

CULTURAL COMPETENCE AND KNOWLEDGE OF SOUTH ASIAN
CULTURE OF REGISTERED NURSES WORKING IN AN URBAN HOSPITAL
SETTING

A DISSERTATION
SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY
IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

NISHA MATHEWS, MSN

DENTON, TEXAS

DECEMBER 2020

Copyright © 2020 by Nisha Mathews

DEDICATION

To my father, Chittinappilly Ousaphe Cheria, who has inspired me in different ways in my life, this journey included. Thank you for believing in me. Rest in Peace, dearest Father!

ACKNOWLEDGEMENTS

I would like to thank my husband Jobin Mathews who has been very supportive of this journey in many ways; my children Aaron and Nora; my mother Elsy Cheria; my sister Gisha Paul; My in-laws P.T. Mathews and Rosamma Mathews; and all my friends for their encouragement and love during this journey.

I would like to acknowledge my dissertation committee Dr. Ann Malecha, Dissertation Chair, and committee members, Drs. Sandra Cesario, Pinky Shani, and Joan Edwards, who have led me on this journey to this path with support and encouragement. I would like to add heartfelt thank you to my advisor, Dr. Ann Malecha, Dissertation Chair. She believed in me and was my inspiration and played a significant role in my success. I really want to carry out her outstanding nurse scientist legacy. I would also like to thank Dr. Wyona Frey Steinson, who guided me as an academic advisor along with Dr. Sandra Cesario. I would also like to thank Dr. Judith McFarlane, who challenged me to develop a strong research design, and the project's statistician, Dr. Wanyi Wang.

I am thankful to Sigma Theta Tau International (Beta Beta Houston) for awarding a research grant that allowed me to finish my research. I also want to thank the Center for Student Research, Texas Woman's University, for providing me with a research grant to support my research.

ABSTRACT

NISHA MATHEWS

CULTURAL COMPETENCE AND KNOWLEDGE OF SOUTH ASIAN CULTURE OF REGISTERED NURSES WORKING IN AN URBAN HOSPITAL SETTING

DECEMBER 2020

Little research has been done to examine the cultural competence (CC) and knowledge of the South Asian culture of registered nurses (RNs) working in an urban hospital setting. The purpose of this correlational descriptive study was to examine the CC and knowledge of the South Asian culture of RNs working in an urban hospital setting. The hospital in the study consisted of a culturally diverse patient population showing the importance for nurses to provide holistic nursing based on cultural differences, and cultural skills. Convenience sampling was used to recruit the participants for the study. This study could be used as the foundation for future studies related to cultural competence and South Asian knowledge of RNs in an urban hospital setting. Data analysis involved the use of descriptive statistics, Pearson's correlation, an independent *t*-test, and one-way ANOVA. The alpha was set at 0.05. The one way ANOVA showed that the South Asian Knowledge Score and ethnic comparison yielded a statistically significant difference amongst the groups. There was a weak positive relationship between South Asian knowledge score and Cultural Awareness ($r = .209$ p value = .021). The mean total CC scores were 71.9705 ranging from 57-88. The standard deviation was 6.47168. Significant findings were that the RNs were culturally aware,

required more cultural knowledge, and were highly motivated in cultural desire. There is an opportunity for educators to improve RN's level of cultural knowledge. As the United States' population becomes more culturally diverse, it is most important for RNs to gain cultural knowledge to meet the needs of patients from diverse cultures.

TABLE OF CONTENTS

	Page
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
LIST OF TABLES	xi
LIST OF FIGURES	xii
Chapter	
I. INTRODUCTION.....	1
Statement of Purpose	1
The Rationale for the Study.....	2
Theoretical Framework	3
Assumptions	4
Research Questions	5
Research Question 1	5
Research Question 2.....	5
Research Question 3.....	5
Definition of Terms.....	5
Cultural Competence	5
Registered Nurse	6
Exposure to Diverse Cultures	6
Public Urban Hospital	7
Knowledge of South Asian Culture.....	7

II. LITERATURE REVIEW	9
Introduction.....	9
Identification of Problem.....	9
Aim.....	11
Search Methods and Strategy	11
Study Selection and Search Strategies	12
Quality Appraisal	15
Results	15
Importance of Cultural Competence	21
An Introduction to South Asia.....	24
India.....	26
Religion and Rituals	26
Treatments and Medications	27
End of Life	28
Attitudes Towards Healthcare Providers	29
Pakistan.....	30
Religion and Rituals	30
Treatments and Medications	31
Bangladesh.....	31
Religion and Rituals	31
Treatments and Medications	32
Attitude Towards Healthcare Providers.....	33
Sri Lanka	34
Religion and Rituals	34
Beverage and Food	34
Treatments and Medications	35
Attitudes Towards Healthcare Providers	36

