

A Systematic Review of the Academic Literature Related to the Use and Development of Cultural Competence in Health Promotion and Community Service Professionals

Alberta Cancer Board and University of Alberta
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About the Alberta Cancer Board

The Alberta Cancer Board is a Provincial Health Authority operating cancer facilities and programs in Alberta. Services include cancer prevention, early detection, diagnosis, treatment, research and education. Also included in this role is coordinating, in cooperation with others, the planning, development and delivery of provincial cancer initiatives.

As part of this mandate, five divisions carry out the business of the Alberta Cancer Board:

Two are facility-based and deliver patient care - the Cross Cancer Institute in Edmonton, responsible for patients in northern Alberta, and the Tom Baker Cancer Centre in Calgary, responsible for patients in Southern Alberta.

Medical Affairs and Community Oncology (MACO) Division was created to ensure that the same quality of cancer services is available to all Albertans, regardless of where they live, and is particularly focused on the delivery of cancer care to rural centres.

The Division of Population Health and Information (PHI) is focused on the front-end of the cancer spectrum to determine and have an impact on the environmental, biological and behavioural factors that lead to the development of cancer. PHI encompasses the Cancer Prevention Program, Population Health Research, the Alberta Cancer Registry, Screening Programs, the Integrated Cancer Care Network (ICCN), the

Information Security and Privacy Office (ISPO), and Information Systems.

Finally, the Research Division coordinates the basic, applied, clinical and population-based research that is performed in the facilities and divisions of the Alberta Cancer Board.

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The University of Alberta Extension has a proud history of collaborative research and development with community partners and is pleased to have had the opportunity to continue that practice with the Alberta Cancer Board.

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Background

In the past few decades Canada has grown to be a more and more ethnically and culturally diverse country. This stems from the influx of immigrants and refugees arriving from Asia, Latin America, Africa and the Middle East, many of whom are visible minorities (defined as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color” (Statistics Canada, 2001a, p. 143). From 1981 to 2001, the visible minority population rose from 1.1 million to nearly 4.0 million (Statistics Canada, 2003a). However, these figures do not account for Aboriginal people (First Nations, Métis and Inuit), who are considered a special case ‘visible minority’. From 1981 to 2001, the Aboriginal population increased from just under half a million to just under one million (Statistics Canada, 2001b). The visible minority population and the Aboriginal population account for 5.0 million people, approximately 16.7% of the total Canadian population. Over the coming years, the population of visible minority persons in Canada is expected to increase from about 4.0 million in 2001 to a level estimated between 6.3 million and 8.5 million in 2017 (Statistics Canada, 2005a). Moreover, the Aboriginal population is expected to increase from approximately 0.98 million in 2001 to an estimated 1.39 million to 1.47 million during the same period (Statistics Canada, 2005b).

Aboriginal Health

Although, overall, health has improved for Aboriginal people since the early 1900s, there is still a very significant disparity between the health of Aboriginal Canadians and the remainder of the Canadian population. The hearings to the Royal Commission on Aboriginal Peoples (RCAP) in the mid-1990s focused much of the responsibility for the poor

health of the Aboriginal population on the Canadian government’s paternalistic and colonial policies. The Royal Commission’s mandate was to investigate the relationship among Aboriginal peoples, the Canadian government, and Canadian society as a whole and to find solutions to the myriad of problems that are plaguing Aboriginal people today (Hurley et al., 1996).

Health Canada’s *A Statistical Profile on the Health of First Nations in Canada*, released in 2003, highlights the health status of First Nations people as follows:

- Mortality rates are higher than the rest of Canadians, caused by endocrine, immune, and digestive diseases; diabetes is seen as an evolving epidemic among First Nations population;
- The overall mortality rate for First Nations people is 76.6 years for females and 68.9 years for men compared to 81.8 years and 76.3 respectively for the rest of Canada, with the infant mortality rate at 1.5 times the Canadian average;
- Tuberculosis, once thought to be close to eradicated in First Nations communities, is now 8 to 10 times higher than the national average;
- The proportion of Canada’s AIDS cases contracted by Aboriginal people climbed from 1% in 1990 to 7% in 2001;
- The suicide rate for First Nations is twice that of other Canadians; and,
- Injury and poisons are the leading cause of death for First Nations (almost 3 times the national average) at 124 per 100,000 population.

(paraphrase pgs. 14-42)

Two First Nations health surveys were conducted by Health Canada's First Nations and Inuit Health Branch and the Assembly of First Nations. These surveys took place in 11 provinces and territories throughout Canada and represented 238 First Nations communities (approximately 5.9% of First Nations population). The initial results of the *First Nations and Inuit Regional Longitudinal Health Survey (RHS)* were released by Health Canada (1999), the later results were released by the National Aboriginal Health Organization & First Nations Governance Committee (2004). The goal of the RHS is to explore First Nations' health in ways that are pertinent to their cultures and regions, while gathering core national information on the health status of First Nations people across Canada¹. Cardinals' (2004) report entitled *First Nations in Alberta: A Focus on Health Service Use*, also outlines the disparity in health facing First Nations people.

The *First National Longitudinal Survey 2002/03 (RHS)* found that there is very strong support for traditional cultural events, spirituality, and religion within the Aboriginal community. This is significant to the mainstream health care system as the survey also found that those who speak an Aboriginal language and those who consider cultural events important were "more likely to experience barriers" in accessing health care services (First Nations Centre, 2005, p. 36). Among those who follow traditional Aboriginal cultural ways more closely, the survey found that these respondents felt that health services were not culturally appropriate, and that they had difficulty in accessing mainstream forms of care (First Nations Centre, 2005). The RHS notes that language and culture are closely associated

with "quality and access to health care...[and that]... linguistic and cultural barriers, as well as racism and stereotypes, lead not only to misunderstandings and frustration, but can result in inferior diagnosis, care and outcomes" (First Nations Centre, 2005, p. 33).

Immigrant Health

The health status of new immigrants in Canada is usually better than native born Canadians due to immigration laws that promote the immigration of healthy applicants. However, the health status of immigrant populations who have been in Canada for an extended period of time is often worse than the non-immigrant population (McDonald and Kennedy, 2004). The following are a few case and point examples:

- Dunn and Dyck (2000) completed an analysis of 1994-95 National Population Health Survey (NPHS) data and found that immigrants were more prone to poor health than non-immigrants;
- Flakerud & Kim (1999) in their research found that the cancer within Asian and Pacific Islanders advanced faster than any other ethnic or racial group of people; and,
- Health Canada (1998b) produced a document stating that between 1980 and 1995 there was an increase of cases of tuberculosis among immigrants compared to a decline for Canadian born non-Aboriginal people.

McDonald and Kennedy (2004) provide some possible underlying reasons for the change

¹ The 2005 survey asked questions addressing such topics as disabilities, chronic conditions, diabetes, injuries, access to dental care, non-traditional tobacco use, alcohol and drug use, sexual health, health care access, mental health and wellness, and personal support. It also had a strong section on language and culture, community wellness and the impact of residential schools.

in immigrant people's health. Although some hypothesize that it is exposure to environmental factors and the acculturation process, others speculate that it may be a function of the difficulties immigrants face when attempting to access, navigate, and use mainstream health services. "This leads to a worsening immigrant health status over time because of relative under-use of preventative health screening and under-diagnosis and treatment of health problems" (McDonald and Kennedy, 2004, p. 1614).

Health Policy

With the projected increase in the diversity and the poorer health of Aboriginal and immigrant populations, health officials have begun to realize the importance of delivering culturally appropriate care, as reflected in the Canada Health Act (1984):

The Canada Health Act sets out nine requirements that provincial governments must meet through their public health-care insurance plan in order to qualify for the full federal contribution under the Canadian Health Social Transfer. These nine requirements include five criteria, two specific provisions and two conditions. The five criteria are public administration, comprehensiveness, universality, portability, and accessibility; they apply to insured health services. The fifth criterion, accessibility, is set out in section 12: insured persons must have *reasonable and uniform access* to insured health services, free of financial or other barriers (pgs. 4-6).

In response to the Canada Health Act, each province has developed its own interpretation of the nine requirements. Specifically, in regards to the fifth criterion, accessibility, the Provincial Health Council of Alberta (1998) states:

An accessible health system makes health services available to all who need them without barriers or long delays. *Language, culture*, distance, lack of common standards, regional boundaries, and other obstacles to effective health services are identified and eliminated as much as possible. The distance to health services does not present a major health risk to citizens. Citizens understand how and where to access the services they need. Citizens and providers are encouraged to identify and report access problems. Reducing access barriers is considered a high priority (npa).

With the high priority of an accessible health system, a Diversity Framework (Oelke, 2003) was developed for the Prevention and Screening Programs of the Alberta Cancer Board (ACB):

The Diversity Framework seeks to provide a structure to guide work with population groups of a wide diversity, focusing on those groups with a variety of barriers in accessing information or services related to cancer prevention and screening. These barriers could include but are not limited to cultural barriers, language, isolation and the like (p. 2).

The overall goal of the Diversity Framework is to decrease the incidence of cancer in underserved populations in Alberta by: (1) increasing knowledge and awareness of cancer prevention and early detection and (2) increasing positive behavior changes related to cancer prevention and early detection (Oelke, 2003). Recognizing that meeting the needs of underserved populations requires cross-cultural knowledge and skills, the ACB contracted the Faculty of Extension, University of

Alberta, to complete a literature review and provide evidence-based recommendations for cultural competency training. Ultimately, this work fulfills, in part, the ACB's goal to increase the knowledge and skills of staff and enhance their ability to work with underserved populations.

What is Cultural Competence?

The ACB adapted University of Toronto's Department of Public Health Sciences' definition of cultures as "the totality of ideas, beliefs, values, knowledge, norms, communication styles and way of life of a group of individuals who share certain ethnic, historical, linguistic, racial, religious and social background" (University of Toronto, 2006, npa). However, the term 'cultural competence' is still often misunderstood. Many definitions exist for cultural competence (Robinson, 2000; Rorie et al., 1996; Siegel et al., 2000; Abrums and Leppa, 2001; Crampton, et al. 2003; Betancourt, 2004; Purden, 2005). We have chosen to define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989, npa). This is the basis for our understanding of what it means to be culturally competent. Robinson (2000) however, gives a stern warning: "cultural competence involves more than knowledge acquisition; it involves skills, awareness, encounters, desire and knowledge" (p. 131). Ndiwane et al. (2004) state that "cultural awareness is a process involving the examination of one's own biases as a preliminary attempt to be sensitive and appreciative of others' cultures" (p. 119). This is vitally important, as cultural awareness, along with knowledge and skills, is critical to becoming culturally competent.

Why be Culturally Competent?

As was previously stated, Canada is increasingly a multi-cultural country. Providing culturally appropriate care is essential to improving health outcomes of under-served populations. One premise for providing culturally appropriate care comes from Ramsden (1992) who says, "[w]hen one group far outnumbers another or has the power to impose its own norms and values upon another, a state of serious imbalance occurs which threatens the identity, security and the ease of the other cultural groups, thus creating a state of disease" (p. 21). For example, Williams (1997) found that clients who perceive themselves as visible minorities expected to be negatively evaluated by the public systems that serve them, to be looked down upon and discriminated against, and have their background and culture misunderstood. Furthermore, when the culture of a patient is overlooked or not completely understood, there is the potential for health care providers to make harmful and inappropriate decisions. A lack of cultural competence also results in limited ability to engage and build on the strengths of families and communities (Williams, 1997). The inability to communicate with health care providers creates a barrier to access and undermines trust in the quality of medical care and decreases the likelihood of follow-up, resulting in diagnostic errors and inappropriate treatment (Anderson et al., 2003). The rationales for incorporating cultural competence into organizational policy are numerous. Goode and Dunne (2003) of the National Center for Cultural Competence (NCCC) have provided six significant components of cultural competency that are relevant to Canada's multicultural society.

- **To respond to current and projected demographic changes in Canada.**

As was stated at the beginning of this report,

the make-up of the Canadian population is changing as a result of immigration and refugee patterns, leading to significant changes in the racial, ethnical, cultural and linguistic diversity of our nation.

- **To eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds.** Statistics show that an individual's race, ethnicity and culture have an impact on their health. Despite the current advancement in the nation's overall health, there continues to be a disproportionate incidence of death and disease among immigrant and Aboriginal populations.
- **To improve the quality of services and health outcomes.** Even though there are similarities amongst people of all cultures, fundamental differences arise, creating 'racial cliques' within society. These individual differences influence health beliefs, perceptions, attitudes, and behaviors as well as the relationships between the patient and provider, thus making culturally competent health care an important aspect of health care delivery. To increase favorable health outcomes and make the health care experience more rewarding, culturally competent health services must be accessible and utilized.
- **To meet legislative and regulatory mandates.** The federal government of Canada has a pivotal role in ensuring culturally competent health care services. The Canada Health Act explicitly states that health care must be accessible to all peoples of Canada. Moreover, the Province of Alberta has deemed culture as a factor in the provision of and access to care.

- **To gain a competitive edge in the market place.**

When Premier Klein introduced the 'Third Way' (Edmonton Journal, July 13, 2005), the provision of publicly financed health care services was seen to be increasingly delegated to the private sector. Issues of concern in the current health care environment include the management and cost-effective delivery of health care services. Culturally competent care has the potential to increase the satisfaction of individuals seeking health care services.

- **To decrease the likelihood of liability/malpractice claims.**

With this new 'Third Way' being introduced in Alberta, the possibility exists for an increase in medical lawsuits. Lack of awareness about cultural differences may result in liability in several ways. For example, health care providers may discover that they are liable for damages "as a result of treatment in the absence of informed consent" (Goode and Dunn, 2003, p. 5) because of language or cultural misunderstandings. Also, health care organizations and programs face potential lawsuits if their failure to understand health beliefs, practices, and behavior on the part of providers or patients breaches professional standards of care.

Not all six are equally important, but one can see that providing culturally competent care is valuable not only for the client, but also for the health provider and health system. Cultural competence allows health care providers to feel comfortable in a cross-cultural setting and thus improves client outcomes. It enables clients to feel good about their interactions with their health care provider

so both parties can grow personally because of the interaction (Brislin, Cushner, Cherrie, & Young, 1986).

So far, cultural competence has been discussed only in general terms. The next section explores some of the current theoretical understandings of cultural competence and the process of cultural competency acquisition by health care professionals.

Theories in the Field of Cultural Competence

Leininger's Culture Care Diversity and Universality Theory

Although health care professionals have always attempted to make some concessions to the cultures of their patients, this practice was not considered of much importance within health academia until 1978, when Madeline Leininger published her landmark text, *Transcultural Nursing: Concepts, Theories, Research and Practice*. This book not only made a convincing case for the significance of culture in delivering effective health care, but also outlined a framework through which the process of transcultural nursing could be assessed. Leininger's theory, formally known as the *Culture Care Diversity and Universality Theory*, has four central tenets: (1) culturally based care has some universal practices, and others that vary with individual patients; (2) health outcomes are influenced by culture, beliefs, and worldviews; (3) both biomedical practices and alternative health care practices have a place in healing, and both can influence health outcomes; and (4) culturally appropriate care occurs through a combination of maintaining current clinical practice, negotiating treatment with patients, or restructuring the type of care provided to the patients' wishes, as dictated by the situation. The most frequently used aspect of Leininger's theory is the Sunrise

model, which is a visual representation of the effect of culture on a patient's care. This model, which consists of domains such as kinship, religious beliefs, and cultural values, among others, can be used generally to understand the process of culturally based care. It can also be filled out with details specific to a given culture using a research technique known as ethn nursing, in which ethnographic research is conducted by trained nurses into the health beliefs and practices of a given population in order to provide them with better quality care (Leininger, 2002).

