.

5 MAIN RESULTS

This section presents the main results, which focus on: the nurses' working conditions and cultural competence (study I); the nurses' assessment of health risks in children based on their psychosocial conditions (study II); the importance of parents' believing that a rapport can be established (study III); and the effects of specific training in cultural competence (study IV). For studies II and III, this section also highlights the results of the validating interviews regarding the theoretical models. For more detailed information, consult the articles attached at the end of this thesis.

5.1 STUDY I

This study aimed to investigate the nurses' working conditions and cultural competence when interacting with children and parents of foreign origin. Many of the nurses reported unsatisfactory working conditions, i.e. dissatisfaction with the quality of their healthcare work and a lack of written guidelines and support. The majority of nurses experienced several difficulties, which were increased by: a high proportion of children of foreign origin, long professional experience and by working more than half-time on child health services assignments. Most of them felt that their cultural competence was inadequate and only one-third had any formal training in cultural competence (i.e. more than 1 day).

5.1.1 Working conditions

More than half of the nurses stated that they were only partially or not at all satisfied with the quality of their health-care work with children and parents of foreign origin. All nurses were responsible for children having foreign origin, although to varying degrees. More than half of the nurses stated that they lacked available written guidelines and nearly one fourth said that it was not possible for them to obtain any support or help in their health-care work with children and parents of foreign origin.

In reply to the open-ended questions, the nurses made the following suggestions to improve their working conditions and the interaction between the parents and the nurse:

Suggestions for improved working conditions included more time for personal reflection and for each family, training in cultural competence, supervision, flexible and better working routines and cooperation with e.g. the social services and the Swedish Migration Board.

Suggestions for improved dialogue and interaction between the parents and the nurse included mutual understanding, openness and respect. It was suggested that they needed to listen, be humble and tolerant. According to the nurses, parents needed to show respect for the nurses' profession and clinical work. Additionally, they pointed out that parents should show respect for the appointments at the health centres by being on time.

5.1.1.1 Experiences of difficulties

A total of 84% of the nurses reported that they experienced difficulties when interacting with children and parents of foreign origin. A total of 21% of the nurses reported additional difficulties beyond those already mentioned, including difficulties in dealing

with the parents' various expectations and requirements from the child health services, and dealing with some of these parents' problematic backgrounds as refugees.

In general, many of the nurses commented that English-speaking parents and parents of foreign origin married to a Swede caused fewer difficulties.

5.1.1.2 Factors associated with experiences of difficulties

The following factors exacerbated the nurses' experiences of difficulties: having over 20 years' professional experience in child health services, working half-time or more on child-health care assignments, and if more than 50% of the children in the nurse's specific geographical area of responsibility were of foreign origin.

5.1.2 The nurses' opinions regarding cultural competence

Most of the nurses stated that they were only partially, or not at all satisfied with their formal and clinical cultural competence. Furthermore, most thought that formal training in cultural competence would reduce the difficulties and improve their health-care work with children and parents of foreign origin.

5.2 STUDY II

The study aimed to theoretically explain the nurses' core problem regarding their interaction with children and parents of foreign origin. Anxiety about missing children, exposed to risks of ill-health, due to various conditions in the child's home environment, turned out to be the nurses' main concern. The theoretical model that was developed explains how nurses strive to assess whether or not psychosocial conditions in a child's home environment constitute a health risk for that child (Figure 1).

For the nurses, assessing the health risk meant assessing the child's physical and mental health, psychosocial development and home environment. The difficulty was that this assessment was not always easy or possible to do, at least not immediately.

When the conditions in the child's psychosocial environment were familiar and understandable to the nurse, the nurses found them easy to assess without much uncertainty, as either conditions almost certainly risk-filled or conditions almost certainly risk-free for the child's health. In such cases, the nurse was also clear about what action to take. When conditions existed that were almost certainly risk-filled, she turned over responsibility for continued assessment of health risks to another level of care or profession, or shared the responsibility. When conditions were almost certainly risk-free, she discontinued or dropped her assessment of health risks since no further action was needed. On the other hand, when conditions in the child's psychosocial environment were unfamiliar and not understandable to the nurse, the nurse found them difficult to assess and open to doubt. This created uncertainty and even anxiety about missing children exposed to risks of ill health, and the nurse could not make up her mind about whether the conditions were risk-filled or risk-free for the child's health.