Nepal	36
Religion and Rituals	36
Treatments and Medications	37
Bhutan	38
Religion and Rituals	38
Treatments and Medications	38
The Maldives	39
Religion and Rituals	39
End of Life	40
Treatments and Medications	40
Afghanistan.....	41
Religion and Rituals	41
Treatments and Medications	42
Summary.....	43
III. METHODOLOGY	45
Research Design	45
Setting.....	45
Sample Population	46
Protection of Human Subjects	46
Instruments	47
Data Collection Procedures: Pilot Study.....	48
Data Collection Procedures	49
Data Analytic Techniques	50
Pilot Study Findings.....	51
Instrument Reliability and Validity.....	58
Recommendations for Revisions	60
Conclusions.....	61

IV. ANALYSIS OF DATA	62
Description of the Sample.....	62
Instrument Reliability and Validity.....	78
Conclusions.....	79
V. SUMMARY OF THE STUDY	81
Research Question 1	81
Research Question 2	82
Research Question 3	82
Discussion.....	82
Theoretical Framework, Study Findings, and Relations	85
Implications for the Nursing Practice.....	87
Recommendations for Further Research	87
Strengths and Limitations of the Study	88
REFERENCES.....	90

APPENDICES

A. IRB Approval Letter	106
B. Cover Letter to Participants.....	109
C. Demographic Data Form.....	112
D. South Asian Knowledge Survey.....	117
E. Flyer with IRB Information	120
F. Recruitment Email.....	122
G. Cover Letter.....	125
H. Permission Letter 1	128
I. Permission Letter 1.....	129
J. TWU IRB Letter with Modification	134

LIST OF TABLES

Table	Page
1. <i>Search Methods and Strategy</i>	12
2. Review of Literature Table.....	16
3. South Asian Countries and Capital Cities.....	25
4. Demographic Data ($n = 25$).....	52
5. Knowledge of South Asian Culture.....	56
6. Cultural Competence Scores ($N = 25$).....	56
7. Reliability Analysis ($N = 25$).....	60
8. Reliability Statistics.....	60
9. Demographic Data ($n = 122$).....	64
10. Knowledge of South Asian Culture.....	70
11. Cultural Competence Scores ($N = 122$).....	71
12. Pearson Correlation.....	73
13. T-Test.....	76
14. Reliability Analysis ($N = 122$).....	79
15. Reliability Statistics.....	79
16. Study Findings and Conceptual Model.....	86

LIST OF FIGURES

Figure	Page
1. Flowchart of search and screening process	14
2. Picture of South Asia	26

CHAPTER I

INTRODUCTION

Statement of Purpose

The purpose of this study was to examine the relationship between cultural competence (CC) and knowledge of South Asian culture of registered nurses (RNs) working in an urban hospital setting in Houston, Texas. Asian Americans in the United States of America (USA) comprise the following groups: South Asians come from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives. East Asians include those descending from Japan, Korea, mainland China, Mongolia, Macau, Hong Kong, and Taiwan. Southeast Asians comprise those from Brunei, Cambodia, Indonesia, Laos, Myanmar, Malaysia, Philippines, Singapore, Thailand, and Vietnam (Paik et al., 2017). The Immigration and Nationality Act of 1965 led to an increase of migrants from South Asia. The Immigration and Nationality Act of 1965 prioritized immigrants with either direct family ties to current Americans or with high levels of scientific educations, mostly South Asians who were professionals. Since then, the demographics of South Asians in United States have also become more diverse: documented and undocumented immigrants, refugees, second, third, and fourth-generation South Asian Americans (Jan & Ali, 2020).