Although Leininger's theory has been very influential in the field of cultural competence (it has even spawned a journal, *The Journal of Transcultural Nursing*, to report on new findings in ethn nursing), it has been criticized for focusing solely on individuals while ignoring structural factors in society which can impact health (Polaschek, 1998). The result of this focus is that the theory inadequately addresses the power imbalances that occur between members of dominant and minority groups and between health care providers and patients (Mulholland, 1995). As well, Leininger's theory minimizes variations within cultures and so contributes to essentialism (Ibid.).

Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services

A more recent theory, developed by Campinha-Bacote, is entitled the *Process of Cultural Competence in the Delivery of Healthcare Services*. Unlike Leininger's theory, Campinha-Bacote's was not designed specifically for nurses, but can be applied to any health care practitioner. Cultural competence, in this theory, consists of five components: (1) cultural desire, which is

the motivation from within to become culturally competent; (2) cultural awareness, which is an understanding of how one's own culture, biases, and background affect one's cross-cultural interactions; (3) cultural knowledge, which is information about other cultural groups; (4) cultural skill, which is the ability to conduct cultural assessments of patients; and (5) cultural encounters, which are opportunities to put theoretical understandings of the other components into practice. Cultural desire is the foundation upon which the others rest, but by itself cannot lead to the delivery of effective cross-cultural care: awareness, knowledge, skills, and encounters necessary for effective care must be acquired through education (Campinha-Bacote, 2002).

The strength of this theory is that it recognizes that cultural competence is a process rather than a state which can be obtained (Campinha-Bacote, 2002). A drawback is that, like Leininger's theory, Campinha-Bacote's theory can be criticized for ignoring the societal context in which provider-client interactions take place. This includes a dismissal of the role of institutions in motivating individuals to become culturally competent by focusing on individual desire alone. It also means that awareness is defined primarily in terms of the health care provider's self-awareness, rather than awareness of the impact that sociocultural factors have on cross-cultural interactions.

Ramsden's Cultural Safety

A final theory of cultural competence is *Cultural Safety*, developed by Ramsden, whose objective was to facilitate better health care experiences for New Zealand's Maori peoples. This theory focuses on reducing 'unsafe' nursing practices, that is, any action that, by imposing Western beliefs on indigenous peoples, threatens their identity and security, and

therefore their health. Cultural safe practice is accomplished primarily through attitude change, with a progression by health care providers from culturally sensitive to culturally aware to culturally safe. An understanding of the political and historical context in which Maori people live is essential to providing culturally safe care, as is an awareness of the power relations which pervade provider-patient interactions (Ramsden, 1992). In this way it incorporates elements of post-modern and post-colonial theory.

Although this theory has been criticized for being vague in terms of what constitutes culturally safe care and for focusing more on attitudes than on practice (Polaschek, 1998), it has been quite influential and is applied far beyond the borders of the New Zealand/Maori context for which it was designed. Recently, for example, Smye and Browne (2002) have explored the meaning of cultural safety in understanding the health care needs of Canada's minority cultures.

Other Theories

While Leininger, Campinha-Bacote, and Ramsden are among the most prominent theorists in the field of cultural competence, they are by no means the only authors addressing the topic. Betancourt (2003) has written about theories of cultural competence education; Purnell (2000) and Davidhizar and Giger (2001) have developed models of cultural assessment; and Kleiman et al. (2004) and Abrums and Leppa (2001) have discussed the application of post-modern theories to cultural competence. While all of these theories have their strengths, as do the three theories discussed above, none were deemed sufficient to guide the development of a framework for assessing the effectiveness of cultural competence-enhancing

educational strategies. This led us to develop a new theory which synthesizes and expands on those currently in use.

Proposed Theory of Cultural Competence

Based on the perceived gaps in existing cultural competence theories, we propose a new theory to explain the process of becoming culturally competent. A visual representation of this theory is presented in Figure 1.

Individual Desire / Institutional Support

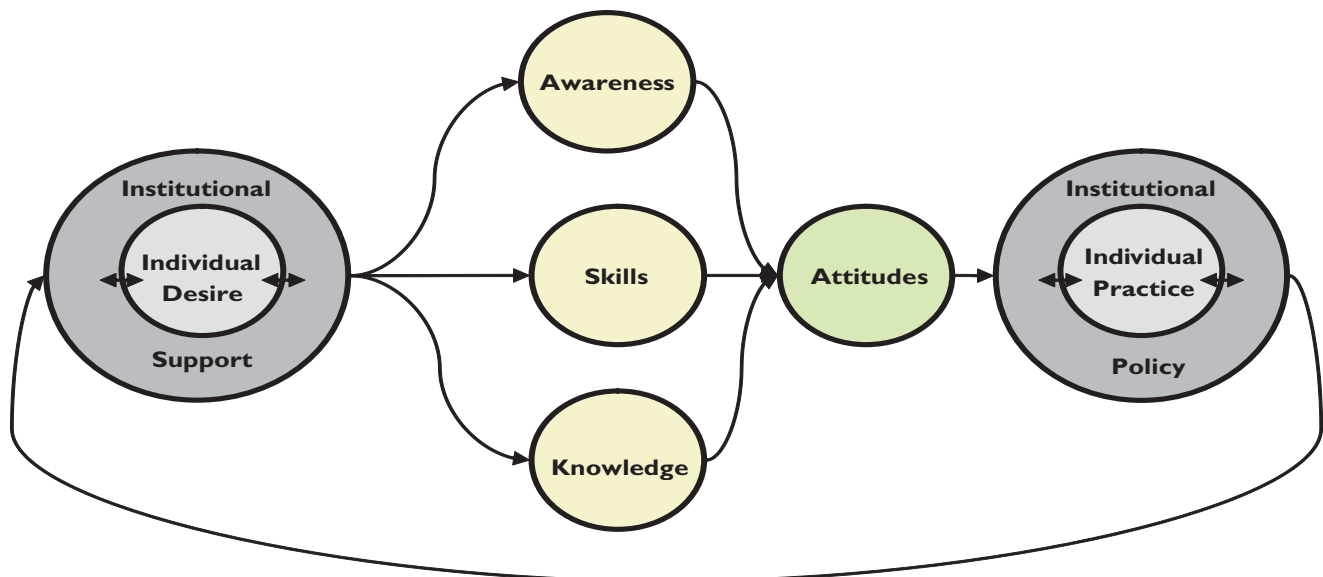
The model shows the process of developing cultural competence as beginning with individual desire situated within a context of institutional support. This is to highlight the fact that individuals are situated in specific contexts which can either hinder or help their progress towards cultural competence. Arrows between the two levels of motivation represent how the institutional environment can

affect an individual, and, conversely, how individuals can impact the institution. Desire and support lead an individual to seek opportunities to acquire awareness, skills, and knowledge related to cultural competence.

Awareness, Skills, and Knowledge

Awareness includes an understanding of one's own culture/worldview and how it impacts cross-cultural interactions, an appreciation for the differences that exist between one's own and other cultures, insight into the fluidity of culture and the danger of stereotyping, and/or consciousness of the biomedical model within the Western health system and its impact on the health care of other cultures. Awareness is identified as a vital component of cultural competence (Doutrich and Storey, 2004; Leishman, 2004; Kawaga-Singer and Kassim-Lakha, 2003; Abrums and Leppa, 2001; and Rorie et al., 1996).

Figure 1: Visual representation of proposed cultural competence theory



Cultural competence skills include cultural assessment (the process of investigating a patient's cultural beliefs in order to provide better care), communication skills (such as listening and negotiating), and the ability to work with a patient's family and community. The literature demonstrates these skills are recognized as essential to cultural competence (Pena Dolhun et al., 2003; Matzo et al., 2002; Nunez, 2000; Tervalon and Murray-Garcia, 1998; and Rorie et al., 1996).

Knowledge refers to specific knowledge about other cultures, such as their worldviews, health beliefs, and common health problems, in order to better understand their needs. While this information is important to the provision of quality care, in order to avoid the pitfalls of Leininger's theory, it is essential that this knowledge is acquired keeping in mind that "groups, cultures and the individuals within them are fluid and complex in their identities and relationships" (Fuller, 2002, p.198). Knowledge, with this caveat in mind, is advocated as part of cultural competence by Eschiti (2004), Abbott et al. (2002), Ahmann (2002), and Flores (2000).

Attitudes and Individual Practice / Institutional Policy

The next step in the model is an essential one if training in cultural competence is to lead to better health care for clients. The health care provider's newly-acquired awareness, skills, and knowledge must give rise to a change in attitudes about clients of other cultures and the provider's interactions with them. If this occurs, the awareness, skills, and knowledge will be put into practice, as indicated in the model. As with desire, individual practice does not occur in a vacuum; rather, it must be supported by appropriate policies at the institutional level. Again, individuals and institutions can and do influence each other in this area.

An arrow leading from practice and policy back to desire and support represents the concept that becoming cultural competent is an on-going process, and that acquiring some awareness, skills, and knowledge, with its influence on practice, may lead to an increased desire to learn more.

This new theory provided important direction in the development of criteria that would form the basis for ranking academic literature in order to ensure an evidence-based approach to recommendation for cultural competence training. In the following section, we describe the search strategies as well as the implementation of the ranking schema.

Methods

Search Strategy

Articles were located for this review using the databases Medline, Academic Search Premier, PsycINFO, ERIC, and CINAHL. Search terms included various combinations of the words 'cultural competence,' 'cultural diversity,' 'cultural sensitivity,' 'aboriginal,' 'immigrant,' 'program,' 'education,' 'health,' 'evaluation,' 'nursing,' 'medical,' and 'student'. Additional articles were located through hand-searching of references and indexes of selected journals. Articles were chosen for inclusion based on assessment of their relevance to the review and excluded based on age (older than 1990, unless they had a notable impact on the evolution of cultural competence training), language other than English, and unavailability at the University of Alberta during the time frame of the review. This generated 219 articles for review.

Review Strategy

Two hundred, nineteen articles were reviewed using a ranking matrix, evaluating the criteria presented below.

Each article was read and entered into the matrix by one reviewer. Sub-scores were generated for each entry for content related to awareness, skills, and knowledge, which were further combined to

generate scores for content related to practices for enhancing cultural competence. Scores were also generated for content related to evaluation of the identified practices. The articles were then sorted by evaluation score in order to locate articles in which the cultural competence-enhancing practices had been evaluated for effectiveness, resulting in 61 articles which were deemed to have been evaluative.

1)	Does the article discuss a cultural competency theory or model?
a)	Does the article provide critiques of cultural competency training? (y=1, n=0)
b)	Does the article provide strategies for increasing ability to critique cultural materials? (y=1, n=0)
2)	Does the article discuss skill development?
a)	Does the article address the use of cultural assessment tools? Rank=x/4
i.	Does the article address the flexible nature of the tool? (y=1; n=0)
ii.	Does the tool provide specific questions? (y=1, n=0)
iii.	Is the tool patient centered? (y=1, n=0)
iv.	Does the article discuss strengths and weaknesses of assessment tool? (y=1, n=0)
b)	Does the article address skill development related to Patient Centered Care? Rank = x/5
i.	What patient-centered skills are identified (work with family, negotiating, flexibility, communication) each skill = 1, to a max of 4
ii.	Are details about the skills discussed? (y=1;n=0)
3)	Does the article address cultural competency awareness practices? Rank = x/4
a)	Does awareness of culture include the concept of fluidity of culture? (y=1, n=0)
b)	Is the awareness raising related to one's own culture? (y=1, n=0)
c)	Is the awareness raising related to the client's culture? (y=1, n=0)
d)	Is the awareness raising related to the health system? (y=1, n=0)
4)	Does the article address knowledge of cultures? Rank = x/4
a)	Does it discuss impact of history on health perception, beliefs and practices? (y=1, n=0)
b)	Does it discuss sociopolitical impact on access and use of health resources? (y=1, n=0)
c)	Does it examine the impact of customs and beliefs on health practices? (y=1, n=0)
d)	Does it explore unique health problems in other cultures (epidemiology)? (y=1, n=0)
5)	Practical Total: Sum of (2)skills, (3) awareness, and (4)knowledge
6)	Did the article address the evaluation of the tool? Rank=x/8
a)	Was this an evaluation of a pilot (1) or program (2)?
b)	Did the program evaluate knowledge? (y=1, n=0)
c)	Did the program evaluate a skill (y=1, n=0)
d)	Did the program evaluate awareness? (y=1, n=0)
e)	Were the evaluation methods quantitative, qualitative, or mixed? not ranked
f)	Specify method/approach used
g)	Did the evaluation have internal validity? (y=1, n=0)
h)	Specify type of population(s) included (care providers, clients)
i)	Did the evaluation results identify a change in providers' knowledge? (y=1; n=0)
j)	Did the evaluation results identify a change in providers' skills? (y=1; n=0)
k)	Did the evaluation results identify a change in providers' awareness? (y=1; n=0)
l)	Did the evaluation results identify a change in patient satisfaction? (y=1; n=0)
m)	Did the evaluation results identify a change in patient outcomes? (y=1; n=0)
7)	Did the article make recommendations? (y=1; n=0) Specify type of recommendations

A second reviewer assessed each of these 61 articles and excluded those which provided no information on the cultural competence-enhancing practices being evaluated and those in which too little information was given about the evaluation to assess internal validity. This resulted in 30 articles to be used to assess best practices in enhancing cultural competence. An abridged version of the ranking matrix is included in its entirety in Appendix A.

addressed, teaching strategies, evaluation type (including design, sample size, and validity), and evaluation findings. All 30 articles were entered into this matrix independently by two different reviewers, with a final draft generated by the synthesis of information on each article. This was done in order to increase the validity and reliability of the review process. The evaluative matrix is included in its entirety in Appendix B.

Best practices were assessed using the evaluative matrix presented in Table I.

In this matrix, the following details were recorded about the cultural competence-enhancing practices outlined in the article: the theory on which they were based, aspects of cultural competence

Table I: Evaluative Matrix Criteria with Examples of Content Considered

Author (date)	Course Type and Model	Delivery	Content	Teaching Strategies	Evaluation findings	Evaluation Methods
Name (date)	Student population, duration Name of model (if any)	Student population duration	Awareness? Skills? Knowledge?		Impact of intervention	Qual/quant/mxd? Design? Tools? Internal validity? Number?

Literature Review of Evidence-Based Learning

A thorough review of the literature allowed us to do a comprehensive review of not only the effectiveness of evaluated cultural competency training approaches, but to provide more in-depth information on the tools and strategies used in training interventions. This section will be presented in two phases. First, the evaluative articles will be summarized in terms of content and outcomes. Second, the tools and strategies that proved most effective will be discussed in more detail in anticipation of their possible use in future cultural competency training programs.