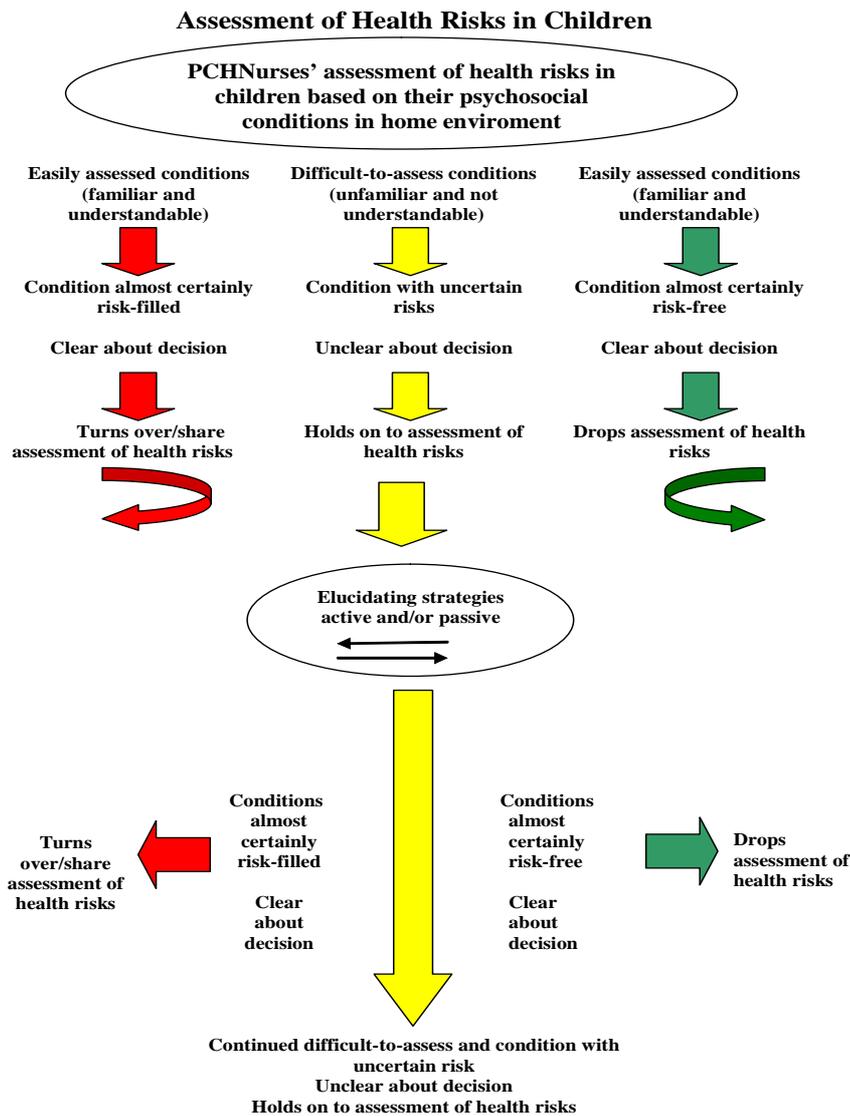


Figure 1. Interaction with children and parents of foreign origin: the PCHNurses' assessment of health risks in children based on psychosocial conditions in the child's home environment.

During the validating interviews the majority of the eight participating nurses confirmed that the presented model reflected their work and was clear and easy to understand:

It's a good method; it feels good to be validated in our work situation and described this way, with the three colours. Being validated, knowing that people are aware of our situation, and being able to use these colours to define our problems, is a relief.

The nurses confirmed that the model was useful to them:

*Symbols are important to help us define what we do!
I can use it when I meet with parents of foreign origin, but I can also see
that it will be useful when I work with Swedish families.*

5.3 STUDY III

This study aimed to construct a theoretical model that could explain and promote further understanding of the variety of experiences that parents of foreign origin have when interacting with nurses in the child health services. This study revealed the social process of parents watchfully checking rapport with the nurse. The theoretical model illustrates an interactive process in which parents observe the nurses' demeanour and check for signs of being judged in order to determine whether it is possible to establish a rapport. The main finding is the importance of parents perceiving that it is possible to establish rapport, i.e., sympathy and understanding, with the nurse. Hence, it benefits the child's attendance in the child health services when parents feel convinced that the child's check-ups at the health centre are useful. In contrast, if parents perceive rapport to be uncertain or impossible to establish, they feel hesitant and/or unwilling to take the child to check-ups.