The South Asian community in the United States includes nearly 5.4 million individuals who trace their ancestry to Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka. The South Asian American community grew roughly 40%

between 2010 and 2017. By 2065, it is projected that Asian Americans will be the largest immigrant population (South Asian Americans Leading Together [SAALT], 2019). This forecast creates pressure on the healthcare system to respond to the present and future healthcare needs of the diverse population of the United States. Persons who immigrate to the United States from South Asian countries also represent many non-Western religious backgrounds such as Buddhism, Hinduism, Islam, Jainism, and Sikhism. Many of these religions have values, codes, and or traditions that require the United States' healthcare providers to have cultural awareness, knowledge, and skills to provide competent care. For example, many Buddhists follow a strict vegetarian diet that may impact specific disease processes and treatment recommendations. It is unknown how knowledgeable RNs are about South Asian culture.

The Rationale for the Study

Eche and Aronowitz (2017) explained that the nursing workforce's homogeneity might not allow the process of culturally congruent care as the workforce does not represent the population it serves. Aboshaigah et al. (2017) emphasized that culturally competent nursing care is an essential component in a multicultural environment to improve the quality of care and protect the safety of patients and nurses alike from potential risks. Providing culturally competent services has been identified as one strategy to eliminate healthcare disparities and improve healthcare quality (Watters et al., 2016). Individual cultural aspects that could make a difference for patients need to be recognized by nurses. Individual differences imply that each client must be assessed for unique cultural differences. Nurses can influence professional policies and practices in response to cultural diversity (American Nurses Association, 2018).

Theoretical Framework

Campinha-Bacote's (2002) conceptual model of CC in delivering healthcare services was the guiding theoretical framework for this study. CC is an ongoing process whereby healthcare providers, such as nurses, engage with their clients and families in a culturally appropriate way. Since CC is not considered an event, nurses should see themselves as becoming culturally competent instead of already being CC (Campinha-Bacote, 2002). The five constructs of the model are 1) cultural awareness, 2) culture desire, 3) cultural skills, 4) cultural knowledge, and 5) cultural encounters:

1. Cultural awareness involves self-examination of one's cultural background and recognition of biases and prejudice.
2. Cultural desire involves caring and engaging in the process of cultural competence.
3. Cultural skills involve collecting relevant cultural data and utilizing information to perform culturally-based assessments.
4. Cultural knowledge involves seeking and obtaining a broad knowledge base of diverse populations.
5. Cultural encounters involve face-to-face interactions with patients of diverse backgrounds to prevent stereotyping (Campinha-Bacote, 2002).

CC is viewed as a critical factor and a major component in providing relevant, effective, and culturally responsive healthcare services to an increasingly more diverse U.S. population (Campinha-Bacote, 2002). Campinha-Bacote (2002) stated that "Cultural competence involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire" (p.181). CC has been consistently

recognized as a continuous, developmental, evolutionary, evolving, and dynamic process by most researchers (Campinha-Bacote, 2002; Jeffreys, 2010). CC consists of two sub-concepts: culture and competence. The competence may vary depending on which component researchers are presently focusing. With competence as the focus, the characteristic of competence may be manifested explicitly as sensitivity, knowledge, and skill. With culture as the focus, the domains of culture may be presented as cultural values, religion, and health beliefs (Shen, 2015).

Assumptions

Enhancing culturally competent nursing care is vital in today's multicultural environment to improve the quality of care and protect patients and nurses' safety from potential risks (Aboshaigah et al., 2017). Regardless of one's cultural background, nurses need to function in a culturally competent manner for better patient outcomes (Aboshaigah et al., 2017). Thus, the assumptions for this study are:

1. Today's multicultural society brings new challenges and demands for CC in healthcare (Hemberg & Vilander, 2017).
2. Culturally congruent care is considered a standard of practice for nurses (National League for Nursing Accrediting Commission, 2016).
3. Since nurses provide the most direct healthcare services, the expectation of being knowledgeable about diverse health beliefs and practices is critical (Bauce et al., 2014).
4. Nurses must authentically explore their cultural backgrounds to prevent them from imposing their cultural beliefs on their patients and families (Campinha-Bacote, 2009).

Research Questions

The following research question was addressed in this study: What is the relationship between the CC of urban hospital RNs, their South Asian knowledge, and their exposure to diverse populations? It could be divided into three different research questions.

Research Question 1

What is the relationship between the CC of urban hospital RNs and their South Asian knowledge?

Research Question 2

What is the relationship between the CC of urban hospital RNs and their exposure to diverse cultures?

Research Question 3

Is there any difference in the CC of RNs by their demographics?

Definition of Terms

In this study, the independent variables were RNs, exposure to diverse cultures, urban hospitals, and knowledge of South Asian culture. The dependent variable was the CC score. The conceptual and operational definitions for the independent and dependent variables for this research study are listed below.