Content and Outcomes

One of the main strategies in doing the literature review was to take an evidence-based approach. In doing so, the recommendations on cultural competency training tools and strategies would be evidence of program effectiveness and provide details on tried and proven practices. For that reason, the following section focuses on teaching strategies employed in pilots or on-going cultural competency training that have been evaluated.

Of the 219 articles, 109 reported on tools or strategies for teaching cultural competency and only 30 reported on program implementation and evaluation. In the following section, a detailed review of the evaluative articles shows that the evaluation varied in the following ways: sample size and makeup (for example, undergraduate or continuing education, medical or non-medical students), the types of program (one day workshops to 16 week courses), the amount of specificity provided with regard to the evaluation tools or processes (for example, no information, the use of a standardized cultural competency evaluation tool or evaluation tools

designed specifically according to course objectives), and the data analysis; all having direct impact on the validity of the evaluation (see Appendix B: Evaluative Summary of Articles). The following information was gathered on the 30 evaluative articles: theory or model upon which the program was built, student population and course duration, tools used to evaluate the program, and program components/teaching strategies and their effectiveness.

Theory or Model

Seventeen courses or programs were based upon a theory or framework of cultural competency (13), learning theory (3), and the last was based upon professional association guidelines (Hansen, 2002). Of the literature reviewed, Campinha-Bacotes' model of cultural competency was used in five studies (Anderson, 2004; Brathwaite, 2005; Doutrich and Storey, 2004; Nokes et al., 2005; Ott et al., 2004), Leininger's *Theory of Transcultural Nursing* in three cases (Chevannes, 2002; Hilgenberger and Schlickau, 2002; Williamson et al., 1996), while another study drew upon Kleinman's theory whereas Leininger's principles of cultural safety (Chevannes, 2002), and Pusch's process model for multicultural awareness were the bases for another study (Carpio and Majumdar, 1993). Bonder's cultural emergent model was implemented in one study (Ekelman et al., 2003) and cultural competency continuums was the basis for two studies (Assemi et al., 2004; Worrell-Carlise, 2005). The remaining 3 articles cited theories of active learning (Armour et al., 2004), developmental learning (Heuberger and Gerber, 1999) and experiential learning (Sideling et al., 2005).

It is difficult to be certain of the impact of theory on program planning as it is difficult to know whether some articles simply neglected to identify the role of theory in program development. In some cases,

program development, delivery, and evaluation strategies seem to indicate that a theoretical model was employed (Crosson et al., 2004; Dogra, 2001; Hansen, 2002; Heuberger and Gerber, 1999). Programs that clearly identified or appear to be guided by a theoretical model were more likely to include tools and strategies that addressed at least two, often three of: cultural awareness, skill development and culture-specific knowledge. Brathwaite (2005), Clark and Thornam (2002), Dogra (2001) and Heuberger and Gerber (1999) provide exceptional examples of programs that were well developed in terms of breadth of information. These programs also tended to take a more holistic approach to cultural competency training, employing multiple teaching tools and strategies. Again, Brathwaite (2005) provides a good example of multiple teaching methods.

In general, those programs that were not clearly based on a theory or framework tended to pose one or more of the following shortcomings: lacked detail in terms of the learning objectives or methods; appear to have little impact (Beagan, 2003); relied heavily on international immersion to have significant impact on cultural competency (Caffrey et al., 2005; Dowell et al., 2001; Haq et al., 2000); used course evaluation to gather feedback on delivery as opposed to change in cultural competency (Abrums and Leppa, 2001; Blackford and Street, 1999; Heuberger and Gerber, 1999); used measures that lack internal validity, for example, assessing knowledge when intervention was focused on cultural awareness (Moffat and Tung, 2004); or focused on something other than cultural competency, for example, Godkin and Savageau's (2003) measure of medical practitioners' humanism, idealism and appreciation for community orientation to health. In general, those approaches that did

not identify a theoretical basis appeared less likely to address all the facets of cultural competency included in the model proposed earlier.

Student population and course duration

The majority of the cultural competency training programs were offered through undergraduate nursing programs or undergraduate medical courses. Pilots and programs were also offered for undergraduate students in pharmacy, public health, occupational and physical therapy. There were far fewer examples of continuing or adult education, but some courses were offered to social workers, psychologists, and practicing public health nurses. In some cases, these were accredited by their professional associations.

When the training was offered as part of an undergraduate program, it was either integrated throughout or delivered as a module in a 16 week, 3 credit course. In other cases, interventions for teaching cultural competence were developed as workshops that were, for example, eight hours in duration and offered over two or three days or short courses/seminars that were approximately fifteen hours in duration and offered over a period of weeks or months. Because the focus of the Alberta Cancer Board and the Faculty of Extension is continuing adult education/professional continuing medical education, a detailed analysis of the non-graduate programs delivery, effectiveness and recommendations is worthwhile.

Continuing education for health practitioners were offered to social workers (Armour et al., 2004), registered nurses (Brathwaite, 2005), a diverse group of health professionals in the fields of occupational therapy, physiotherapy, speech and language therapy, chiropody, radiography,

dietetics, community nursing, midwifery and pharmacy (Chevannes, 2002), and doctoral students (Hansen, 2002)². Interestingly, all three were based upon either a theory of cultural competency or learning and had significant impact on learners' understanding of the impact of culture on health care needs of ethnic minorities, and increased their confidence to deliver culturally competent care and their self-perceived knowledge of culture. Two of the three (Armour et al., 2004 and Brathwaite, 2005) used mixed methods to evaluate the program's impact and all three included post-follow up evaluation 6 months (Armour et al., 2004), 3 months (Brathwaite, 2005) or 4 weeks (Chevannes, 2002).

Armour et al. (2004) focused on the training of field instructors working with culturally diverse social work students with the specific objective of decreasing avoidant behavior by increasing cultural competence. This is considered professional development as it delivered and assessed the impact of diversity training for field supervisors, not students. Six, 3-hour sessions, spaced one month apart, dealt with issues of prejudice, stereotyping, individual social and cultural difference, interpersonal differences, and social and cultural differences in the workplace. Training outcomes included "increased self-knowledge and empowered them to take initiative to address diversity issues with the agency, student, or client system" (p. 34).

Brathwaite's (2005) intervention with public health nurses included an introduction to terms and models of cultural competency, exercises to increase cultural awareness, didactic lecture and small group discussions to increase knowledge cultural groups,

opportunities to practice cultural assessments and cultural encounters. Brathwaite (2005) found that "the majority of participants had moved from culturally aware to culturally competent and proficient levels, indicating a meaningful change in their behavior/clinical practice following the intervention..., experienced an increase in their self-confidence to care for diverse populations..., were better prepared to provide services to cultural groups" (p. 367). Unfortunately, the details of the delivery mode were not provided.

Chevannes's (2002) training for a diverse group of health professionals was delivered through lecturers who work with ethnic minorities on a daily basis and skill-based sessions led by health participants and health workers. The content was delivered over a 10 week period. Eighty-two percent of the participants believed that the training added to their knowledge about ethnic minority groups and improved their understanding of concepts like ethnicity and race and made them more aware of local community resources to enhance their delivery of culturally competent care.

Hansen (2002) documents a teaching strategy that makes use of distance education technology in combination with an intensive 2-day 'laboratory' and monthly face-to-face gatherings on quarterly faculty/student gatherings to cover 8 multicultural assessment competencies in the areas of awareness, knowledge and skills. Based on comprehensive evaluations of students' pre-internship clinical comprehensives and true/false surveys of cultural knowledge, Hansen found that participants increased their knowledge base but does not elaborate on skill development. The author does note, however,

² Hansen (2002) makes note of the fact that, although this program was developed as a network learning model for clinical psychology graduate students, it could easily be adapted for continuing education credits for practising psychologists.

the need for follow up on the intensive 2-day laboratory with an advanced laboratory devoted to reviewing the course content and its application.

Other authors, whether documenting undergraduate or continuing education, note the importance of extended delivery or, at the very least, opportunities for students to reflect upon their learning and its implementation and/or evaluators to study the long-term impact (Carpio and Majumdar, 1993; Dogra, 2001; Hansen, 2002; Ott et al., 2004).

Evaluation tools

The approach to program evaluation varied in their use of quantitative, qualitative or mixed methods. Of the programs evaluated using quantitative methods, five employed a pre-post test design. In many cases only quantitative measures were taken, sometimes using standardized tests such as the Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals (Brathwaite, 2005; Doutrich and Storey, 2004; Nokes et al., 2005), the Health Beliefs Attitude Survey (Crosson et al., 2004), the Ethnic Competency Skills Assessment Inventory (Napholz, 1999), or the Cultural Self-Efficacy Scale (Williamson et al., 1996). However, studies were much more likely to use quantitative, likert scale-type measures developed in tandem with learning objectives (Assemi et al., 2004; Armour et al., 2004; Caffrey et al., 2005; Dogra, 2001; Godkin and Savageau, 2003; Haq et al., 2000; Hansen, 2002; Heuberger and Gerber, 1999; Moffat and Tung, 2004). Of the studies using quantitative methods, only three used a control group (Brathwaite, 2005; Caffrey et al., 2005; Nora et al., 1994), and two used a control group specifically to assess the impact of adding cultural immersion or service learning to a cultural competency training program (Godkin and Savageau, 2003; Worrell-Carlisle, 2005).

Qualitative methods were frequently used for program evaluation. Data was collected from participants through student reflections (Anderson, 2004; Armour et al, 2004; Carpio and Majumdar, 1993; Dowell et al., 2001; Sidelinger et al., 2005), interviews and focus groups (Beagan, 2003; Chevannes, 2002), open-ended questionnaires (Beagan, 2003; Brathwaite, 2005; Chevannes, 2002; Dogra, 2001; Haq et al., 2000; Hilgenberger and Schlickau, 2002) and student simulations to measure student competency (Clark and Thornam, 2002). Whether studies employed quantitative, qualitative or mixed methods, all but two demonstrated internal validity as they used or developed tools that were relevant to their teaching goals or had proven validity for cultural competency assessment from previous studies.

There were only two cases when post-program evaluations were used to test the long-term impact of the program. Brathwaite (2005) used open-ended questions to understand the impact of the course in terms of student's integration of the learning into practice and changes to practice and found that the majority of participants had progressed from culturally aware to culturally competent having made meaningful changes in their behaviors and clinical practice. Armour et al. (2004), using both quantitative and qualitative measures of awareness and skills, found that participants were more prepared to take the initiative in day-to-day practice to address diversity issues. Both studies showed long-term impact on behaviors and practices.

Program Components

Of the broad learning goals identified in our proposed model – cultural awareness, knowledge of cultures, and skills – very few of the programs

that were evaluated had all three components in their learning objectives. In the following section, the extent to which various programs address each of these facets of cultural competence is reviewed and a summary of their teaching strategies will be discussed. It is important to note here that the analysis is based on the information provided in the articles and their attention to the details regarding program components and learning tools or strategies vary.

Cultural Awareness

Cultural competence requires that the learner gain one or more of the following: an awareness of one's own culture; the culture of others; and health as having a culture of its own. Twenty-three of the programs documented in the evaluative articles dealt with increasing the individuals' awareness of their own culture. The attention paid to increasing self-awareness reflects the wealth of literature that emphasizes the importance of recognizing the impact of one's culture on perceptions of self and of others and, in turn, on the way that we interact with others. This emphasis stems from the importance of avoiding stereotyping and making generalizations.

Second only to teaching about one's own culture was teaching about the client's culture. Twenty-two of the authors identified awareness of client culture as a program component and documented increasing the participants' understanding of how culture may impact client's perceptions of health and health choices. In most cases, this was paired with awareness of own culture, with the exception of programs using cultural immersion or service learning as the only teaching strategies.

The culture of the health system was a facet of cultural learning in only four of the programs

(Abrums and Leppa, 2001; Crowshoe, 2005; Doutrich and Storey, 2004; and Worrelle-Carlisle, 2005). In fact, authors were more likely to comment on the difficulties encountered by students when returning to their place of practice as they felt powerless to change or influence the policies and practices of health systems and structures.

Knowledge

Very few provided tools or strategies for teaching cultural-specific knowledge. For those that chose to provide cultural-specific knowledge, they tended to focus on those marginalized populations most prevalent in their local area. Nora et al. (1994) and Williamson et al. (1996) for example, focused on language, traditional healing and epidemiology of Hispanic people. Haq et al. (2000) took a similar approach in preparing medical students for work in developing countries. In this case, epidemiology of tropical disease and mental health in developing countries were the two main foci.

However, there were a number of articles that provided information from cultural groups regarding what knowledge would be beneficial to health providers in cross-cultural situations. This is more prolific in Aboriginal than immigrant literature. This literature will be documented in the following section.

Skills

A number of programs aimed at increasing student skills in the area of negotiation, communication and cultural assessment. Variations on this theme included cultural considerations in history taking (Crosson et al., 2004) and eliciting client stories (Doutrich and Storey, 2004), rapport and effects of language difference (Hansen, 2002), use of

interpreters (Assemi et al., 2004; Caffrey et al., 2005) and cultural brokers, cross-cultural student supervision (Armour et al., 2004), client cultural assessment (Brathwaite, 2005; Caffrey et al., 2005), triaging and health assessment (Chevannes, 2002), physical examinations (Crosson et al., 2004) and culturally sensitive care in charting and care planning (Napholz, 1999).

Strategies and Tools

The most commonly cited strategies for teaching cultural competence include community interaction through experiential (or service) learning (Nokes et al., 2005; Ott et al., 2005; Sidelinger et al., 2005; Williamson et al., 1996; Worelle-Carlisle, 2005), immersion (Caffrey et al, 2005; Carpio and Majumdar, 1993; Dowell, 2001; Ekelman et al., 2002; Godkin and Savageau, 2003; Haq et al., 2000), interviews with and guest lectures by community members (Chevannes, 2002; Heuberger and Gerber, 1999; Napholz, 1999; Nokes et al, 2005), active learning including self-assessment (Heuberger and Gerber, 1999; Napholz, 1999), games (Assemi et al., 2004; Brathwaite, 2005; Carpio and Majumdar, 1993; Heuberger and Gerber, 1999; Worrell-Carlisle, 2005), simulated client encounters and role play (Armour et al., 2004; Blackford and Street, 1999; Heuberger and Gerber, 1999), case studies and problem-based learning (Blackford and Street, 1999; Crosson et al, 2004; Hilgenberger and Schlickau, 2002; Moffat and Tung, 2004) and the use of literature and audiovisual materials (Abrums and Leppa, 2001; Anderson, 2004; Blackford and Street, 1999; Heuberger and Gerber, 1999; Hansen, 2002; Moffat and Tung, 2004; Sidelinger, 2005).

Based on the proven success of teaching approaches and tools demonstrated in the evaluative articles, specific details of those approaches and tools will be discussed.