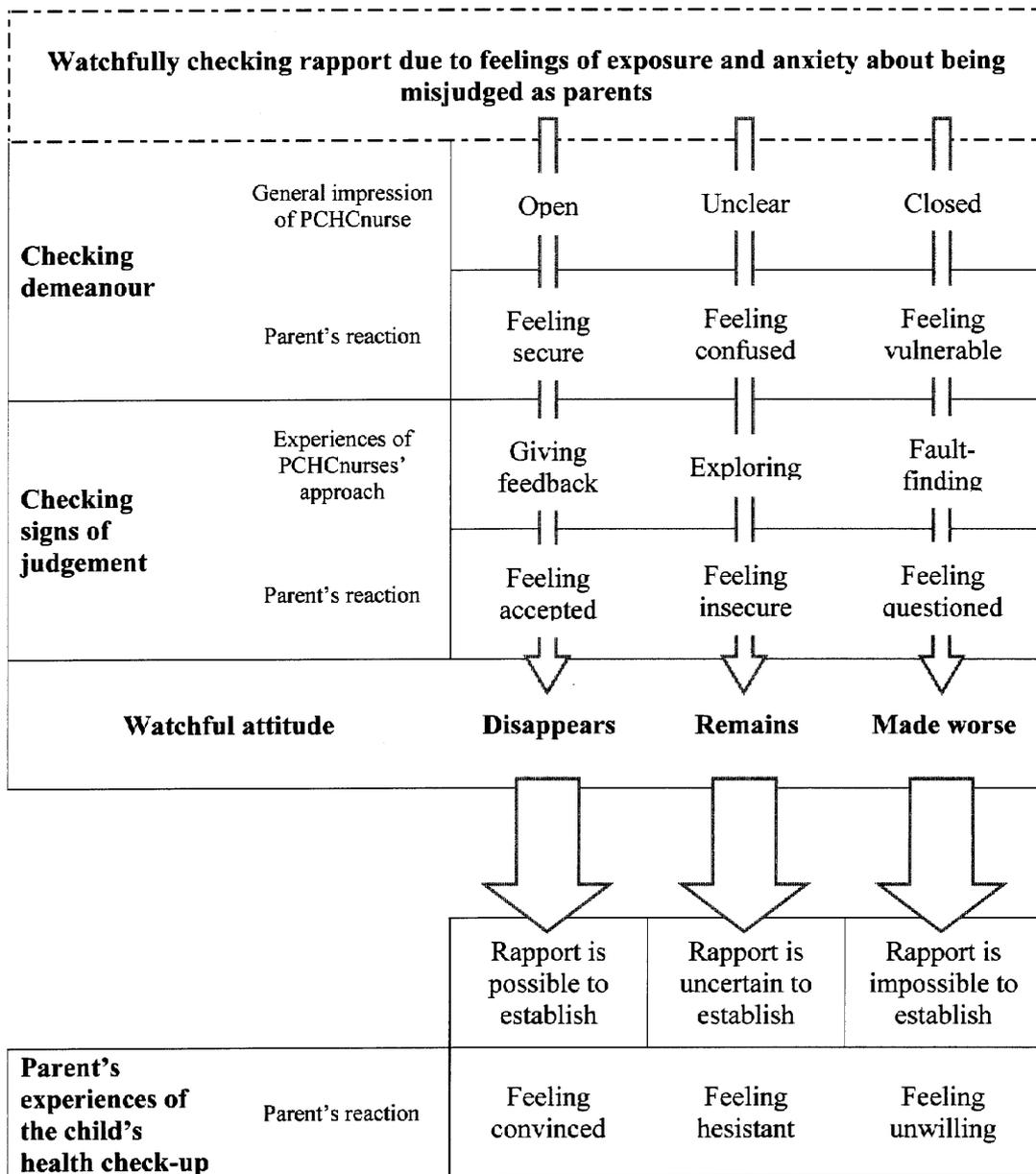


Figure 2. Parents of foreign origin watchfully checking rapport with the Primary Child Health Care Nurses (PCHC nurses).

During the validating interviews the majority of the participating parents confirmed that the presented model reflected their situation and was clear and easy to understand. One mother originating from Africa with one child, 6 months, had this to say regarding an open demeanour:

Yes, I recognise that open PCH nurse. I've only met friendly staff, but I've heard others talk about unpleasant people.

A mother and father originating from Southern Europe with two children, 3 months and 1½ years, said this about the unclear demeanour:

Yes, that's just how it is, exactly. We had one like the middle category ... unclear. Every time we'd been to the clinic, we asked ourselves, "Doesn't she know her job?" It was like her thoughts were elsewhere. She never gave a clear answer to anything. And I thought, "Is she like this with everyone, or is she reacting this way because I'm a foreigner?"

A mother and father originating from Turkey with four children, 5 weeks, 3, 7 and 9 years, stated:

*We've met all three kinds!
One of the closed nurses was a foreigner herself!*

The parents confirmed that the model was useful:

It's good for parents and staff alike. Parents usually don't dare to say anything if they meet closed, unpleasant staff, they just keep it inside. If you show them this model, maybe they'll feel that it's okay to talk about things that were hard to talk about – that other parents also had negative experiences. It's important for the staff to understand how sensitive we can be.

5.4 STUDY IV

This study aimed to evaluate the extent to which specific training affected how nurses rate their own cultural competence, difficulties and concerns, and to study how the nurses evaluated the training. The nurses appreciated the three days of training (Table 10).

Findings indicated that the specific training somewhat improved their cultural competence and was specifically effective in improving the nurses' cultural skills and lessening their difficulties and concerns.

Cultural awareness: No statistically significant changes were found on this level.

Cultural knowledge: The intervention group (IG) showed a statistically significant improvement compared with the control group (CG), demonstrating improved knowledge of the national policy for cultural diversity in the Swedish health care system (question 9) and the policy for cultural diversity in the health services (question 10).

Cultural skills: The IG showed a statistically significant improvement compared with the CG as regards improved skills for eliciting the parent's perspective about health and illness (question 2), eliciting information about the use of folk remedies and/or other alternative healing modalities (question 3), performing a culturally sensitive physical examination (question 5), negotiating a culturally sensitive health care plan for the child (question 6), providing culturally sensitive parent education and counselling (question 7) and providing culturally sensitive preventive health care services (question 8).

Cultural encounter: The IG showed a statistically significant improvement compared with the CG, demonstrating improved confidence when identifying beliefs

that the parent does not specifically express, but which might interfere with the child’s health care (question 4).

Cultural desire: 92% in the IG showed an increased desire to learn more about the subject of “culturally competent” health services.

Table 10. Evaluation of the training in cultural competence. Opinions of 24 nurses in the intervention group (IG) post training. The results are given as number (n) and percentage (%).