Cultural Competence

The conceptual definition of CC is defined as an ongoing process in which healthcare professionals continuously strive to achieve the ability and availability to work effectively within the patient's cultural context (individual, family, community; Campinha-Bacote, 2003). For this study, CC is operationally defined using the Inventory

for Assessing the Process of Cultural Competence-Revised tool (IAPCC-R; Campinha-Bacote, 2002).

The RNs would complete the IAPCC-R tool, which measured the CC score (Campinha-Bacote, 2002). The level of CC has been categorized based on the scores achieved using IAPCC-R tool. Campinha-Bacote's (2002) level of CC is as follows: culturally proficient (91-100), culturally competent (75-90), culturally aware (51-74), culturally incompetent (25-50).

Registered Nurse

An RN is conceptually defined as an individual who has graduated from a state-approved school of nursing, passed the NCLEX (National Council Licensure Examination) RN Examination and is licensed by a state board of nursing to provide care, and functions within the legal scope of practice (National Council of State Board of Nursing, 2020; Texas Board of Nursing, 2020). The RNs were measured by using the self-reported demographic data instrument, PsychData, which was accessed by a link, including the year they started working as an RN and the year of the participant's first RN license.

Exposure to Diverse Cultures

Cultural diversity and multiculturalism are words that are often interchanged. Multiculturalism is defined as a system of beliefs and behaviors that recognizes and respects the presence of all diverse groups in an organization or society, acknowledges and values their socio-cultural differences, and encourages and enables their continued contribution within an inclusive cultural context that empowers that all within the organization or society (Purdue Global University, 2020). The operational definition of

exposure to diverse cultures is defined as the measurement of the instrument item exposure to diverse cultures. The exposure to diverse cultures was measured by asking the participant to list the zip codes where they have lived for the past five years. Race and ethnicity of those zip codes were analyzed to find the mean percentage race and mean percentage ethnicity of the participants' neighborhood in which they had lived for the previous five years.

Public Urban Hospital

In Houston, Texas, this is conceptually defined as a hospital that is operated by or under a lease contract with the Harris County Hospital District (Texas Health and Human Services, 2017). The public urban hospital in this study is defined as a specific hospital located in the Houston metropolitan area. Operationally, the urban hospital was measured by using the instrument item in the demographic data form via the PsychData survey link. The participants were asked about their job status (full-time/part-time).

Knowledge of South Asian Culture

South Asia is described as the eight nations around the Indian subcontinent, including the island nations of Sri Lanka and the Maldives that are situated south of India. Although South Asia (also referred to as Southern Asia) only occupies approximately 3% of the world's land area, the region is home to over 24% of the world's population (nearly 1.9 billion), making it the most densely populated place on earth (Rodgers, 2019). Per most modern definitions, eight countries officially belong to the South Asian Association for Regional Cooperation (Khan et al., 2019): Afghanistan (population 31.6 million; 2018), Bangladesh (population 166.3 million; 2017), Bhutan (population 817,000; 2017), India (population 1.35 billion; 2017), Maldives (444,000;

2017), Nepal (29.6 million; 2017), Pakistan (212.7 million; 2017), and Sri Lanka (21.7 million; 2018; Rodgers, 2019).

Operationally, knowledge of the South Asian culture of participants was measured by using a South Asian knowledge survey developed by the researcher via the PsychData survey link. The South Asian Knowledge survey consisted of 11 questions. The participant answered the following questions, 1) What are the eight nations of South Asia? 2) What are the two most common languages spoken in India? 3) What are the two most common languages spoken in Pakistan? 3) What is the most common religion in South Asia? 4) What are some special accommodations to be provided to the South Asian patients regarding, 5) Three diet questions, 6) female patient attire, 7) female patient preferring female nurse, 8) strict fasting during religious events, and 9) end of life rituals. The maximum score possible was 32.

CHAPTER II
REVIEW OF THE LITERATURE

Introduction

Healthcare professionals need to provide quality and CC, which is the ability of healthcare professionals to provide quality and successful healthcare to clients of diverse backgrounds—culturally and ethnically (Leininger & McFarland, 2002). Several positive effects of providing CC care include client empowerment, respect as perceived by the clients, improved client adherence to the treatment regimen, and improved outcomes (Brown et al., 2002). CC has been defined as possession and use of the cognitive, affective, and psychomotor skills needed to bridge the gaps that often occur when diverse individuals interact (Schim & Doorenbos, 2010). Nurses' CC influences their ability to provide individualized healthcare for families from various cultural backgrounds (Suk et al., 2018).