Community Interaction

Since the goal of cultural competence is for health care providers to be more responsive to the needs of members of specific communities, it seems natural that the most effective strategies for enhancing cultural competence would involve interaction with these communities. In fact, this has been the case, with many of the evaluated strategies mentioned above having a community-involvement component. These strategies can be grouped into five types: experiential learning, immersion, mentoring, interviewing, and presentations by community experts.

Kolb (1975) cited in Carpio and Majumdar (1993, p. 6) describes experiential learning as 'learning by doing'. This type of learning had four essential stages: concrete experience, reflection, abstract representation (i.e. assigning meaning to the experience), and active experimentation with new experiences. In terms of teaching cultural competence, experiential learning often involves facilitating cross-cultural encounters for students. Fahrenwald et al. (2001) for example, describe an undergraduate nursing course in which students were assigned to conduct a culturally appropriate community health needs assessment in local Hutterite colonies. The students, described by Sidelinger (2005) and Worrell-Carlisle (2005) become involved with local community organizations, those in the article by Albritton and Wagner (2002) assisted senior health care workers in providing one-day clinics for migrant workers, and those in Ott et al.'s (2004) piece presented a health promotion workshop to inner-city high school students. The common theme in these experiences is that they provide a chance for those learning cultural competence to gain awareness of other cultures, practice skills related

to delivering care, and develop knowledge of specific communities. Many cultural competence experiential learning encounters involve some form of service or volunteerism; they do not just benefit the student, but also provide some advantage to the hosting organization or community (Nokes et al., 2005). Pairing the students with more experienced mentors can enhance the service learning experience by offering a chance for students to see how cultural competence skills are used in the field (Doutrich and Storey, 2004; Flores, 2003).

Teaching cultural competence through immersion can seem a daunting task, since it often involves extended overseas experiences. Caffrey et al. (2003) describe a five-week immersion course for undergraduate nurses in which the students lived in small communities and participated in the towns' activities, assisted at local health centers, and met with traditional healers. A similar (though briefer) immersion experience is detailed by Nora et al. (1994) which additionally had students plan and shop for a nutritious meal on the daily wage of a local worker. In the cross-cultural immersion described by Ekelman et al. (2003) physical therapy students assisted with research conducted in Belize while also learning about local life and conditions. International immersion experiences are not the only options for those wishing to impart the lessons of cultural competence on health care providers, however. Crampton et al. (2003), Warner (2002) and Kavanagh et al. (1998) all describe immersion experiences on indigenous peoples' land, which provides an important opportunity to understand another culture's way of life without the costs associated with overseas travel. Ramsden (1992) suggests that these types of opportunities should be offered primarily to those who already have some background delivering culturally competent

care; inexperienced students can find the experience overwhelming and can become resentful. While immersion can be a valuable strategy for enhancing cultural competence, care must be taken to avoid a 'safari' atmosphere, and instead give the students an opportunity to understand the lives of the people they are visiting (Wear, 2003).

In a course described by Dogra (2001) students were assigned the task of interviewing several people of other cultures about several topics related to their backgrounds. More specifically, Robinson (2000) explores the use of an assignment in which students were to interview a nurse who was a member of a minority group. Interviews in both cases allowed the students to have one-on-one conversations with members of another culture and to address sensitive topics in a non-threatening manner.

A final strategy for enhancing cultural competence through community involvement is by inviting community members to speak to the students. Along with the low cost, this approach has the advantage that it can provide learners with information about the cultural groups in their areas, including information about health problems faced and the community resources available (Hoffman et al, 2005; Siegel et al., 2000). Suggestions for the type of speaker include community leaders (both formal and informal), members of advocacy groups, traditional healers, and cultural brokers (people who are comfortable in both cultures and act as facilitators between them) (Like et al., 1996).

Active Learning

The term 'active learning' encompasses a wide range of teaching strategies, but all have one general characteristic: the students do something and think about what they are doing. Often, active learning

is paired with didactic learning in order to present the 'big picture' and to give the students context in which to place their activities. Below are presented active learning tools which have been successfully used to increase cultural awareness, skills, and/or knowledge.

Self-assessment tools are used to challenge the assumption, held by many with little experience in cross-cultural situations, that culture is something that 'others' have but which white, middle-class people do not possess (Abrums and Leppa, 2001). They often take the form of open-ended questions about the student's traditions, beliefs, and values, and can be used to stimulate further discussion amongst the students and to lead into dialogue about ethnocentrism and white privilege (Brathwaite, 2005; Matzo et al., 2002; Dogra, 2001). An innovative approach used by Abrums and Leppa (2001) was to have the class read a description of American culture written for an exchange student audience; the stereotypes presented forced the class to consider not only their own culture, but also the assumptions they were making about other cultures. Cultural self-assessment is often very personal in nature, and it is therefore recommended that debriefing occur in small groups (Ferguson et al., 2003).

Games are another type of active learning commonly used to promote culture competence. One frequently cited game is called BaFa BaFa; developed for the US military in the 1970s, it consists of a simulation in which students are assigned to one of two cultures, whose customs they learn, and told to interact with the other culture according to certain rules. This is followed by a debriefing period in which issues of culture are addressed (Brathwaite, 2005; O'Connor et al., 2002; Carpio and Majumdar, 1993). An advantage

of this game is that, since both cultures are fictitious, students can openly express feelings engendered by the game without fear of being seen as ignorant or politically incorrect.

Cultural competence has been taught effectively through simulated client encounters, which can take the form of role play, forum theatre, or using actors to represent clients. Role play can be used not only to practice skills on simulated clients, but also to encourage students to imagine the feelings of their clients. It is important that the role play have specific goals and guidelines in order for it to be effective as a teaching strategy, and it should always be followed by a debriefing session in which students can express their feelings about the activity and teachers can present feedback and critiques for cross-cultural skills (Armour et al., 2004; Shearer and Davidhizar, 2003). Forum theatre is an activity in which a dramatized provider-client encounter is presented once with no interruptions, then run through a second time with students encouraged to stop the actors when they feel inappropriate behaviors are occurring (for example, degradation or stereotyping). The students who stop the action then have the opportunity to replace the actor and continue the play. A debriefing session which follows gives an opportunity for students to reflect on the lessons they have learned (Crowshoe et al., 2005). Simulated patients are common in medical and nursing schools; in the context of cultural competence education, they can provide students with the chance to practice newly-acquired skills and their peers with the opportunity to observe another person in a cross-cultural situation. If the same patient is used for several students, they can also be used to provide a standardized method of evaluating student skills (Brathwaite, 2005; Rutledge, 2004; Carillo, 1999; Tervalon and Murray-Garcia, 1998).

Problem-based learning consists of a plausible scenario being provided by the teacher, for which the students must then find a solution. The teacher's role in this type of learning is as facilitator rather than expert, which gives the students power over their own education and prepares them for situations in which the instructor will not be present (Blackford and Street, 1999). Case studies are a particular form of problem-based learning which are commonly used in health education. One advantage of using case studies is that cultural considerations can be integrated with discussions of clinical care, which makes cultural competence more relevant to the students (Betancourt, 2004; Dogra, 2001). Another advantage is it values and builds on knowledge the students already have (Blackford and Street, 1999). In some situations, the cases to be analyzed can be from the students' practice, and the solutions generated applied in real life (Hansen, 2002).

Literature and Audiovisual

Teaching cultural competence through the use of literature and audiovisual materials can be effective because these strategies allow students to connect emotionally with the concepts presented. One piece of literature that is often mentioned is *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Anne Fadiman (1997). This text tells the story of the difficulties that arise when Western medical staff attempt to care for an epileptic child without an understanding of the cultural context in which her illness is viewed by her family. The book can be used to stimulate discussion (Sidelinger, 2005; Clark et al., 2000), encourage personal reflection (Anderson, 2004), and give students who have limited or no clinical experience a 'client family' to whom they can apply cultural competence concepts

they are learning (Anderson, 2004). Furthermore, Abrums and Leppa (2001) noted such resources as the *American Ways* (Althen, 1988) and *Essay of the Bahamas* (Jordan, 1998) as exemplary teaching material due to their discussions about how individuals can have multiple cultural identities at one time and across their lifespans.

Two videos about a teaching experiment in the Southern US in the 1960s, in which teacher Jane Elliot had students experience discrimination on the basis of eye colour, are suggested as effective in raising students' awareness about racism and authority figures: *A Class Divided* (1985) and *The Essential Blue Eyed: Trainers Edition* (1999) (Bamberg et al, 2002; Abrums and Leppa, 2001). Another recommended video is *The Color of Fear* (1994) which is a documentary of North American men of different cultures talking about their experiences of and feelings on racism (Abrums and Leppa, 2001).

Didactic Learning

Few cultural competence courses are taught without some amount of didactic (or lecture-based) learning (Pena Dolhun et al., 2003), although it is most effective when combined with other teaching methods as outlined above (Hueberger et al., 1999). It is suggested that cultural competence training should begin with presentation of the basic concepts and terminologies, such as the differences between race, ethnicity, and culture (Moffat and Tung, 2004); diversity vocabulary, trends in local demographics that make cultural competence important, and common challenges in cross-cultural patient encounters (Clark and Thornam, 2002); legislation in place to prevent discrimination (Dogra, 2001) and introduction of cultural competence and communication theories (Brathwaite, 2005).

Cultural assessment tools, which are resources for soliciting information from patients about their culture and how it will impact care, can also be taught through didactic learning, although they should eventually be practiced by the students in order to be useful as skills (Assemi et al., 2004). While cultural assessment tools can consist of a long list of specific questions to ask the client (Hunter, 2005) more frequently they consist of a mnemonic device to help providers remember a few key areas to discuss with patients. One commonly used cultural assessment tool is Berlin and Fowkes' (1983) LEARN model; providers use this to remember to **L**isten to the patient with empathy and understanding, **E**xplain how they see the problem, **A**cknowledge and discuss ways in which this assessment is different from the patient's beliefs, **R**ecommend a treatment plan, and **N**egotiate until that plan is satisfactory to both parties. Another mnemonic is ETHNIC(S): solicit the client's **E**xplanation, inquire about **T**reatment (including traditional healing) that he or she has already undergone, ask about **H**ealers that he or she has visited, **N**egotiate a plan of action, suggest medical and non-medical **I**nterventions, **C**ollaborate with the client, the client's family, and other health care providers/traditional healers, and remember not to forget spirituality if it is a part of the client's life (adapted from Levin, 2000, by Kobylarz et al., 2002).

Didactic learning can also be used to teach culture-specific knowledge, such as demographics, health problems (epidemiology), systems and characteristics of culture (Heuberger and Gerber, 1999) and health beliefs of a culture that the providers will commonly encounter in practice. In every case, authors emphasize the importance of recognizing the heterogeneity of cultures and the dangers of stereotyping (Dogra, 2001; Heuberger and Gerber,

1999; Nora et al, 1994). Didactic learning should be followed by class discussion (Assemi et al., 2004; Matzo et al., 2002) that encourage students to explore the issues within a comfortable and safe environment (Abrums and Leppa, 2004).

Conclusion

An evidence-based approach enabled us to take a critical look at the programs that have been developed, delivered and evaluated. Based on this review, a number of specific recommendations for cultural competence training as well as suggestions for next steps in the development and delivery of a cultural competence education program are suggested.

Recommendations for cultural competence training:

- ✓ Base program development on a model or theory of cultural competence education.
- ✓ Provide learning opportunities for practitioners (who do not have the opportunities available to university undergraduate students) and work in partnership with professional organizations to ensure courses are given continuing medical education credit.
- ✓ Engage learners through active, experiential learning strategies.
- ✓ Provide opportunities to meet members of cultural groups through guest lectures or immersion opportunities. Seek opportunities for cross-cultural experiences through local community multicultural and Aboriginal organizations and create service learning opportunities through community-learning institution collaborations.

- ✓ Provide opportunities to become familiar with and practice cultural assessment tools.
- ✓ Plan programs that allow time for self-reflection and opportunities to implement what they have learned by offering education over an extended period of time (for example, weeks as opposed to a single, 3 hour workshop).
- ✓ Use existing tools of self-assessment as well as measures of cultural competence to supplement student learning and evaluate student progress.
- ✓ Plan pre- and post-testing so that the effectiveness of teaching strategies may be evaluated.

Next Steps for Development and Delivery

The literature review provided in-depth information on the evolution of cultural competence training, theoretical frameworks and models for teaching cultural competence, tools and strategies, as well as critiques of current approaches to cultural competence education. However, more work is required in the following areas:

- (1) The opinions and experiences of culturally diverse clients who receive services from mainstream health practitioners are seldom heard and, from what we have found, rarely documented with the exception of Aboriginal peoples. As a result, there may be gaps in service for clients from diverse cultures that are overlooked in the academic literature review. Focus groups with representatives from newcomer and immigrant populations may confirm the findings and recommendations and/or highlight gaps in the existing literature.

- (2) Chevannes (2002) provides an exemplary piece documenting, prior to program planning, what health professionals know about providing services and information to clients from cultural groups and their perceptions of what their training needs are. Focus groups, drawing on the experiences of a diverse group of service providers, would provide insight into their priorities for knowledge, skills and awareness training.
- (3) There are a number of programs and resources that are not documented in the academic literature. Prior to the development and delivery of cultural competence training, it would be prudent to do a gray literature review of programs and resources that are used in current cultural competence training initiatives.
- (4) There are very few delivered and evaluated programs that provide opportunities to develop cross cultural skills, explore cultural awareness (of self, others and the health system) and gain culture specific knowledge. Based on the findings of (1), (2), and (3) pilot (and eventually standardized, accredited) courses with an evaluative component would be a valuable addition to the field of health practitioners' professional development as well as the literature on cultural competence training.