Variables	Results	
	n	%
Satisfied with the quality of the educational intervention in cultural competence		
– not at all – a little – somewhat	1	4
– quite a bit – very	23	96
Cultural desire: a desire to learn more about the subject of “culturally competent PCHC services”		
– decreased significantly – decreased somewhat	0	-
– remained the same	2	8
– increased somewhat – increased significantly	22	92
Impact on everyday practice		
– do not know	1	4
– none – a little – some	1	4
– quite a lot – very significant	22	92

6 DISCUSSION

6.1 MAIN FINDINGS

The results from study I showed deficient working conditions and lack of cultural competence among the nurses. The results from study II contributed to new, in-depth knowledge about the nurses' experiences of difficulties. The main concern found was anxiety about missing children being exposed to risks of ill-health, due to various conditions in the child's home environment, which confirmed and gave plausible explanations to results from study I that having a large proportion of children of foreign origin increased the odds that nurses will experience difficulties. According to study II these circumstances could lead to a time-consuming assessment of health risks in children, requiring elucidating strategies (difficult to assess, unfamiliar, not understandable, uncertain, unclear, holds on to assessment). This was reported to create a heavy social and health care workload. Study III illuminated the social process of parents watchfully checking rapport – looking for sympathy and understanding from the nurses – and highlighted the importance of parents believing that rapport was possible to establish. If rapport was perceived to be uncertain or impossible to establish there seemed to be a risk for disturbance in the child's attendance in child health services. Study IV found that a three-day training programme was appreciated by the nurses and that they rated their cultural competence, difficulties and concerns to be somewhat improved.

6.2 CULTURAL COMPETENCE

Cultural competence in healthcare describes the ability of professionals to provide high-quality care to patients with diverse values, beliefs, and behaviours [7, 38].

We all have a culture, a set of experiences that shape the way we interact with our environment [38]. Cultural competence is the process of developing an understanding of others and oneself [7, 38]. Campinha-Bacote [7] stressed that cultural competence is an individual process in which health care providers continuously “strive to achieve the ability and availability to effectively work within the cultural context of a client” (p 181). To become culturally competent, the individual has to go through a process of five different constructs or levels: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. According to Dunn [38], becoming culturally competent is an ongoing interactive process of change in relation to other people that is “without end and hard to pin down”. Furthermore, it requires a “fundamental change” in thinking, understanding and interacting with people and the world around us (p 107).

By integrating findings from the four conducted studies it was possible to outline and elaborate on the specific concern of cultural competence in the context of child health services. Hence, the concept of elucidating strategies found in study II elaborates on the level of cultural skills needed to be developed and framed when assessing health risks in the child's psychosocial home environment. In addition, the concept of establishing rapport found in study III elaborates on the level of cultural encounter in the context of child health services. The findings indicated that establishing rapport

involves two levels. First, the behaviour level: the immediate reaction to the general impression of the nurse's demeanour – for example, a nice, smiling face. Second, the in-depth level: experienced as mutuality, sympathy and understanding. The concepts of establishing rapport and of cultural competence seem to have similarities in the sense of building or developing trust [94, 113], improving health care [114, 115], promoting compliance and contributing a positive perception of the client–nurse interaction [1, 7, 93, 94, 115]. The results of studies I–IV will be discussed in relation to the theoretical model by Campinha-Bacote [7] with its five levels and further elaborated on using Dunn's [38] focus on cultural competence and the primary care provider.

Cultural awareness (a provider starts to examine his or her own biases and culture): This level initiates the process of cultural competence development [7] and is also regarded as the heart of the process [116]. Dunn [38] pointed out the importance for providers to work on changing their personal worldview by consciously and deeply looking into their personal values, beliefs and assumptions. This awareness is known to be associated with feelings of frustration [117]. In study I the nurses' experiences of difficulties were discussed as equivalent to this frustration. A number of findings from study I indicated that the nurses had a cultural awareness such as: the nurses thought that cultural competence would reduce the difficulties they experienced and improve their health-care work with children and parents of foreign origin. Furthermore, the nurses suggested that their dialogue and interaction could be improved by a mutual understanding, openness and respect. Parents in study III also considered this to be of utmost importance. The nurses' level of awareness found in study I corresponds to some of the findings from study IV i.e., that both CG and IG nurses rated themselves as having an awareness of the importance of sociocultural aspects in interaction with parents and the importance of cultural competence training. These results might explain why there were no changes in the cultural awareness level when evaluating the effects of the training in study IV.

Cultural knowledge (obtaining knowledge of different cultures and ethnic groups): A majority of the nurses participating in study I reported a lack of cultural knowledge, which according to Campinha-Bacote [7] is the second step in the cultural competence process. Moreover, they reported that cultural knowledge was necessary in order to improve their interactions and help them to deal with the difficulties involved in their health care work. After the specific training in study IV the nurses rated their cultural knowledge to be somewhat improved, i.e. they felt they had “moved beyond” the awareness level and continued the cultural competence process [7]. According to Dunn [38], it is unrealistic to expect that a provider can have an awareness of every culture. Nevertheless, it is important to become familiar with “core cultural issues” (p 108) and to explore and communicate these issues with the client.

In study III the parents made comments about the nurses' knowledge and competence, whether the parents felt welcome, remembered and confirmed, whether they felt that the nurses liked co-operating with and were competent in working with foreigners. If the nurse asked unclear questions and explained poorly, the parents experienced the nurse as lacking in knowledge and needing to take a course to learn how to work with “foreigners”.