Identification of Problem

CC is expected worldwide from nurses due to the increasing cultural diversity of people in healthcare establishments (Cai et al., 2017). There has been a tremendous rise in the South Asian population in the United States of America, especially Texas. Communities that have the highest foreign-born numbers are Bhutanese (92%), Nepalese (88%), Sri Lankans (78%), Bangladeshis (74%), Indians (69%), and Pakistanis (67%; SAALT, 2019). As a result of international migration and the process of globalization,

healthcare systems face challenges in delivering equitable healthcare within increasingly diverse and multicultural societies (Bhopal, 2014). Globalization is defined as a set of unequal exchanges in which a certain artifact, condition, entity, or local identity extends its influence beyond its local or national borders, and, in so doing, develops an ability to designate as local another rival artifact, condition, entity, or identity, (de Sousa Santos, 2006). Ways to embrace diversity is a common challenge for healthcare organizations (Oikarainen et al., 2018). Improving healthcare professionals' CC has been identified as central in reducing health disparities and improving the provision of healthcare to culturally and linguistically diverse groups (Betancourt et al., 2014; Truong et al., 2014).

There is a lack of conceptual clarity of the concept of CC, which may inhibit the implementation of it into the delivery of nursing care (Cai, 2016). An essentialist perspective views culture as static and unchanging. It is focused on a set of defined values, beliefs, and traditions of a specific cultural group, whereas a constructivist perspective views culture as a dynamic process and the product of social constructions (Garneau & Pepin, 2015). The constructivist view respects differences and uniqueness amongst individuals, families, and communities, meaning it is also more consistent with nursing philosophical underpinnings (Gray & Thomas, 2006). CC is an ongoing process and requires a continuous commitment by nurses to achieve the ability to work effectively in culturally diverse environments (Oikarainen et al., 2018). Emphasis on individual variation over homogenous groups and efforts to draw attention to diversity amongst health professionals may, however, lead to a decontextualized approach to a culture that lacks consideration of social and cultural context (Jenks, 2011).

Aim

Given the importance of CC for RNs when taking care of patients from diverse cultures, the identification of factors contributing and barriers to CC is of high relevance. Therefore, an integrated literature review was performed to review CC in 21st-century healthcare. The purpose of this literature review is to investigate existing evidence regarding the cultural competence of nurses, with emphasis on hospital settings, and the potential relationship between CC and other related variables.

Search Methods and Strategy

This systematic review was done using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Moher et al., 2009; see Table 1). The study populations, intervention, comparison, and outcomes (PICO) elements were used to schematize the process for verifying eligibility for this systematic review (Joanna Briggs Institute, 2011). Regarding PICO methodology, the target population is RNs between less than 25 years old and 65 years old, the interventions, methodologies for the studies, and the findings related to cultural competence.

Table 1

Search Methods and Strategy

Records identified through database searching Scopus, EBSCOhost, CINAHL Complete and PubMed (<i>n</i> = 2,110)	
Results = Records screened by title/ abstract (<i>n</i> = 673)	Records excluded (<i>n</i> = 1313) They were disqualified due to the title/abstract after the initial terms/words of search
	Records excluded (<i>n</i> = 124) (duplicates or irrelevant)
	Full-text articles excluded, (Did not match the criteria) (<i>n</i> = 622)
Number of records eligible (<i>n</i> = 11)	
Studies included in qualitative synthesis (<i>n</i> = 2)	
Studies included in quantitative synthesis (<i>n</i> = 9)	
Full-text articles included in integrative literature review (<i>n</i> = 11)	