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APPENDIX A: RANKING MATRIX

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Brathwaite, A. E. (2005)	Evaluation of a cultural competence course. <i>Journal of Transcultural Nursing</i> , 16 (4): 361-369.	1	4	0	2	7	1
Sidelinger, D. E.; Meyer, D.; Blaschke, G. S.; Hametz, P.; Batista, M.; Salguero, R.; Reznik, V. (2005)	Communities as teachers: learning to deliver culturally effective care in pediatrics. <i>Pediatrics</i> , 115: 1160-1164.	1	2	2	2	7	1
Chevannes, M. (2002)	Issues in educating health professionals to meet the diverse needs of patients and other service users from ethnic minority groups. <i>Journal of Advanced Nursing</i> , 39 (3): 290-298.	1	2	1	1	7	1
Williamson, E.; Strecchi, J. M.; Allen, B. B.; Coppens, N. M. (1996)	Multiethnic experiences enhance nursing students' learning. <i>Journal of Community Health Nursing</i> , 13 (2): 73-125.	1	7	2	3	7	1
Worrell-Carlisle, P. J. (2005)	Service-learning: a tool for developing cultural awareness. <i>Nursing Education</i> , 30 (5): 197-202.	1	0	2	2	7	1
Haq, C; Rothernberg, D.; Gjerde, C.; Bobula, J.; Wilson, C.; Bickley, L.; Cardelle, A.; Joseph, A. (2000)	New World Views: Preparing Physicians in Training for Global Health Work. <i>Family Medicine</i> , 32 (98): 566-572.	0	5	4	4	7	1
Doutrich, D.; Storey, M. (2004)	Education and practice: dynamic partners for improving cultural competence in public health. <i>Family Community Health</i> , 27 (4): 298-307	1	1	4	0	6	1
Ekelman, B.; Dal Bello Haas, V.; Bazyk, S. (2003)	Developing cultural competence in occupational therapy and physical therapy education: a field immersion approach. <i>Journal of Allied Health</i> , 32 (2): 131-137.	0	0	1	2	6	1

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Nora, L. M.; Daugherty, S. R.; Mattis-Peterson, A.; Stevenson, L.; Goodman, L. J. (1994)	Improving cross-cultural skills of medical students through medical school-community partnerships. <i>The Western Journal of Medicine</i> , 161 (2): 144-147.	0	1	0	3	6	1
Armour, M., Rubio, R., Bain, B. (2004)	An evaluation of diversity training for fieldinstructors: a collaborative approach to enhancing cultural competence. <i>Journal of Social Work Education</i> , 40 (1): 27-38	1	3	2	0	6	1
Caffrey, R.A.; Neander, W.; Markle, D.; Stewart, B. (2005)	Improving the cultural competence of nursing students: results of integrating cultural content in the curriculum and an international immersion experience. <i>Journal of Nursing Education</i> , 44 (5): 234-240.	1	7	4	4	6	1
Clark, L.; Thornam, C. (2002)	Using educational technology to teach cultural assessment. <i>Journal of Nursing Education</i> , 41 (3): 117-120.	1	3	2	0	5	1
Dowell, A. Crampton, P.; Parkins, C. (2001)	The first sunrise: an experience of cultural immersion and community health needs assessment by undergraduate medical students in New Zealand. <i>Medical Education</i> , 35 (3): 242-249.	0	1	2	0	5	1
Ott, C.; Doyle, L. H.; Tarantino, S. (2004)	The impact of an urban outreach teaching project: developing cultural competence. <i>International Journal of Nursing Education Scholarship</i> , 1 (1).	1	2	1	0	5	1
Crosson, J., Deng, W., Braeau, C., Boyd, L., Soto-Greene, M. (2004)	Evaluating the effect of cultural competency training on medical student attitudes. <i>Family Medicine</i> , 36 (3): 199-203	0	3	1	3	5	1
Assemi, M., Cullander, C., Hudmon, K. S. (2004)	Implementation and evaluation of cultural competency training for pharmacy students. <i>The Annals of Pharmacotherapy</i> , 38 (5): 781-786.	0	1	1	1	4	1

Godkin, M.; Savageau, J. (2003)	The effect of medical students' international experiences on attitudes toward serving underserved multicultural population. <i>Family Medicine</i> , 35 (4): 273-278.	0	4	4	3	4	1
Blackford, J.; Street, A. (1999)	Problem-based learning: an educational strategy to support nurses working in a multicultural community. <i>Nurse Education Today</i> , 19 (5): 364-372.	1	0	4	4	4	1
Anderson (2004)	Teaching cultural competence using an exemplar from literary journalism. <i>Journal of Nursing Education</i> , 43 (6): 253-259.	0	0	3	0	3	1
Dogra, N. (2001)	The development and evaluation of a programme to teach cultural diversity to medical undergraduate students. <i>Medical Education</i> , 35 (3): 232-241.	0	0	2	0	3	1
Hansen, N. D. (2002)	Teaching cultural sensitivity in psychological assessment: a modular approach used in a distance education program. <i>Journal of Personality Assessment</i> , 79 (2): 200-206	0	4	2	0	3	1
Crowshoe, L., Bickford, J., Decottingnes, M. (2005)	Interactive drama: teaching Aboriginal health medical education. <i>Medical Education</i> , 39 (95): 719-723.	0	1	1	1	3	1
Hilgenberg, C.; Schlickau, J. (2002)	Building transcultural knowledge through intercollegiate collaboration. <i>Journal of Transcultural Nursing</i> , 13 (3): 241-247	1	0	1	1	3	1
Heuberger, B., Gerber, D.; Anderson, R. (1999)	Strength through cultural diversity. <i>College Teaching</i> , 47 (3): 107-113.	0	0	3	0	3	1
Abrums, M. E.; Leppa, C. (2001)	Beyond cultural competence: teaching about race, gender, class, and sexual orientation. <i>Journal of Nursing Education</i> , 40 (6): 270-275	1	0	4	0	2	1
Beagan, B. L. (2003)	Teaching social and cultural awareness to medical student. <i>Academic Medicine</i> , 78 (60): 605-614.	0	0	0	0	2	1

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum: H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Napholz, L. (1999)	A comparison of self-reported cultural competency skills among two groups. <i>Journal of Nursing Education</i> , 38 (2): 81-83.	0	1	2	4	2	1
Moffat, J.; Tung, J. (2004)	Evaluating the effectiveness of culture brokering training to enhance cultural competence of independent living center staff. <i>Journal of Vocational Rehabilitation</i> , 20 (1): 59-69.	1	2	2	0	2	1
Carpio, B.; Majumdar, B. (1993)	Experiential learning: an approach to transcultural education for nursing. <i>Journal of Transcultural Nursing</i> , 4 (2): 4-11	1	1	0	0	1	1
Strickland, J. C.; Squeoch, M. D.; Chrisman, N. J. (1999).	Health promotion in cervical cancer prevention among the Yakama Indian women of the Wa'Shat Longhouse. <i>Journal of Transcultural Nursing</i> , 10 (3): 190-196.	1	0	2	4	5	
Albritton, T.A.; Wagner, P. J. (2002)	Linking cultural competency and community service: a partnership between students, faculty, and the community. <i>Academic Medicine</i> 77 (7): 738-739.	1	0	3	3	5	
O'Conner, B. B.; Rockney, R.; Alario, A. (2002)	BaFa BaFa: a cross-cultural simulation experience for medical educators and trainees. <i>Medical Education</i> , 36 (11): 1102-1102.	0	0	2	0	2	
Kim-Godwin, Y. S.; Clarke, P. N.; Barton, L. (2001)	A model for the delivery of culturally competent community care. <i>Journal of Advanced Nursing</i> , 35 (6): 918-925.	1	6	4	3	9	
Beach, M. C.; Price, E. G.; Gary, T. L.; Robinson, K. A.; Gozu, A.; Palacio, A.; Smarth, C.; Jenckes, M. W.; Feuerstein, C.; Bass, E. B.; Powe, N. R.; Cooper, L. A. (2005)	Cultural competence: a systematic review of health care provider educational interventions. <i>Medical Care</i> , 43 (4): 356-373.	0	0	0	0	8	

Moffitt, P.; Wuest, J. (2002)	Spirit of the Drum: The development of cultural nursing praxis. <i>Candadian Journal of Nursing Research</i> , 34 (4): 107-116.	1	8	4	4	4	7
Reynolds, P.J. (2005)	How service-learning experiences benefit physical therapist students' professional development: a grounded theory study. <i>Journal of Physical Therapy Education</i> , 19 (1): 41-54.	1	7	3	3	1	7
Kavanagh, K.; Absalon, K.; Beil, W. Jr.; Schliessmann, I. (1999)	Connecting and becoming culturally competent: A Lakota example. <i>Advances in Nursing Science</i> , 21 (3): 9-31.	1	7	2	2	3	7
Wittig, D. R. (2004)	Knowledge, skills, and attitudes of nursing students regarding culturally congruent care of Native Americans. <i>Journal of Transcultural Nursing</i> , 15 (1): 54-61.	1	6	4	4	3	7
Benkert, R.; Polh, J. M.; Coleman-Burns, P. (2004)	Creating cross-racial primary care relationships in a nurse-managed center. <i>Journal of Cultural Diversity</i> , 6 (2): 60-80.	1	6	3	3	1	7
Bottorff, J. L.; Balneaves, L. G.; Sent, L.; Grewal, S.; Browne, A. J. (2001)	Cervical cancer screening in ethnocultural groups: case studies in women-centered care. <i>Women Health</i> , 33: 3-4, 29-46.	1	6	3	3	4	7
Griffin, J. A.; Gilliland, S. S.; Perez, G.; Helitzer, D.; Carter, J. S. (1999)	Participant satisfaction with a culturally appropriate diabetes education program: the Native American Diabetes Project. <i>Diabetes Education</i> , 25 (3): 351-363.	0	3	2	2	4	6
Ryan, M.; Carlton, K. H.; Ali, N. (2000)	Transcultural nursing concepts and experiences in nursing curricula. <i>Journal of Transcultural Nursing</i> , 11 (4): 300-307.	1	1	1	1	0	6

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Browne, A. J. (1995)	The meaning of respect: A First Nations perspective. Canadian Journal of Nursing Research, 27 (4): 95-105.	0	5	3	3	5	
Bent, K. (2003)	Culturally interpreting environment as determinant and experience of health. Journal of Transcultural Nursing, 14 (4): 305-312.	1	1	2	2	5	
Smith, L. S. (2001)	Evaluation of an educational intervention to increase cultural competence among registered nurses. Journal of Cultural Diversity, 8 (2): 50-63.	1	5	2	2	5	
Garwick, A. (2000)	What do providers need to know about American Indian culture? recommendations from urban Indian family caregivers. Families, Systems and Health: The Journal of Collaborative Family Health Care, 18 (2): 177.	1	5	3	2	5	
Mitchell, A. M.; Gale, D. D.; Matzo, M. L.; McDonald, M. C.; Gardner, N. (2002)	Critique of transcultural practices in end-of-life clinical nursing practice. Nursing Forum, 37 (4): 24-31.	1	5	4	3	5	
Shapiro, J.; Hollingshead, J.; Morrison, E. H. (2002)	Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. Medical Education, 36 (8): 749-759.	1	7	3	2	5	
Kennell, L. S.; Nyback, M. J.; Ingalsbe, K. S. (2005)	Increasing cultural competence through asynchronous web-based interactions between two nursing programs. Journal of Nursing Education, 44 (5): 244.	0	0	2	1	4	

Austin, Wendy; Gallop, R.; McCay, E.; Peterneli-Taylor, C.; Bayer, M. (1999)	Culturally competent care for psychiatric clients who have a history of sexual abuse. <i>Clinical Nursing Research</i> , 8 (1): 5-23.	0	4	3	3	3	4
Jeffreys, M. R.; O'Donnell, M. (1997)	Cultural discovery: an innovative philosophy for creative learning activities. <i>Journal of Transcultural Nursing</i> , 8 (2): 17-22	1	1	2	1	1	4
Abbott, P.D.; Short, E.; Dodson, S.; Garcia, C.; Perkins, J.; Wyant, S. (2002)	Improving your cultural awareness with culture clues. <i>Nursing Practice</i> , 27 (2): 44-47.	1	3	2	3	3	4
Amerson, R. M. (2001)	Cultural nursing care: the planning, development, and implementation of a learning experience. <i>Journal for Nurses in Staff Development</i> , 17(1): 20-26	1	5	4	4	4	3
Dodgson, J. E.; Struthers, R. (2005)	Indigenous women's voices: marginalization and health. <i>Journal of Transcultural Nursing</i> , 16 (4): 339-346.	0	0	3	3	3	2
Rutledge, C. M.; Garzon, L.; Scott, M.; Karlowicz, K. (2004)	Using standardized patients to teach and evaluate nurse practitioner students on cultural competency. <i>International Journal of Nursing Education Scholarship</i> , 1 (1).	1	1	0	0	0	2
Brainin-Rodriguez, J. E. (2001)	A course about culture and gender in the clinical setting for third-year students. <i>Academic Medicine</i> , 76 (5): 512-513.	0	0	4	0	0	2
Schim, S. M.; Doorenbos, A. Z.; Borse, N. N. (2005)	Cultural competence among Ontario and Michigan health-care providers. <i>Journal of Nursing Scholarship</i> , 37 (4): 354-360.	1	0	0	0	0	2
Hodge, F. S.; Pasqua, A.; Marquez, C. A.; Geishirt-Centrell, B. (2002)	Utilizing traditional storytelling to promote wellness in American Indian communities. <i>Journal of Transcultural Nursing</i> , 13 (1): 6-11.	0	3	2	3	3	1
Yurkovich, E. E.; Clairmont, J.; Grandbois, D. (2002)	Mental health care providers' perception of giving culturally responsive care to American Indians. <i>Perspectives in Psychiatric Care</i> , 38 (4): 147-156.	1	0	2	4	4	0

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum: H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Richardson, S. (2004)	Aoteaoroa/New Zealand nursing: from eugenics to cultural safety... Nursing Inquiry, 11 (1):35-42.	1	0	2	4	0	
Spence, D. G. (2005)	Hermeneutic notions augment cultural safety education. Journal of Nursing Education, 44 (9): 409-414.	0	0	0	0	0	
Wear, D. (2003)	Insurgent Multiculturalism: rethinking how and why we teach culture in medical education. Academic Medicine, 78 (6): 549-554.	1	0	3	0	0	
Fuller, K. (2002)	Eradicating essentialism from cultural competency education. Academic Medicine, 77 (3): 198-201.	1	0	2	0	0	
Vega, W.A. (2005)	Higher stakes ahead for cultural competence. General Hospital Psychiatry, 27 (6): 446-450.	1	0	0	0	0	
Leishman, J. (2004)	Perspectives of cultural competence in health care. Nursing Standard, 19 (11): 33-38.	0	0	1	0	0	
Albritton, T.A.; Wagner, P.J. (2002)	Linking cultural competency and community service: a partnership between students, faculty, and the community. Academic Medicine, 77 (7): 738-739	0	0	0	0	0	
Polaschek, N. R. (1998)	Cultural safety: a new concept in nursing people of different ethnicities. Journal of Advanced Nursing, 27 (3): 452-457	1	0	0	0	0	

Nunez, A. E. (2000)	Transforming cultural competence into cross-cultural efficacy in women's health education. <i>Academic Medicine</i> , 75 (11): 1071-1080.	1	0	2	0	0	0
Richardson, F., Carryer, J. (2005)	Teaching cultural safety in a New Zealand nursing education program. <i>Journal of Nursing Education</i> , 44 (5): 201-208.	1	0	2	2	0	0
Ehrmin, J. T. (2005)	Dimensions of culture care for substance-dependent African-American women. <i>Journal of Transcultural Nursing</i> , 16 (2): 117-125.	0	2	1	1	0	0
Fahrenwald, N. L.; Boysen, R.; Fischer, C.; Maurer, R. (2001)	Developing cultural competence in the baccalaureate nursing student: a population-based project with the Hutterites. <i>Journal of Transcultural Nursing</i> , 12 (1): 48-55.	0	1	1	3	0	0
Eschiti, V. S. (2004)	Holistic approach to resolving American Indian/Alaskan Native health disparities. <i>Journal of Holistic Nursing</i> , 22 (3): 201-208.	0	0	0	1	0	0
Dokis, L. (2004)	Cultural Competence for Registered Nurses. <i>The Canadian Women's Health Network Magazine</i> , 4/5 (4/1).	0	0	0	0	0	0
Dean, R. A. (2003)	Native American humor: implications for transcultural care. <i>Journal of Transcultural Nursing</i> , 14 (1): 62-65.	0	2	0	1	0	0
Crow, K.; Matheson, L.; Steed, A. (1999)	Informed consent and truth-telling: cultural directions for health care providers. <i>Journal of Nursing Administration</i> , 30 (3): 148-152.	0	2	2	1	0	0
Abbott, P. D.; Short, E.; Dodson, S.; Garcia, C.; Perkins, J.; Wyant, S. (2002)	Improving your cultural awareness with culture clues. <i>Nurse Practitioner</i> , 27 (2): 44-47.	0	0	0	1	0	0
Andersen, S. R.; Belcourt, G. M.; Langwell, K. M. (2005)	Building healthy tribal nations in Montana and Wyoming through collaborative research and development. <i>American Journal of Public Health</i> , 95 (5): 784-789.	0	0	0	0	0	0
Berlin, E. A.; Fowkes, W. C. Jr. (1983)	A teaching framework for cross-cultural health care. <i>Western Journal of Medicine</i> , 139 (6): 934-938.	0	5	0	0	0	0
Betancourt, J. R. (2003)	Cross-cultural medical education: conceptual approaches and frameworks for evaluation. <i>Academic Medicine</i> , 78 (6): 560-569.	0	0	0	0	0	0