Cultural skills (an ability to collect and assess culturally based information): The importance of improved cultural skills was revealed because the difficulties experienced by nurses in study I are known to result in communication problems [114, 118]. They are also known to negatively affect the nurses' ability to meet the needs and expectations of this group of children and their parents [38, 114]. In addition, they also risk damaging the relationship between the nurse and the parents as revealed in the interviews with the parents in study III. Study II found that the nurses needed improved skills in assessing health risks for children of foreign origin. This task is prescribed by law [26] and may cause tension and ethical dilemmas in relation to children and their parents [63]. Some of the elucidating strategies used by the nurses may be perceived as fault-finding by the parents if not done and communicated in an open, warm and straightforward way, and this may trigger a vicious circle of misunderstandings, mutual hesitance and insecurity in the interaction between the parents and the nurse; i.e., the parents become more watchful when checking for rapport. In study II the nurses had difficulties assessing the parents' care of the child, the use of unfamiliar household remedies and medicines from the native country and their effect on the child. In study IV the theoretical model and the concept elucidating strategies from study II were used when discussing and resolving difficult clinical cases in reflective practice groups. After training, the IG of nurses rated themselves as having obtained the necessary skills to elicit the parent's perspective on health and illness and information about the use of folk remedies and/or other alternative healing modalities. The nurses also rated themselves as having improved skills in negotiating a culturally sensitive health care plan for the child.

As stated by Elsass [119], the most important aspect of intercultural interaction is that the client feels understood. Therefore, health care providers really need to make an effort to listen and use the clients' views and beliefs as a point of departure when discussing and solving the health issues/problem [38, 84]. Negotiating a mutually acceptable and understandable care intervention has been described as of utmost importance [38]. A successful culturally competent negotiation assumes that providers are willing to discuss and adapt their suggestions to what parents are willing to do [38]. In contrast, neglecting the parents' view, not asking, but telling their own view as a nurse is to give incomplete care [38].

Negotiation ensures that parents are fully included in the decision-making process about the child's health care in a client-centred [120], self-empowering [31] way. The health care provider needs to know how to value the parents' suggestions and also judge the effects on the child – i.e., if it's helpful, encourage it; if it's innocuous, encourage it; if it's harmful, further negotiate by explaining your view in an open manner [38]. This corresponds with the findings of study III, where parents reported that they felt accepted when the nurses were clear and straightforward, fully explaining their views and giving them feedback on their ideas and care practices. Dunn [38] encouraged providers to “be curious about what you see clients doing and ask respectfully for explanations to help you understand better” (p 109). Open and complete communication between the client and provider requires a relationship of trust. This creates a comfortable feeling, allowing the client to reveal personal ideas that may be hard to share with the health care provider [38].

Cultural encounter (engaging in face-to-face cultural interactions): Study III emphasised the importance of parents believing that rapport – i.e., sympathy and

understanding – was possible to establish. Moreover, it reiterated the importance of nurses considering their own demeanour. The results indicated that the general impression of the nurses' demeanour was critical for the parents' further interaction and the child's attendance at check-ups. A lack of nurses' awareness in this sense might undermine the most ambitious health care plan, with negative consequences for the child's health. Some parents expressed that if rapport was uncertain or impossible to establish it made them hesitant or unwilling to bring the child to check-ups.

The concept of establishing rapport further elaborated the level of cultural encounter and what the nurses must consider in face-to-face interaction with parents and their children in child health services. In study III parents were found to check the nurse's demeanour for signs of judgement in order to find out whether rapport was possible to establish. Therefore, nurses need to be aware of the importance of having an open, relaxed, gentle and calm approach on the behavioural level, as parents in study III described this as important. In study IV the theoretical model from study III was used for training in cultural competence so the nurses could consider their demeanour when interacting with parents. This is the concept of establishing rapport on a behavioural level.

However, there is more to establishing rapport than just showing a friendly face. The in-depth level of establishing rapport, according to the parents in study III, was a feeling of mutuality, sympathy and understanding, described by one parent as "a two-way thing" between her and the nurse.

In order to fully understand and explore the concept on this level, we had to look into psychology and psychotherapy [121-123]. Establishing rapport means developing an alliance of emotional bonds that lead to positive personal attachments [121], the perception of being empathically listened to, cared for and understood [123]. Moreover, it is described as a dynamic structure of mutual attentiveness, positivity, a developing relationship between individuals involving both verbal and nonverbal behaviour [122]

Establishing rapport is close to a therapeutic alliance, and according to Elsass [119], in intercultural face-to-face counselling it includes a positive non-judgemental attitude, conveying hope, trust, empathy and authenticity.

In study II, some of the elucidating strategies used by the nurses could be interpreted as a way of establishing rapport. In addition to what is typical in a therapeutic relationship, the nurses seemed to add something personal, doing things they did not normally do. The nurses tried to gain insight and understand the family's psychosocial situation through home visits or more frequent contacts, and thus establish a relationship with the parents. They made an effort to be more open in order to further improve their relationship with the parents and to create trust. They sometimes went beyond the scope of their responsibilities and were more open-hearted and personal in order to get closer to the family. In addition, they helped the parents with matters that actually lay outside their regular job responsibilities. Sometimes they made a special effort to establish a good relationship with the father, with the aim of facilitating a relationship with the child's mother.

In study IV, when evaluating the specific training in cultural competence, the nurses were asked to rate how comfortable they felt when dealing with various cultural aspects. The IG of nurses receiving training rated themselves more comfortable when dealing with cross-cultural situations. According to Dunn [38], culturally competent communication in the face-to-face cultural encounter requires a well thought-out attitude, a respectful interaction based on dignity, including an awareness of possible

misunderstandings. With this in mind one might presume that a culturally competent provider would also be able to establish rapport, as cultural competence aims at contributing to understanding.