Study Selection and Search Strategies

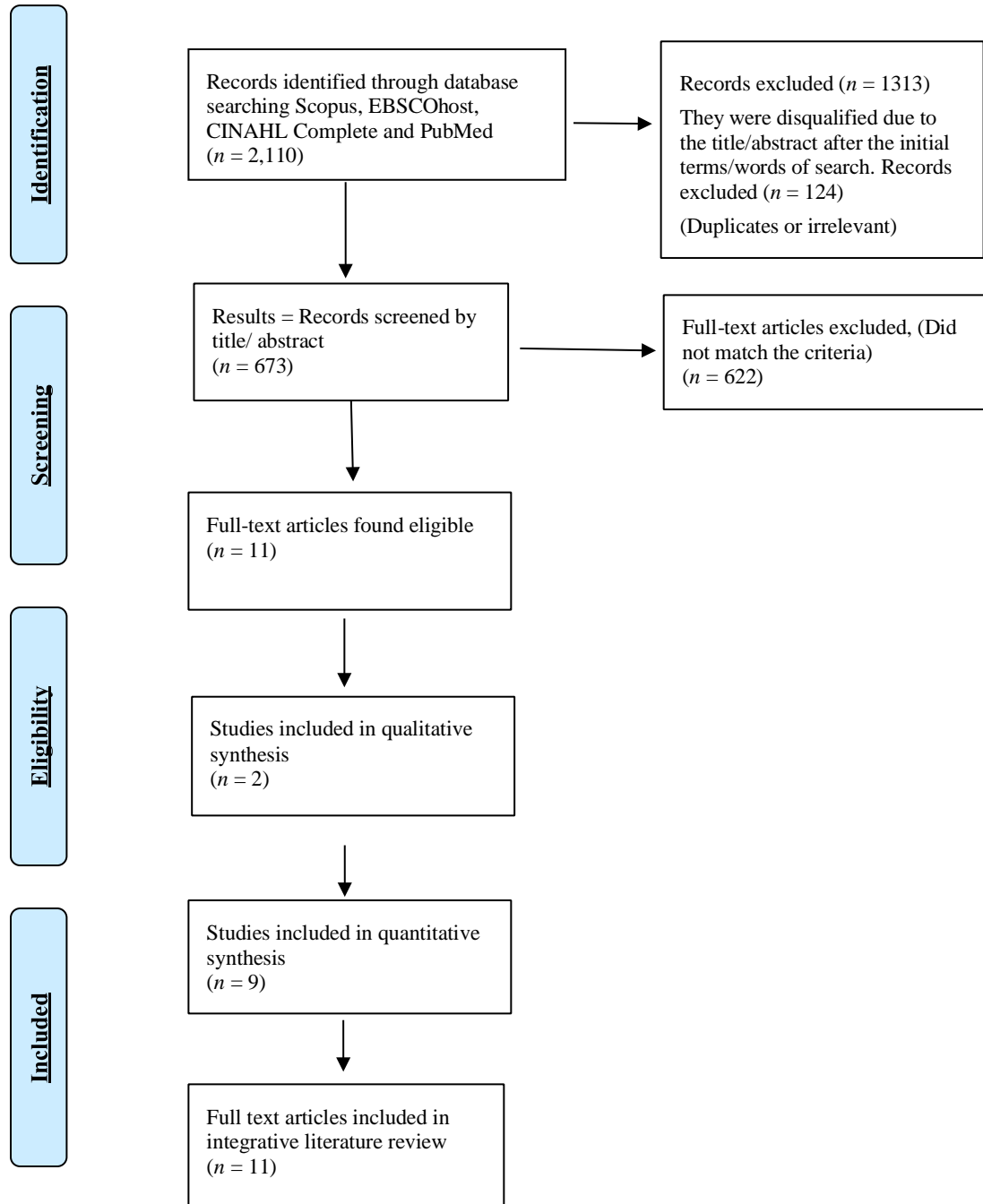
The literature review was conducted after consultation with the Texas Woman's University librarian. The databases searched for this review were ProQuest

Nursing and Allied Health, Medline with full text (EBSCO), Cumulative Index of Nursing and Allied Health Literature (CINAHL) Complete, and PubMed Remote. The combinations of MeSH search terms were culture, cultural competence, nursing, caregiving, ethnic differences, nurses, nursing competence, and intervention. The search was limited to human subjects, published between 2000 and 2019 in English, and peer reviewed.

There were no systematic reviews of nurses' CC regarding knowledge of South Asian culture located that had been published between 2000-2019. The PICO elements were used for the inclusion criteria. Excluded criteria were study intervention programs not focused on cultural competence, and South Asian knowledge for only adults. Records identified using key terms through database searching Scopus, EBSCOhost, CINAHL Complete, and PubMed resulted in a large number ($n = 2,110$). Records ($n = 1313$) were disqualified due to the title/abstract after the initial terms/words of search. Records screened by title/abstract resulted in 673 results. A total of One hundred twenty-four records were excluded due to duplicates or irrelevant. Number of Full-text articles found eligible were $n = 11$. A total number of 622 full-text articles were excluded, which did not match the criteria ($n = 622$). Studies included in qualitative synthesis included two citations and nine citations for quantitative synthesis. Fulltext articles included the integrative literature review resulted in 11 citations (see Figure 1).