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Carillo, J. E.; Green, A. R.; Betancourt, J. R. (1999)	Cross-cultural primary care: a patient-based approach. Annals of Internal Medicine, 130 (10): 829-834.	1	7	2	0	0	
Severson, M. A.; Leinonen, S. J.; MattHensrud, N. N.; Ruegg, J. A. (1999)	Transcultural patient care committee: actualizing concepts and developing skills. Journal for Nurses in Staff Development, 15 (4): 141-147.	1	2	3	0	0	
Friedemann, M.; Anderson, K. H. (2005)	Family nursing network. Family health care across cultures: an international online program. Journal of Family Nursing, 11 (1): 79-82.	0	0	1	0	0	
Chronicle of Higher Education. (2005)	Dangerous competence. Chronicle of Higher Education, 52 (11): B4.	1	0	1	0	0	
American Academy of Pediatrics. (2004)	Ensuring culturally effective pediatric care: implications for education and health policy. Pediatrics, 114 (6): 1677-1685.	1	5	4	2	0	
Journal for Quality and Participation. (2004)	A checklist for cultural competence self-assessment. Journal for Quality and Participation, 27 (4): 20-20.	0	2	1	0	0	
Counselling and Psychotherapy Journal. (2004)	Training in cultural competence. Counselling and Psychotherapy Journal, 15 (5): 21-21.	1	0	0	0	0	

Nurse Practitioner. (2003)	Using cross-cultural definitions of health care. Nurse Practitioner, 28 (1): 61-62.	0	2	3	0	0	0
Outcomes and Accountability Alert. (1999)	Performance measures reflect how well systems serve diverse populations. Outcomes and Accountability Alert, 4 (1).	0	1	0	0	0	0
National Center for Cultural Competence. (2002)	Developing cultural competence in health care settings. Pediatric Nurse, 28 (2): 133-137.	0	5	4	4	0	0
Nursing Management. (1998).	A model for cultural change. Nursing Management, :29 (10): 62-66.	1	2	2	0	0	0
Bamberg, R.; Pitts, B. B.; Maloney, E. M. (2002)	Curriculum resources for cultural diversity education... allied health leadership development program. Journal of Allied Health, 31 (2): 117-120.	0	1	2	2	0	0
Browne, A. J.; Fiske, J. A. (2001)	First Nations women's encounter with mainstream health care services. Western Journal of Nursing Research, 23 (2): 126-147.	0	5	2	3	0	0
Saskatchewan Institute of Applied Science and Technology. (2002).	SIASST cultural competency: managing and developing equity skills. SIASST Human Resources Services, http://www.gov.sk.ca/shrc/equity/pdf/CulturalComp.pdf .	0	0	0	0	0	0
Smye, V.; Browne, A. J. (2002)	"Cultural safety" and the analysis of health policy affecting aboriginal people. Nurse Researcher, 9 (3): 42-56.	1	0	0	0	0	0
Anderson, J.; Perry, J.; Blue, C.; Browne, A.; Henderson, A.; Khan, K. B.; Reimer, K., S.; Lynam, J.; Semeniuk, P.; Smye, V. (2003)	"Rewriting" cultural safety within the postcolonial feminist project: toward new epistemologies of healing. Advances in Nursing Science, 26 (3): 196-214.	1	0	0	0	0	0
Allegante, J. P.; Moon, R. W.; Auld, M. e.; Gebbie, K. M. (2001)	Continuing-education needs of the currently employed public health education workforce. American Journal of Public Health, 91 (8): 1230-1234.	0	0	0	0	0	0
Clark, L.; Zuk, J.; Baramee, J. (2000)	A literary approach to teaching cultural competence. Journal of Transcultural Nursing, 11 (3): 199-203	0	0	3	4	0	0

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Bartol, G., Richardson, L. (1998)	Using literature to create cultural competence. <i>Journal of Nursing Scholarship</i> , 30 (1): 75-79	0	0	4	0	0	
Hunter, L. et al. (2006)	Aboriginal healing: regaining balance and culture. <i>Journal of Transcultural Nursing</i> , 17 (1): 13-22	0	0	2	2	0	
Congress, E. P. (2004)	Cultural and ethical issues in working with culturally diverse patients and their families: the use of the culturagram to promote cultural competent practice in health care settings. <i>Social Work Health Care</i> , 39 (3/4): 249-262.	0	2	0	2	0	
Divac, A.; Heaphy, G. (2005)	Space for GRRRAACCES: training for cultural competence in supervision. <i>Journal of Family Therapy</i> , 27 (3): 280-284	0	0	2	0	0	
Andrulis, D. in Kramer, E. J.; Ivey, S. L.; Ying, Y. editors (1999)	"Cultural competence assessment of practices, clinics, and health care facilities" in <i>Immigrant women's health: problems and solution</i> .	0	1	0	0	0	
Kramer, E. J.; Bateman, W. B. in Kramer, E. J.; Ivey, S. L.; Ying, Y. editors (1999)	"A cultural competence Curriculum" in <i>Immigrant women's health: problems and solutions</i> .	0	4	4	4	0	
Ferran, E.; Tracy, L.; Gany, F. M.; Kramer, E. J. in Kramer, E. J.; Ivey, S. L., Ying, Y. editors (1999)	"Culture and Multicultural competence" in <i>Immigrant women's health: problems and solutions</i> .	0	0	4	4	0	

Kramer, Elizabeth J.; Ivey, Susan L.; Ying, Yu-Wen (1999)	Immigrant Women's Health: Problems and Solutions, Jossey-Bass Publications: San Francisco	1	0	3	3	0	0
Rumay, A. (2002)	A mind for multicultural management. Nursing Management, 33, Issue 10: 30.	1	0	0	0	0	0
Andrews, M. M.; Boyle, J. S. (2002)	Transcultural concepts in nursing care. Journal of Transcultural Nursing, 13 (3): 178-180.	1	0	0	0	0	0
Bechtel, G.A.; Davidhizar, R. (1999).	A cultural assessment model for ED patients. Giger-Davidhizar model of transcultural assessment. Journal of Emergency Nursing, 25 (5): 377-80, 432-6.	1	0	4	0	0	0
Bennett, D. L.; Chown, P.; Kang, M. S. (2005)	Cultural diversity in adolescent health care. Medical Journal of Australia, 183 (8): 436-438.	1	0	3	3	0	0
Betancourt, J. R. (2004)	Cultural competence -- marginal or mainstream movement? New England Journal of Medicine, 351 (10): 953-955.	1	0	0	3	0	0
Bonder, B.; Martin, L.; Miracle, A. (2001)	Achieving cultural competence: the challenge for clients and healthcare workers in a multicultural society. Generations, 25 (1): 35.	1	0	3	2	0	0
Brach, C.; Fraser, I. (2000)	Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Medical Care Research & Review, 57 (Suppl 1): 181-217.	1	0	2	4	0	0
Brathwaite, A. C. (2003)	Selection of a conceptual model/framework for guiding research interventions. Internet Journal of Advanced Nursing Practice, 6 (1): 38-49.	1	0	0	0	0	0
Byrne, M. M.; Weddle, C.; Davis, E.; McGinnis, P. (2003)	Educational innovations. The Byrne guide for inclusionary cultural content. Journal of Nursing Education, 42 (6): 277-28.	1	0	1	0	0	0

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Campinha-Bacote, J. (2002)	The process of cultural competence in the delivery of healthcare services: a model of care. <i>Journal of Transcultural Nursing</i> , 13 (3): 181-184.	1	0	4	0	0	
Campinha-Bacote, J. (1998)	Cultural diversity in nursing education: issues and concerns. <i>Journal of Nursing Education</i> , 37 (1): 3-4.	1	0	1	0	0	
Campinha-Bacote, J., Yahle, T.; Langenkamp, M. (1996)	The challenge of cultural diversity for nurse educators. <i>Journal of Continuing Education in Nursing</i> , 27 (2): 59-64.	1	0	4	4	0	
Dean, R. G. (2001)	The Myth of Cross-Cultural Competence. <i>Family in Society</i> , 82 (6): 623-630.	1	0	2	0	0	
Dogra, N.; Connin, S.; Gill, P.; Spencer, J.; Turner, M. (2005)	Teaching of cultural diversity in medical schools in the United Kingdom and Republic of Ireland: cross sectional questionnaire survey <i>British Medical Journal</i> , 330 (7488): 403-404.	0	0	0	0	0	
Fox, R. (2005)	Cultural competence and the culture of medicine. <i>New England Journal of Medicine</i> , 353 (13): 1316-1319.	1	0	2	0	0	
Giger, J. N.; Davidhizar, R.; Johnson, J. Y.; Poole, V. L. (1997)	Health promotion among ethnic minorities: the importance of cultural phenomena. <i>Rehabilitation Nursing</i> , 22 (6): 303-307.	1	0	0	0	0	
Jones, M. E.; Cason, C. L.; Bond, M. L. (1998)	Where does culture fit in outcomes management? <i>Journal of Nursing Care Quality</i> , 13 (1): 41-51.	1	0	4	0	0	
Kai, J.; Spence, J.; Woodward, N. (2001)	Wrestling with ethnic diversity: toward empowering health educators. <i>Medical Education</i> , 35 (3): 262-271.	0	0	3	0	0	

Kaplan, S. H.; Greenfield, S. (2004)	The patient's role in reducing disparities. <i>Annals of International Medicine</i> , 141 (3): 222-223.	1	0	3	0	0	0
Kirkham, S. R. (1998)	Nurses' descriptions of caring for culturally diverse clients. <i>Clinical Nursing Research</i> , 7 (2): 125-146.	1	0	0	0	0	0
Lipson, J. G.; Rogers, J. G. (2000)	Cultural aspects of disability. <i>Journal of Transcultural Nursing</i> , 11 (3): 212-219.	1	0	0	0	0	0
Luna, I. (2002)	Diversity issues in the delivery of healthcare. <i>Lippincott's Case Management</i> , 7 (4): 138-143.	1	0	4	0	0	0
Malina, D. (2005)	Compliance, caricature, and culturally aware care. <i>New England Journal of Medicine</i> , 353 (13): 1317-1318.	1	0	2	0	0	0
Meleis, A. I. (1999)	Culturally competent care. <i>Journal of Transcultural Nursing</i> , 10 (1): 12.	1	0	3	0	0	0
Siegel, C.; Haugland, G.; Chambers, E. D. (2003)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. <i>Administration & Policy in Mental Health</i> , 31 (2): 141-170.	1	0	1	0	0	0
Stubben, J. D. (2001)	Working with and conducting research among American Indian families. <i>American Behavioral Scientist</i> , 44 (9): 1466.	1	0	3	4	0	0
Talabere, L. R. (1996)	Meeting the challenge of culture care in nursing: diversity, sensitivity, competence, and congruence. <i>Journal of Cultural Diversity</i> , 3 (2): 53-61.	1	0	3	1	0	0
Tatemichi, S.; Miedema, B.; Leighton, S. (2002)	Breast cancer screening. First Nations communities in New Brunswick. <i>Canadian Family Physician</i> , 48 (June): 1084-1089.	0	1	0	1	0	0
Taylor, R. (2005)	Addressing barriers to cultural competence. <i>Journal of Nurses Staff Development</i> , 21 (4): 135-144.	1	0	0	0	0	0
Taylor-Brown, S.; Garcia, A.; Kingson, E. (2001)	Cultural competence versus cultural chauvinism: implications for social work. <i>Health and Social Work</i> , 26 (3): 185.	1	2	2	0	0	0

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Walsh, S. (2004)	Formulation of a plan of care for culturally diverse patients. <i>International Journal of Nursing Terminologies & Classifications</i> , 15 (1): 17-26.	0	1	0	0	0	
Wepa, D. (2003)	An exploration of the experiences of cultural safety educators in New Zealand: an action research approach. <i>Journal of Transcultural Nursing</i> , 14 (4): 339-348.	0	0	0	0	0	
Yeo. S. (2004)	Language barriers and access to care. <i>Annual Review of Nursing Research</i> , 22: 59-73	0	0	0	0	0	
Benoit, C.; Carroll, D.; Chaudhry, M. (2003)	In search of a healing place: Aboriginal women in Vancouver's downtown eastside. <i>Social Science and Medicine</i> , 56 (4): 821.	0	0	0	4	0	
Brunt, J. H.; Lindsey, E.; Hopkinson, J. (1997)	Health promotion in the Hutterite community and the ethnocentricity of empowerment. <i>Canadian Journal of Nursing Research</i> , 29 (1): 17-28.	1	0	0	3	0	
Canales, M. K.; Bowers, B. J. (2001)	Expanding conceptualizations of culturally competent care. <i>Journal of Advanced Nursing</i> , 36 (1): 102-111.	1	0	0	0	0	
Coffman, M. J. (2004)	Cultural caring in nursing practice: a meta-synthesis of qualitative research. <i>Journal of Cultural Diversity</i> , 11 (3): 100-109. 1	1	0	0	1	0	
Cook, C. T.; Kosoko-Lasaki, O.; O'Brien, r. (2005)	Satisfaction with and perceived cultural competency of healthcare providers: the minority experience. <i>Journal of the National Medical Association</i> , 97 (8): 1078-1087.	0	0	0	1	0	