One might ask if the skill of establishing rapport in an intercultural/multicultural setting is a question of personality. According to Elsass [119] it requires a well-integrated, enthusiastic, genuine personality. It is conceivable that nurses naturally in possession of this personality trait find it easier to establish rapport and become culturally competent. Henriksson [124] found that the degree of cultural competence was related to the health care provider's personality but also to their educational level. Hence, people who are less neurotic and more open, conscientious and university-educated were found to be more "prone to be culturally competent" (p 2). Nevertheless, the author concluded that the focus should not be on the provider's personal level alone but on the health organisational level as well.

Cultural desire (motivation, willingness, genuine interest in becoming culturally competent): The evaluation of the specific training in study IV showed that a majority (92%) of the IG of nurses had increased their desire to learn more about "culturally competent child health services". Or, in the words of Campinha-Bacote [7] "want to" rather than "have to" go into the process of becoming culturally competent (p 182). In order to maintain this desire the nurses need to continue their professional learning in their clinical setting in child health services.

As Ellström and Koch [125] pointed out, competence development in the workplace requires reflection of practice, continuity and a supportive learning environment and the balance between routine and reflection is difficult. The participating nurses in **study I** seem to be aware that having time for reflection is a way to improve their working conditions. Competence development in the workplace is essential for development and effective work, and to enhance the employees' know-how, social and emotional capacity [126]. Ellström [127] named three important aspects of learning. First, mastery, learning something based on stated goals, tasks and methods. Second, questioning, to develop the acquired knowledge into a personal perspective. Third, developmental, creative learning, which is another form of questioning that allows the individual to surpass the teaching by developing and testing new ways of thinking.

From this perspective, the first aspect – mastery learning – was achieved by the specific training in study IV aiming to improve the nurses' cultural competence and capacity to solve clinical scenarios using case methodology and the theoretical models derived from studies II and III. As Henderson et al. [128] stated, learning a practise discipline such as nursing can be greatly enhanced by experiences in the clinical setting, and this must be effectively facilitated to obtain the desired outcome.

Therefore, a supportive clinical learning environment, leadership and working conditions are required in order to maintain the results of the training in study IV and further evolve the nurses' learning as defined by Ellström [127]. These aspects may also be important in order to continue the process of cultural competence stimulated by the specific training in study IV. These supportive learning features are extremely important, as it is a challenge to try to sustain effects and bring about changes when re-entering the realities of busy work regimens as a multiculturally trained minority in the workplace [4].

6.3 METHOD

6.3.1 Strengths and limitations

Multiple methods were used to answer the research questions, which is a key strength in this thesis. Thörn et al. [129] have stressed that this approach has significant advantages, especially when dealing with complex problems in a clinical setting.

The methods investigated various aspects of the interaction, which is an advantage when trying to explore aspects that might jeopardise high-quality health care. It was also an advantage to be able to use the results to create a specific training programme with a naturalistic design in everyday clinical practice.

To validate the findings and establish trustworthiness for studies included in this thesis, several procedures and measurements were taken throughout the data collection and analysis. In study I, differences between responders and non-responders were analysed and no significant differences were found. To overcome some of the possible limitations in study I regarding the use of the non-validated questionnaire, the study-specific questionnaire was pilot tested. The response scales, measurability, content, intelligibility, and relevance of each question were assessed by experts at Statistics Sweden and the Department of Child Health Services.

A strength of this thesis is the conceptualisation of the two processes of ‘nurses’ assessment of health risks in children of foreign origin’ and ‘parents watchfully checking for rapport’. These models were validated by parents and nurses and compared with an established theory on cultural competency. This is a procedure called for by GTM methodologists but nevertheless not always seen [130]. The GTM approach was used to collect data in studies II and III through interviews with nurses and parents, which provided diverse and comprehensive data. As concepts developed during studies II and III, frequent meetings were held with the supervisor and co-supervisor who became well acquainted with the manuscripts of the interviews, memos and tapes during the data collection and analysis. They helped to exchange, expand and sharpen ideas about concepts, possible connections between concepts and underlying, unspoken issues. These discussions were held on a regular basis at several qualitative academic seminars. A group of 8 nurses (study II) and 10 parents of foreign origin (study III) tested the concepts and theoretical models to ensure that “work”, “fit” and “relevance” were achieved [105]. These validating interviews showed that saturation had been reached in the categories, the models were relevant and comprehensible and the processes could be recognised by nurses and parents.

As a researcher close to and familiar with the clinical field at child health services, there was a need to develop strategies to avoid unduly influencing the data. Prior understanding, pre-existing knowledge and preconceived notions might in some cases help in the concrete understanding of a problem under study; however, they may also constitute a bias and negatively effect the analysis [131].

Memos were written throughout the data collection and analysis in studies II and III, which is known to help researchers to develop an awareness of their own pre-conceptions and their influence on the data [131]. Another method for creating this awareness was discussions at several qualitative academic seminars in a group of co-researchers also dealing with the GTM. The seminar discussions were characterised by reflection aimed at creating “an awareness of the way the researcher as an individual

with a particular social identity and background has an impact on the research process” [132, 133].