Figure 1

Flowchart of search and screening process



Quality Appraisal

The Johns Hopkin Nursing Evidence-Based Practice (JHNEBP) rating scale was used to assess the methodological strength of the evidence (Newhouse et al., 2005). In this systematic review, the data obtained from experimental studies/randomized controlled trials (RCT) were rated as a Level I study, the data obtained from quasi-experimental studies were rated as Level II studies, and the data obtained from non-experimental study, or qualitative study were rated as Level III studies based on JHNEBP rating scale. These were confirmed by three reviewers (Newhouse et al., 2005).

Results

There was one Level I study, one Level II study, and nine Level III studies. Out of these, three studies were conducted in the United States and two studies were conducted in Canada. One study was conducted in each of the six following countries (Ireland, Finland, South Africa, Sweden, Thailand, and Saudi Arabia). The 11 studies combined represented a total of participants of 1,232 RNs. They ranged from years of age from ≥ 25 years to 65 years. Sample sizes ranged from 10 (Hemberg, & Vilander, 2017) to 584 (Aboshaigah et al., 2017). Markey et al. (2018) used 12 RNs and 28 nursing students for the sample. De Beer and Chipps (2014) used 105, and Eche and Aronowitz (2017) used 21. The settings for the studies included hospitals, healthcare centers, schools of nursing, and public health departments. All studies included in the systematic review were compiled into a data extraction matrix that included author/year, sample size/setting, research design, purpose, objective, instruments, and results (see Table 2).

Table 2*Review of Literature Table*

Author(s), Year, Level of Study	Sample Setting	Research Design Purpose/Objective	Instruments	Results
Markey et al., 2018 Level III	Focus groups with nursing students ($n = 8$) and RNs ($n = 2$) plus individual interviews with nursing students ($n = 20$) and registered nurses ($n = 10$) in one region of Ireland. Students recruited from a 4-year undergraduate program. RNs recruited from acute general hospital.	Grounded theory To explore nurses' experiences and concerns when caring for patients from diverse cultural, ethnic, and linguistic backgrounds.	Focus groups had a moderator and co-moderator. Individual semi-structured interviews. All focus groups and interviews were recorded and transcribed.	4 themes: Uncertainty Lack of knowledge Ethnocentricity and stereotyping Culture of the organization Highlights the complexity of the uncertainty experienced when caring for patients from diverse cultures and ethnic groups.
Hemberg and Vilander, 2017 Level III	Nurses ($n = 8$) who spoke Finnish Patients ($n = 2$) who spoke English Hospital in Finland	Qualitative study with a hermeneutic approach What is the significance of communication in a caring community when nurses and patients do not speak the same language?	Surveys developed by researchers. The texts were analyzed through latent content analysis.	5 main categories emerged: human love as the basis for a caring relationship when the patient and nurse do not speak the same language; integrity as vital for cultural respect and consideration of spiritual needs; an affirming presence as essential for sharing suffering in communion when the patient and the nurse do not speak the same language; creative courage as fundamental for cultural competence and communication in a caring relationship and continuous information as vital for establishing trust within a cultural and caring relationship.

Table 2 (continued)

De Beer and Chipps, 2014	RNs from 8 critical care units in a public hospital in KwaZulu-Natal Province, South Africa. (<i>n</i> = 105)	Quantitative descriptive survey	IAPCC-R tool to measure cultural competence Demographic data form	Most RNs (74%) were culturally aware, but only 25% were culturally competent. RNs had higher cultural competence scores if they reported: Being Black Being Christian Non-English language spoke at home
Level III	Stratified quota sampling was used to recruit 168 RNs with 62.5% response rate.	To describe the levels of cultural competence of RNs working in a public hospital.		
Eche and Aronowitz, 2017	Registered nurses, working on the Hematology/Oncology unit at a large Northeastern Urban Pediatric Teaching Hospital. Convenience sampling was used to recruit 38 nurses. (<i>n</i> = 21)	Descriptive cross-sectional design To evaluate registered nurses' self-ratings of cultural competence to develop educational materials or programs to improve cultural competence hospital-wide.	IAPCC- R tool Demographic data form	There were significant correlations between the knowledge and skill subscales ($p = .57, p < .001$) and the knowledge and desire subscales ($p = .42, p < .05$). Cultural desire (mean = 15.5).
Level III				
Berlin et al., 2010	Cluster random sampling by municipality and health center Nurses (<i>n</i> = 51; intervention <i>n</i> = 24; control <i>n</i> = 27)	Randomized controlled trial	The Clinical Cultural Competence Training Questionnaire (CCCTQ-PRE).	There were significant improvements in areas of cultural knowledge, cultural skills, cultural encounters, and difficulties and concerns. But there were no
Level I	Swedish primary child health-care centers	To evaluate the extent to which specific training affected how nurses		