Cornelius, L. J.; Booker, N. C.; Arthur, T. E.; Reeves, I.; Morgan, O. (2004)	The validity and reliability testing of a consumer-based cultural competency inventory. <i>Research on Social Work Practice, 14</i> (3): 201-209.	1	0	0	0	0	0	0
Culley, L. (1996)	A critique of multiculturalism in health care: the challenge for nurse education. <i>Journal of Advanced Nursing, 23</i> (3): 564-570.	1	0	0	0	0	0	0
Donnelly, P. L. (2000)	Ethics and cross-cultural nursing. <i>Journal of Transcultural Nursing, 11</i> (2): 119-126.	1	2	0	0	1	0	0
Dreher, M.; Macnaughton, N. (2002)	Cultural competence in nursing: foundation or fallacy? <i>Nursing Outlook, 50</i> (5): 181-186.	1	0	0	0	0	0	0
MacAvoy, S.; Lippman, D. T. (2001)	Teaching culturally competent care: nursing students experience rural Appalachia. <i>Journal of Transcultural Nursing, 12</i> (3): 221-227.	0	2	2	3	0	0	0
Morell, V. W.; Sharp, P. C.; Crandall, S. J. (2002)	Creating student awareness to improve cultural competence: creating the critical incident. <i>Medical Teacher, 24</i> (5): 532-534.	1	0	1	0	0	0	0
Smith, R. C.; Hoppe, R. B. (1991)	The patient's story: integrating the patient- and physician-centred approaches to interviewing. <i>Annals of Internal Medicine, 115</i> (6): 470-477.	0	3	0	0	0	0	0
Ferguson, W. J.; Keller, D. M.; Haley, H. L.; Quirk, M. (2003)	Developing culturally competent community faculty: a model program. <i>Academic Medicine, 78</i> (12): 1221-1228.	0	3	0	0	0	0	0
Eunyoung, E. S. (2004)	The model of cultural competence through an evolutionary concept analysis. <i>Journal of Transcultural Nursing, 15</i> (2): 93-102.	1	0	0	0	0	0	0
Garrouette, E. M.; Kunovich, R. M.; Jacobsen, C.; Goldberg, J. (2004)	Patient satisfaction and ethnic identity among American Indian older adults. <i>Social Science and Medicine, 59</i> (11): 2233-2244.	1	0	0	0	0	0	0

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Flowers, D. L. (2004)	Culturally competent nursing care: a challenge for the 21st century. <i>Critical Care Nurse</i> , 24 (4): 48-52.	1	1	2	0	0	
Flores, G.; Gee, D.; Kastner, B. (2000)	The teaching of cultural issues in US and Canadian medical schools. <i>Academic Medicine</i> , 75 (5): 451-455.	1	0	0	0	0	
Flores, G. Association of Medical Pediatric Department Chairs, Inc. (2003)	Providing culturally competent pediatric care: integrating pediatricians, institutions, families, and communities into the process. <i>Journal of Pediatrics</i> , 143 (1): 1-2.	1	0	0	0	0	
Flores, G. (2000)	Culture and the patient-physician relationship: achieving cultural competency in health care. <i>Journal of Periatrics</i> , 136 (1): 14-23.	0	1	0	3	0	
Gibbs, K. A. (2005)	Teaching student nurses to be culturally safe: can it be done? <i>Journal of Transcultural Nursing</i> , 16 (4): 356-360.	1	0	2	0	0	
Giger, J. N.; Davidhizar, R (2002)	The Giger and Davidhizar transcultural assessment model. <i>Journal of Transcultural Nursing</i> , 13 (3): 185-188.	1	2	0	0	0	
Hart, A.; Hall, V.; Henwood, F. (2003)	Helping health and social care professionals to develop an 'inequalities imagination': a model for use in education and practice. <i>Journal of Advanced Nursing</i> , 41 (5): 480-489.	1	0	4	0	0	

Harvard Medical School's Center of Excellence in Women's Health. (2006)	Cultural competency in women's health: training faculty to teach about providing culturally competent care for minority and underserved women. Online program. http://www.hms.harvard.edu/coewh/cultural/modules/index.html	0	3	4	4	0
Hunt, L. M. (2001)	Beyond cultural competence: applying humility to cultural settings. Bulletin, 24. The Parkridge Center for Health and Faith and Ethics. http://www.parkridgecenter.org/Page1882.html .	1	0	0	0	0
Hunter, J. L. (2005)	Emelda's story: applying ethnographic insights to cultural assessment and cervical cancer control. Journal of Transcultural Nursing, 16 (4): 322-330.	0	2	0	0	0
Jones, M. E.; Cason, C. L.; Bond, M. L. (2004)	Cultural attitudes, knowledge, and skills of a health workforce. Journal of Transcultural Nursing, 15 (4): 283-290.	1	0	0	0	0
Kagawa-Singer, M.; Kassim-Lakha, S. (2003)	A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. Academic Medicine, 78 (6): 577-587.	1	4	3	0	0
Kilpatrick, K. (2004)	New Aboriginal health course increases awareness. Canadian Medical Association Journal, 170 (12): 1780-1780.	0	0	0	0	0
Kobylarz, F.A.; Heath, J. M.; Like, R. C. (2002)	The ETHNIC(S) mnemonic: a clinical tool for ethnogeriatric education. Journal of the American Geriatric Society, 50 (9): 1582-1589.	0	6	0	0	0
Leininger, M. (2002)	Culture care theory: a major contribution to advance transcultural nursing knowledge and practice. Journal of Transcultural Nursing, 13 (3): 1889-192.	1	2	0	0	0
Leininger, M. (2001)	Founder's focus: types of science and transcultural nursing knowledge. Journal of Transcultural Nursing, 12 (4): 333.	1	0	0	0	0
Matzo, M. L.; Sherman, D. W.; Mazanec, P.; Barber; Virani, r.; McLaughlin, M. M. (2002)	Teaching cultural considerations at the end of life: end of life nursing education consortium program recommendations. Journal of Continuing Education in Nursing, 33 (6): 270-278.	0	4	0	0	0

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Nápoles-Springer, A. M.; Santoyo, J.; Houston, K.; Pérez-Stable, E. J.; Stewart, A. L. (2005)	Patients' perceptions of cultural factors affecting the quality of their medical encounters. <i>Health Expectations</i> , 8 (1): 4-17.	1	3	1	2	0	
Ndiwane, A.; Miller, K. H.; Bonner, A.; Imperio, K.; Matzo, M.; McNeal, G.; Amertil, N.; Feldman, Z. (2004)	Enhancing cultural competencies of advanced practice nurses: health care challenges in the twenty-first century. <i>Journal of Cultural Diversity</i> , 11 (3): 118-121.	1	2	0	0	0	
Purden, M. (2005)	Cultural considerations in interprofessional education and practice. <i>Journal of Interprofessional Care</i> , 19 (Suppl 1): 224-234.	1	2	0	0	0	
Purnell, L. (2002)	The Purnell model for cultural competence. <i>Journal of Transcultural Nursing</i> , 13 (3): 193-196.	1	0	0	4	0	
Reynolds, P. P.; Kamei, R. K.; Sundquist, J.; Khanna, N.; Palmer, E. J.; Palmer, T. (2005)	Using the PRACTICE mnemonic to apply cultural competency to genetics in medical education and patient care. <i>Academic Medicine</i> , 80 (12): 1107-1113.	0	5	0	0	0	
Ryan, M. and Twibell, R.S. (2002)	Outcomes of a transcultural nursing immersion experience: confirmation of a dimensional matrix. <i>Journal of Transcultural Nursing</i> , 13, 1, 30-39.	1	0	0	0	0	
Shearer, R.; Davidhizar, R. (2003)	Using role play to develop cultural competence. <i>Journal of Nursing Education</i> , 42 (6): 273-276.	0	0	2	0	0	
Sloand, E.; Groves, S.; Brager, R. (2004)	Cultural competency education in American nursing programs and the approach of one school of nursing. <i>International Journal of Nursing Education Scholarship</i> , 1 (1): 10.	1	0	0	0	0	

Andrews, M. M.; Boyle, J. S. (2002)	Transcultural concepts in nursing care. <i>Journal of Transcultural Nursing</i> , 13, 30: 178-180.	1	0	0	0	0	0	0
Jones, M. E.; Bond, M. L.; Cason, C. L. (1998)	Where does culture fit in outcomes management? <i>Journal of Nursing Care Quality</i> , 13 (1): 41-51.	1	0	4	0	0	0	0
Kaplan, S. H.; Greenfield, S. (2004)	The patient's role in reducing disparities. <i>Annals of Internal Medicine</i> , 141 (3): 222-223.	1	0	3	0	0	0	0
Lipson, J. G.; Rogers, J. G. (2000)	Cultural aspects of disability. <i>Journal of Transcultural Nursing</i> , 11 (3): 212-219.	1	0	0	0	0	0	0
Siegel, C., Haugland, G.; Chambers, E. D. (2003)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. <i>Administration & Policy in Mental Health</i> , 31 (2): 141-170.	1	0	1	0	0	0	0
Taylor, R. (2005)	Addressing barriers to cultural competence. <i>Journal of Nurses Staff Development</i> , 21 (4): 135-144.	1	0	0	0	0	0	0
Arthur, T. E.; Reeves, I.; Morgan, O.; Cornelius, L. J.; Booker, N. C.; Brathwaite, J.; Tufano, T.; Allen, K.; Donato, I. (2005)	Developing a cultural competence assessment tool for people in recovery from racial, ethnic and cultural backgrounds: the journey, challenges and lessons learned. <i>Psychiatric Rehabilitation Journal</i> , 28 (3): 243-250.	1	7	3	0	0	0	0
Glockshuber, E. (2005)	Counselors' self-perceived multicultural competencies model. <i>European Journal of Psychotherapy, Counselling and Health</i> , 7 (4): 291-308.	1	2	2	0	0	0	0
Eduardo Pena-Dolhun, Claudia Munoz and Kevin Grumbach (2003)	Cross-cultural Education in U.S. Medical Schools: Development of an Assessment Tool. <i>Academic Medicine</i> , 78, 6, 615-622.	1	6	2	0	0	0	0
Davidhizar, R.; Giger, J. (2001)	Teaching culture within the nursing curriculum using the Giger-Davidhizar model. <i>Journal of Nursing Education</i> , 40 (6): 282.	1	3	2	0	0	0	0
Crampton, P.; Dowell, A.; Parlin, C.; Thompson, C. (2003)	Combating effects of racism through a cultural immersion medical education program. <i>Academic Medicine</i> , 78: 595-598.	1	0	4	4	0	0	0

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Narayan, M. C. (2003)	Cultural assessment and care planning. Home Healthcare Nurse, 21(9): 611-618.	1	8	4	4	0	
Silverman, B. E.; Goodine, W. M.; Ladoucer, M. G.; Quinn, J. (2001)	Learning needs of nurses working in Canada's First Nations communities. The Journal of Continuing Education in Nursing, 32 (1): 38-45.	0	5	3	4	0	
Menon, S.; McKinlay, I. A.; Faragher, E. B. (2001)	Knowledge and attitudes in multicultural health care. Child Care Health Development, 27 (5): 439-450.	0	3	3	4	0	
Kleiman, S.; Frederickson, K.; Lundy, T. (2004)	Using an eclectic model to educate students about cultural influences on the nurse-patient relationship. Nursing Education Perspectives, 25 (5): 249-253.	1	5	4	4	0	
Johnson, R. L.; Saha, S.; Arbelaez, J.; Beach, M. C.; Cooper, L. A. (2004)	Original articles: Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. Journal of General Internal Medicine, 19 (2): 101-110.	0	8	3	0	0	
Barrett, K. (2002)	Facilitating culturally integrated behaviors among allied health students. Journal of Allied Health, 31 (2): 93-98	1	0	2	0	0	
Dyche, L.; Zayas, L. H. (2001)	Cross-cultural empathy and training the contemporary psychotherapist. Clinical Social Work Journal, 29 (3): 245-258.	0	2	3	0	0	
McGee, C. (2001)	When the golden rule does not apply: starting nurses on the journey toward cultural competence. Journal for Nurses in Staff Development, 17 (3): 105-114.	1	0	0	1	0	

Browne, C.; Braun, K. L.; Mokuau, N.; McLaughlin, L. (2002)	Developing a multisite project in geriatric and/or gerontological education with emphases in interdisciplinary practice and cultural competence. <i>The Gerontologist</i> , 42 (5): 698-704	0	0	0	0	0	0	0	0
Ancis, J. (1998)	Cultural competency training at a distance: challenges and strategies. <i>Journal of Counselling Development</i> , 76 (2): 134-143.	0	0	0	0	0	0	0	0
Doorenbos, A. Z.; Schim, S. M.; Benkert, R.; Borse, N. N. (2005)	Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. <i>Nursing Research</i> , 54 (5): 324-331.	1	3	0	0	0	0	0	0
Like, R. C. (2005)	Culturally competent family medicine: transforming clinical practice and ourselves. <i>American Family Physician</i> , 72 (11): Editorial.	0	3	1	2	0	0	0	0
Ahmann, E. (2002)	Developing cultural competence in health care settings. <i>Family Matters</i> , 28 (2): 133-137.	0	1	2	1	0	0	0	0
Vancouver Ethnocultural Advisory Committee	Cultural competency assessment tool. Ministry for Children and Families. Http://www.mcf.gov.bc.ca/reports_publications.htm	0	2	0	0	0	0	0	0
Arnold, O. F.; Bruce, A. (2005)	Nursing practice with Aboriginal communities: expanding worldviews. <i>Nursing Science Quarterly</i> , 18 (3): 259-263.	1	0	3	3	0	0	0	0
Goold, S. (2001)	Transcultural nursing: can we meet the challenge of caring for the Australian Indigenous person? <i>Journal of Transcultural Nursing</i> , 12 (2): 94-99.	0	4	4	4	0	0	0	0
Makuchal, P. J. (2003)	Five strategies to develop cultural competence among allied health occupations students. <i>Techniques: Connecting Education and Careers</i> , 78 (8): 8-58.	0	0	2	0	0	0	0	0
McBride, G. (2005)	The coming of age of multicultural medicine. <i>PLOS Medicine (Public Library of Science)</i> , 2 (3): 181-182.	0	0	1	2	0	0	0	0

Author	Article Title & Source	Theory or Model (y=1, n=0)	Skill Development Sum:H + N	Cultural Awareness Rank = x/4	Culture-specific Knowledge Rank = x/4	Evaluative Rank=x/8	Pass Double Review for Evaluative Content (y=1)
Yan, M. and Wong, Y. (2005)	Rethinking self-awareness in cultural competence: toward a dialogic self in cross-cultural social work. Families in Society, 86, 2, 181-188.	1	4	4	0	0	
Moffitt, P. M. (2004)	Colonialization: a health determinant for pregnant Dogrib women. Journal of Transcultural Nursing, 15 (4): 323-330.	1	0	2	3	0	
Nursing Council of New Zealand (2005)	Guidelines for Cultural Safety, the treaty of Waitangi and Maori health, in nursing education and practice. Nursing Council of New Zealand.	1	2	2	1	0	
Parish, T. G. (2003)	Cultural competence: do we agree on its meaning and should it be considered a core competency in training programs? Internet Journal of Academic Physician Assistants, 3 (2): 10-20.	1	2	1	0	0	
Perloff, R. M.; Bonder, B.; Ray, G. B.; Ray, E.B.; Siminoff, L.A. (2006)	Doctor-patient communication, cultural competence, and minority health. American Behavioral Scientist, 49 (6): 835-852.	1	2	2	2	0	
Phelps, L. D.; Johnson, K. E. (2004)	Developing local public health capacity in cultural competency: a case study with Haitians in a rural community. Journal of Community Health Nursing, 21 (4): 203-215.	1	4	1	3	0	
Purnell, L. (2000)	A description of the Purnell Model for Cultural Competence. Journal of Transcultural Nursing, 11 (1): 40-46.	1	8	4	1	0	

Reeves, J. (2001)	Weaving a transcultural thread. <i>Journal of Transcultural Nursing</i> , 12 (2): 140-145.	1	7	4	4	4	0	
Rorie, J.A.; Paine, L. L.; Barger, M. K. (1996)	Primary care for women. Cultural competence in primary care services. <i>Journal of Nurse-Midwifery</i> , 41 (2): 92-100.	1	8	4	4	4	0	
Zambrana, R. E.; Molnar, C.; Munoz, H. B.; Lopez, D. S. (2004)	Cultural competency as it intersects with racial/ethnic, linguistic, and class disparities in managed healthcare organizations. <i>American Journal of Managed Care</i> , 10 (Spec No): SP37-44.	0	0	2	2	1	0	
Committee on Pediatric Workforce (2004)	Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy. <i>Pediatrics</i> , 114, 6, 1677-1685	1	5	4	4	2	0	

A decorative graphic consisting of a red L-shaped line. The vertical line starts with a red dot at the top, goes down, then turns right to end with a red dot. A green horizontal bar with rounded ends is positioned across the middle of the vertical line.