The strength of study IV was that it followed the methodological recommendations of Price et al. (2005). Moreover, despite changes in wording and the omission of some questions in the questionnaire, the Cronbach alpha scores did not change in comparison to a former calculation [96]. Calculations in study IV revealed a Cronbach alpha score between 0.84 and 0.91 on the questions regarding cultural awareness, cultural knowledge, cultural skills and cultural encounters.

Interviewing respondents speaking a second language has its limitations and weaknesses; therefore, parents fluent in the Swedish language were prioritised. This strategic sampling in study III may have had a significant impact on the results, which is a limitation in need of more clarification and new research.

A potential bias in study IV might be the characteristics of study participants in the IG, as they had a higher degree of linguistic abilities and previous training in cultural diversity. Thus, they might have had a greater interest in the topic of cultural competence. Moreover, nurses in the IG had their professional bases at child health services in different county councils (Stockholm and Sörmland), while nurses in CG worked exclusively in Stockholm County. These circumstances might limit the generalisability of the study findings to all nurses in various settings of child health services. Other possible limitations of the study might include the relatively small study sample and the short time for follow-up evaluation.

6.4 CLINICAL IMPLICATIONS

In study I, the nurses perceived their level of cultural competence and their working conditions as unsatisfactory. They experienced difficulties interacting with children and parents of foreign origin and they felt dissatisfied with the quality of their health care work. These factors may result in communication problems, and may also affect the nurses’ ability to meet the needs and expectations of this group of children and parents. In addition, it might prevent them from gaining the trust they need to provide adequate health care.

Nurses have to deal with a heavy workload and be culturally aware, while at the same time providing high-quality health care. Decision-makers in child health services should consider the fact that every third child is of foreign origin in Stockholm today, and that this is a challenging task for many nurses. Therefore nurses require a variety of support measures from decision-makers at the organisational level, as well as in the clinical settings.

Study II illuminated the nurses’ difficulties in performing one of their main tasks: assessing health risks for the child in the psychosocial home environment. The majority of psychosocial conditions described by the nurses were difficult to assess, as they were unfamiliar and not understandable to them and therefore unclear as to risks for the child’s health. These circumstances might lead to a time-consuming assessment of health risks in children, needing elucidating strategies (difficult to assess, unfamiliar, not understandable, uncertain, unclear, holds on to assessment), which – if occurring frequently – creates a heavy social and health care workload. If the nurse’s cultural skills are deficient, this might delay identification of the risk of ill health in a child and

thereby the interventions needed to secure optimal physical, mental and psychosocial health development. It might also harm the relationship between the nurses and the families, although this study showed strategies used by the nurses to overcome this problem. In order to perform this task the nurses seem to need a variety of improved skills, support measures, and personal resources.

Study III illuminated the parents' general feeling of exposure and anxiety about being misjudged as parents due to their origin. Thus, they watchfully checked the possibility of establishing rapport with the nurse by checking the nurse's demeanour and signs of whether and how they were being judged as parents. Our results indicated that the general impression parents get from the nurses' demeanour is critical for further interaction and for the child's attendance at check-ups. If something goes wrong, it might undermine the most ambitious health care plan, with negative consequences for the child's health.

Improved cultural competence is a way of responding to the demographic changes in Swedish society. It is also a way to improve the nurses' working conditions, as nurses feel more skilled and confident when dealing with cross-cultural encounters or situations in child health services after a specific training programme described in study IV. These effects are presumed to contribute to improved quality of child health services with a reduction of the risk for health care disparities among children of foreign origin. The recommendation for health care providers and decision makers is to consider funding formal and continuing training in cultural competence for all nurses working in child health services. In addition, supervision should be conducted on a regular basis to maintain positive effects from training.

7 CONCLUSIONS

- Unsatisfactory working conditions, lack of cultural competence and experiences of difficulties were found among nurses. The difficulties were associated with long professional experience, full-time work and a high proportion of children of foreign origin.
- The theoretical model that was developed illuminates how nurses strive to assess whether or not psychosocial conditions in a child's home environment constituted a health risk. Unfamiliar, not understandable conditions were described as difficult to assess, which created uncertainty and even anxiety about missing children being exposed to risks of ill health. Assessing risk factors in the child's home environment may be a difficult task requiring certain competence, skills and elucidating strategies.
- The elucidating strategies was used when nurses tried to be clear as to whether the conditions were risk-filled or risk-free for the child's health. The strategies could further be developed and frame the nurses' cultural skills when assessing health risks in the child's psychosocial home environment.
- A general feeling of exposure and anxiety about being misjudged as parents due to their origin made parents watchfully check the possibility of establishing rapport with the nurse by checking the nurse's demeanour looking for signs of judgment. The possibility of establishing rapport with the nurse can prevent parents from feeling hesitant and unwilling to bring the child to health check-ups. Thus, it is of utmost importance for nurses to become aware of their own demeanour and way of interacting with parents and children of foreign origin.
- The concept of establishing rapport framed and elaborated the concern of cultural encounters and cultural competence in the context of child health services.
- Short, specific training programmes in cultural competence are helpful for nurses and rated as having an impact on their ability to cope with the demands of work with parents and children of foreign origin.
- The models created in this study about 'assessing health risks in children of foreign origin' and 'parents watchfully checking for rapport' are important tools to be used for professional reflection, as a means for training in cultural competence and as a basis for further exploration and conceptualisation.