APPENDIX B: EVALUATIVE SUMMARY OF ARTICLES

Author (Date)	Course Type and Model	Content	Teaching Strategies	Evaluation Findings	Evaluation Methods
Assemi et al. (2004)	8 hr elective course for pharmacy students Uses Milton-Bennett and Terry Cross Models and the continuum of cultural sensitivity	Awareness (other cultures)	Didactic learning, self assessment, class activity	Improvement	Quantitative analysis (pre- and post-test design) using a 12 item Likert self-assessment questionnaire (designed for this study) Internal validity, n=56
		Skills (communication, cultural assessment)	Didactic learning, role play, class discussion, audiovisual materials	Improvement in most skills	
Abrums and Leppa (2001)	Semester-long course for undergraduate nursing students No model identified	Awareness (self, other cultures, health care system)	Didactic learning, literature, audiovisual materials, informal free writing, final written assignment	Improvement	Quantitative analysis (post-test design) using questionnaire (standard Likert scale university course evaluation); Qualitative analysis of final written assignments Internal validity, n=N/A
Anderson (2004)	Content in a course for undergraduate nursing students Uses Campinha-Bacote's model	Awareness (other cultures)	Literature	Questionnaire showed improvement only on item asking whether the student treated everyone the same; essays showed improvement	Quantitative analysis (pre- and post-test design) using Likert scale (questionnaire from text); Qualitative analysis of short papers Lacked internal validity, n=45
Armour et al (2004)	6 3 hr session "train-the-trainer" workshop for social work professors No model identified	Awareness (self, other cultures)	Class activity, group discussions	Improvement	Quantitative analysis (repeated measures design) using 13-item questionnaire (designed for this course); Qualitative analysis of written assessments (no important findings from written) Internal validity, n=52
		Skills (evaluating agencies' cultural competence, working as a supervisor)	Class activity, role play	Improvement	

Author (Date)	Course Type and Model	Content	Teaching Strategies	Evaluation Findings	Evaluation Methods
Beagan (2003)	Content in a course for undergraduate medical students No model identified	Knowledge (cultural groups and health, epidemiology)	Small group discussions, didactic learning, guest speakers	No improvement	Quantitative analysis (cross-sectional design) using questionnaire (designed for this course); Qualitative analysis of interviews Internal validity, n=61
Blackford and Street (1999)	1 full-day or 2 half-day workshops for practicing nurses No model identified	Skills (communication, patient centered interviewing)	Problem-based learning	No improvement in skills measured although participants were enthusiastic about what they learned	Qualitative analysis of course evaluations Cannot discern internal validity due to lack of detail, n=16
Brathwaite (2005)	Course for practicing nurses Uses Campinha-Bacote's model	Awareness (self, other cultures)	Self assessment, games, individual reflective exercise	Quantitative – overall improvement but not analyzed by subject area; qualitative – most reported improvement	Quantitative analysis (repeated measures design) using questionnaire (IAPCC-R); Qualitative analysis of post-course open-ended questionnaire
		Skills (cultural assessment, negotiation of care)	Cultural assessment of simulated client with peer evaluation, didactic learning	Quantitative – overall improvement but not analyzed by subject area; qualitative – most reported improvement	
		Knowledge (cultural groups and health)	Didactic learning, group discussion, class activity	Quantitative – overall improvement but not analyzed by subject area; qualitative – most reported improvement	

Caffrey et al. (2003)	Part of a undergraduate course and also a 5-week international clinical immersion course for undergraduate nursing students No model identified	Awareness (details not discussed)	CC course content: interactions with Hispanic populations and exchange students; CC immersion: met traditional healers	No improvement in CC course content group; improvement in CC course content plus immersion group	Quantitative analysis (pre- and post-test design with two arms: CC course content and CC course content plus immersion) using questionnaire (designed for this evaluation) Internal validity, n=32
		Skills (details not discussed)	CC immersion: worked in Guatemala on community-directed health projects	No improvement in CC course content group; improvement in CC course content plus immersion group	
Carpio and Majumdar (1993)	Content in undergraduate nursing program Uses Pusch's process model for multicultural awareness	Knowledge (details not discussed)	CC course content: case studies	No improvement in CC course content group; improvement in CC course content plus immersion group	Qualitative analysis of course evaluations and observation of subsequent student activities Lacks internal validity, n=N/A
		Awareness (self)	Games, simulated patients, group discussion	Most students showed no improvement, but some went on to become involved in more cultural learning activities	
Chevannes (2002)	10 week course for practicing health care workers Uses Leininger's model and a needs assessment	Awareness (details not discussed)	Not discussed	Improvement	Qualitative analysis of semi-structured interviews, focus groups, and questionnaires Internal validity, n=17
		Skills (patient centered interviewing)	Didactic learning, peer-led sessions, and audiovisual materials	No improvement for most students	

Author (Date)	Course Type and Model	Content	Teaching Strategies	Evaluation Findings	Evaluation Methods
Clark and Thornam (2002)	On-line course for graduate nursing students Uses Kleinman's theory	Awareness (self)	Website with course material and student discussion area, CD-ROM with videos, list-serve subscription	Students attained expected competencies	Qualitative analysis of performance in mock clinical scenario Internal validity, n=N/A
		Skills (communication, cultural assessment, negotiation of care)			
		Knowledge (cultural groups and health, epidemiology)			
Crosson et al. (2004)	Content in two courses for undergraduate medical students No model identified	Awareness (other cultures)	Problem-based learning	Improvement in some areas of awareness but not others	Quantitative analysis (pre- and post-test) using questionnaire (Health Beliefs Attitudes Survey) Internal validity, n=91
		Skills (cultural assessment)	Problem-based learning, didactic learning	Not assessed	
Crowshoe et al. (2005)	Activity that was part of a course for undergraduate medical students No model identified	Awareness (self, other cultures)	Forum theatre	Improvement	Quantitative analysis (post-test design) of questionnaire (details of instrument not given); Qualitative analysis of questionnaire Cannot discern internal validity due to lack of detail, n=~100
		Awareness (self, other cultures)	Didactic learning, class exercises, self-assessment, interviewing, case studies, class discussion	Improvement	
Dogra (2001)	Content in a course for undergraduate medical students No model identified	Awareness (self, other cultures)	Didactic learning, interviewing	Not assessed	Quantitative analysis (pre- and post-test design) using a questionnaire (designed for this study) Internal validity, n=140
		Knowledge (cultural groups and health, legislation)	Didactic learning, interviewing	Not assessed	

Doutrich and Storey (2004)	Content in a course for Canadian undergraduate nursing students Uses Campinha-Bacote's model and the Minnesota Department of Public Health nursing intervention wheel	Awareness (self, other cultures, health care system)	Workshops with cultural competence consultant, guest speaker	Quantitative analysis (pre- and post-test design) using Critical Thinking Inventory and the IAPCC; Qualitative analysis of student and mentor comments during orientation, workshops, and debriefs as well as of student papers Internal validity, n=13
Dowell et al. (2001)	Content in a course for medical students No model identified	Awareness (other cultures)	Immersion	Improved for almost all students
		Skills (culturally-appropriate community health needs assessment)	Experiential learning	Improved for most students
		Knowledge (cultural groups and health, epidemiology, barriers to health care)	Immersion, individual completion of workbooks	Improved for almost all students
Ekelman et al. (2003)	Course for occupational and physical therapy undergraduate students Uses culture emergent model	Awareness (self, other cultures)	Immersion, daily journals, debriefing sessions, reflection papers	Improved
		Knowledge (cultural groups and health)	Guest lectures, literature, immersion, interviews	Not assessed
Godkin and Savageau (2003)	Elective course for undergraduate medical students	Awareness (self, other cultures, medical system)	Immersion	Improved
		Skills (advocacy)	Immersion	Not assessed
		Knowledge (cultural groups and health)	Immersion	Not assessed
				Quantitative analysis (pres- and post-test design with control group) using questionnaire (developed for this study) Internal validity, n=207

Author (Date)	Course Type and Model	Content	Teaching Strategies	Evaluation Findings	Evaluation Methods
Hansen (2002)	15 hr course, part of a distance education clinical psychology program No theory identified	Awareness (self)	Self-assessment, class activity, didactic learning	Not assessed	Quantitative analysis (cross-sectional design) using a true-false test of knowledge Internal validity, n=N/A
		Skills (cultural assessment)	Didactic learning, interviews, case study, apply cultural assessment to one of own clients, class discussion	Not assessed	
		Knowledge (not discussed)	Not discussed	Improvement	
Haq et al. (2000)	8-10 week fellowship for undergraduate medical students No theory identified	Awareness (self, other cultures, health care system)	Interactive lectures, discussions, role play, case studies, immersion, experiential learning	Improvement	Quantitative analysis (repeated measures design) using a questionnaire designed for the study; Qualitative analysis of narrative responses written for post-field and follow-up assessments Internal validity, n=60
		Skills (communication)	Interactive lectures, discussions, role play, case studies, immersion, experiential learning	Improvement	
Heuberg and Gerber (1999)	Course for undergraduate students No model identified	Awareness (self, other cultures)	Didactic learning, class discussion, self-class activities, self-assessment, games	Improvement	Quantitative analysis (mid- and post-test design) using questionnaires (university evaluation forms); Qualitative analysis of small-group discussions Lacks internal validity, n=36
		Skills (communication, negotiation)	Didactic learning, self-assessment	Improvement	

<p>Hilgenberg and Schlickau (2002)</p>	<p>Content in course for undergraduate nursing students Uses Leininger's model</p>	<p>Knowledge (cultural groups and health)</p>	<p>Case studies (using the internet to connect nursing students from different schools), class discussions</p>	<p>Improvement</p>	<p>Qualitative analysis of questionnaires and student comments Lacks internal validity, n=N/A</p>
<p>Moffat and Tung (2004)</p>	<p>Workshop for practicing health care workers at an independent living centre No model identified</p>	<p>Awareness (self, other cultures) Skills (cultural brokering)</p>	<p>Didactic learning, audiovisual materials, group activities, class discussions Case studies, group discussions</p>	<p>Improvement Improvement</p>	<p>Quantitative analysis (pre-and-post test design) using two questionnaires (designed for this study) Internal validity, n=29</p>
<p>Napholz (1999)</p>	<p>Course content and consultation with cultural competence expert for undergraduate nursing students No model identified</p>	<p>Awareness (self, other cultures) Skills (communication)</p>	<p>Course content -- self-assessment, recording of cultural data about patients, papers; expert consultation – group and one-on-one discussion Expert consultation -- group and one-on-one discussion</p>	<p>Both groups showed improvement (but evaluation did not differentiate between awareness and skills) Both groups showed improvement (but evaluation did not differentiate between awareness and skills)</p>	<p>Quantitative analysis (pre-and post-test design with two groups: course content and course content plus expert consultation) using questionnaire (Ethic Competency Skills Assessment Instrument) Internal validity, n=66</p>

Author (Date)	Course Type and Model	Content	Teaching Strategies	Evaluation Findings	Evaluation Methods
Nokes et al. (2005)	Course content for undergraduate nursing students Uses Campinha-Bacote's model	Awareness (details not discussed)	Experiential learning, didactic learning, small group work via internet	Critical thinking and cultural competence decreased; civic engagement improved	Quantitative analysis (pre- and post-test design) using questionnaires (the California Critical Thinking Disposition Inventory, the IAPCC, and a civic engagement questionnaire designed for this study) Internal validity, n=14
		Skills (details not discussed)	Experiential learning, didactic learning, small group work via internet	Decreased	
		Knowledge (details not discussed)	Experiential learning, didactic learning, small group work via internet	Decreased	
Nora et al. (1994)	1 2 hr class session per week for 20 weeks in each of cultural competence and Spanish for undergraduate nursing students No model identified	Awareness (details not discussed)	Not specified	CC course content: no change on misanthropy scale; immersion: improvement in awareness	Quantitative analysis (pre- and post-test design with control of CC course content group) using multiple choice test and questionnaire (Sullivan and Adelson's misanthropy scale); Qualitative analysis of immersion group's course evaluations and debrief discussion Internal validity, n=15
		Skills (using interpreters)	Not specified	Not assessed	
		Knowledge (cultural groups and health, epidemiology)	CC course content: didactic learning, guest speakers; immersion: met with medical staff and others, experiential learning	CC course content: improvement; immersion: not assessed	
Ott et al. (2004)	Course for undergraduate nursing students Uses Campinha-Bacote's model	Awareness (self, other cultures)	Experiential learning	Improvement	Qualitative analysis of exit surveys, field notes, focus group, and theoretical papers Internal validity, n=28

Sidelinger (2005)	Training for doctors over three years of pediatrics residencies Uses Kolb's theory of experiential learning	Awareness (other cultures, health care system)	Experiential learning, literature; immersion	Improvement	Qualitative analysis using reflection cards grouped thematically Internal validity, n=N/A
		Skills (communication)	Experiential learning	Improvement	
		Knowledge (cultural groups and health)	Experiential learning	Improvement	
Williamson et al. (1996)	Content in course for undergraduate student nurses Uses Leininger's model	Awareness (other cultures)	Literature, audiovisual materials, guest speakers, experiential learning, debriefing sessions	Improvement	Quantitative analysis (repeated measures design) using questionnaire (Cultural Self-Efficacy Scale); qualitative analysis using anecdotal evidence Internal validity, n=49
		Skills (details not discussed)	Literature, audiovisual materials, guest speakers, experiential learning, debriefing sessions	Improvement	
		Knowledge (cultural groups and health)	Literature, audiovisual materials, guest speakers, experiential learning, debriefing sessions	Improvement	
Worrell-Carlisle (2005)	Content in course for undergraduate pre-nursing students	Awareness (self, other cultures, health care system)	Class activities, guest speaker, service learning	Improvement	Quantitative analysis (cross-sectional design) using questionnaire (designed for this study); qualitative analysis of reflection papers, informal observations, and performance on class assignments Internal validity, n=67
		Skills (critical thinking, culturally competent assessment of an agency)	Servicing learning	Improvement	