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SUMMARY IN SWEDISH / SAMMANFATTNING PÅ SVENSKA

BAKGRUND

I dag är vart tredje barn som kommer till barnvårdscentralen (BVC) i Stockholms Län (SL) av utländsk härkomst d v s är själv eller har minst en förälder född utanför de nordiska länderna. Sjuksköterskan på BVC (BVCssk) är huvudpersonen i det hälsobefrämjande arbetet. Såväl nationell som internationell litteratur har beskrivit det som en stor utmaning att erbjuda hälsovård till patienter med varierande kulturellt och nationellt ursprung. En speciell typ av kompetens, kulturell kompetens, anses vara nödvändig. Forskning visar att bristande kulturell medvetenhet och kompetens hos hälso- och sjukvårdspersonal lätt leder till missbedömningar, feltolkningar och slutligen felaktiga beslut om hälsovårdande insatser.

MÅLSÄTTNING

Den övergripande målsättningen med denna avhandling var att undersöka vilka faktorer som försvårar en interaktion av hög kvalitet mellan BVCssk, och föräldrar och barn med utländsk härkomst. Ytterligare en målsättning var att använda denna kunskap till att utforma ett specifikt utbildningsprogram i kulturell kompetens samt utvärdera dess effekter.

MATERIAL OCH METOD

Avhandlingen består av fyra delstudier: två kvantitativa (studie I-IV) och två kvalitativa (studie II-III). Den första studien består av 270 BVCssk åsikter om sina arbetsförhållanden och sin kulturella kompetens. Data samlades in med hjälp av ett frågeformulär och analyserades med logistisk regression. I andra studien intervjuades 19 BVCssk om sina upplevelser av mötet med föräldrar och barn av utländsk härkomst. Metoden grundad teori användes vid datainsamling och analys av materialet. I tredje studien intervjuades 21 utlandsfödda föräldrar om sina upplevelser av mötet med BVCssk. Även i denna studie användes grundad teori vid datainsamling och analys. Den fjärde studien består av data insamlat med frågeformulär före och efter utbildning i kulturell kompetens. Effekten av utbildningen bestod av jämförelser mellan 24 BVCssk i studiegrupp respektive 27 BVCssk i kontrollgrupp. Data analyserades med Wilcoxon signed-rank test, Wilcoxon rank-sum och analysis of variance (ANOVA).

RESULTAT

Majoriteten av BVCssk upplevde bristande arbetsförhållanden och kulturell kompetens i mötet med denna grupp föräldrar och deras barn. Upplevelsen av svårigheter ökade med lång yrkeserfarenhet, heltidsarbete och ett stort antal barn inom det egna

ansvarsområdet. BVCssk hade i dessa möten svårt att utföra en av sina arbetsuppgifter, att bedöma om den psykosociala hemmiljön utgjorde en risk eller inte för barnets hälsa och utveckling. Bedömningsprocessen och de klargörande strategierna som BVCssk använde sig av förklaras med en teoretisk modell som utvecklades genom analysen av intervjumaterialet. Föräldrarna berättade om sin känsla av utsatthet och sin rädsla för att bli missbedömd som förälder på grund av sin härkomst. Denna känsla skapade en vaksamhet hos föräldrarna som gjorde att de genom att titta på BVCssk ansiktsuttryck och kroppsspråk försökte avläsa om det var möjligt att etablera ett samförstånd med BVCssk. Den teoretiska modellen som utvecklades genom analysen av intervjumaterialet beskriver denna process. Beroende på vad föräldrarna upplevde i dessa möten kände de sig antingen övertygade, tveksamma eller ovilliga till att ta barnet till hälsokontrollerna på BVC.

Kunskapen som förvärvades i studie I-III samt en teoretisk modell i kulturell kompetens utgjorde grunden för ett specifikt utformat utbildningsprogram i kulturell kompetens.

Studiegruppen värderade efter utbildningen sin kulturella kompetens som delvis förbättrad, speciellt den egna kulturella färdigheten.

SLUTSATSER

Bristfälliga arbetsförhållanden och kulturell kompetens upptäcktes bland BVCssk. Att bedöma om den psykosociala hemmiljön utgör en risk eller inte för barnets hälsa och utveckling är en svår arbetsuppgift som kräver kompetens, färdigheter och *klargörande strategier*. Dessa strategier kan vidareutvecklas och utgöra en utgångspunkt för hur BVCssk kan förbättra sina kulturella färdigheter när det gäller att bedöma den psykosociala hemmiljöns effekt på barnets hälsa och utveckling.

Möjligheten för föräldrar att utveckla ett samförstånd med BVCssk kan förhindra att föräldrarna känner sig tveksamma och ovilliga att ta barnet till hälsokontrollerna på BVC. Det är därför av stor betydelse att BVCssk är medveten om sitt uppförande och hur de bemöter föräldrar och barn med utländsk härkomst.

Begreppet att *etablera samförstånd* fördjupar innebörden av kulturell kompetens och kulturella möten inom barnhälsovården.

Ett kort specifikt utformat utbildningsprogram är av betydelse för att förbättra BVCssk kulturella kompetens och värderades ha positiv effekt på BVCssk förmåga att hantera krav i sitt arbetet med föräldrar och barn av utländsk härkomst. Avhandlingens resultat och de teoretiska modellerna är viktiga redskap för professionell reflektion inom den kliniska barnhälsovården. Även när det gäller att utforma utbildning i kulturell kompetens samt vidare utveckling och begreppsbyggnad inom området.

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