<i>Table 2</i> (continued)		rated their cultural competence, difficulties, and concerns and to study how the nurses evaluated the training.	The Clinical Cultural Competence Evaluation Training Questionnaire (CCCTQ-POST).	changes in nurses' level of cultural awareness.
Delgado et al., 2013	Nursing Staff of a patient care unit at a large Midwestern medical center.	Time series design. To estimate the baseline cultural competence in the population and to assess the impact of the training on the subjects' cultural competence as measured by the IAPCC- R administered at 3- and 6- months post training.	IAPCC-R tool Demographic data form.	The participants self-reported a statistically significant increase ($p = .03$) in cultural competence within the category range of cultural awareness. Cultural competence scores differed significantly across the three- time points, with both 3- and 6- month scores significantly higher ($p = .02$ and $p = .03$, respectively) than the baseline score.
Level III	Study subjects included registered nurses, patient care assistants, and unit secretaries. A total of 111 samples were recruited via convenience sampling. ($n = 98$)			
Riley et al., 2012	Practicing nurses entering RN – BSN program at 2 Schools of nursing accredited by the Commission on Collegiate Nursing Education. 76 nurses were recruited via Convenience sampling. ($n = 53$)	Exploratory, descriptive study. To examine the cultural competence of practicing nurses entering an RN to BSN program.	Self-administered IAPCC-R tool. Demographic data form.	A strong correlation existed between IAPCC-R scores and student age, with students 20 to 30 years old scoring significantly higher than those in the age range of 41 to 50. Using a Pearson's r test ($p = .05$) all constructs had a positive correlation with the total IAPCC-R scores.
Level III				
Brathwaite, 2005	RNs who worked in public health nursing at a public health department in Southern Ontario. Convenience sampling was used to recruit the RNs.	One group repeated measures and qualitative results (Mixed Methods).	Self-administered scales to collect demographic data.	The results of the RM-ANOVA test for the total scale revealed a significant time effect, which indicated that the group's mean scores differed over time (Wilk's
Level III				

Table 2 (continued)	(n = 76)	To determine the effects of the course on Public Health Nurses' perceived cultural competence.	Adapted version of the IAPCC. Open-ended questions.	Lambda $F [3, 69] = 118.87, P = .000$.
Bunjitpimol et al., 2018	Nurses from 2 private hospitals in Bangkok, Thailand. Nurses were selected using a simple random sampling method.	Quasi-experimental design. To evaluate the effect of case-based cultural competency level and its factors affecting on nurse job in 2 private hospitals of Bangkok, Thailand.	Self-administered modified questionnaire.	The cultural knowledge intervention, attitude and practice competency score levels have significantly increased among the nurses in the intervention group as compared to the control group ($p = <0.05$).
Level II	(n = 166)			
Mahabeer, 2009	Nurses in a hemodialysis outpatient setting in a tertiary academic and research healthcare organization in Canada. Convenience sampling was used to recruit 107 hemodialysis nurses. (n = 58)	Descriptive study What percentage of hemodialysis nurses are judged to be culturally competent based on their score on the IAPCC-R tool? What percentage of nurses believe that their education level influences their cultural competence level? What percentage of nurses believe that the work experience influences their	IAPCC-R tool	15.5% of the nurses were culturally competent; 82.7% of the nurses were culturally aware, and 1.7% were culturally incompetent. The mean score on the IAPCC-R was 65.5%.
Level III				

<p><i>Table 2</i> (continued)</p>	<p>Non- Saudi RNs involved in direct patient care at a large municipal university hospital in Riyadh, Saudi Arabia. Total number of RNs recruited via random invitation was 984. (<i>n</i> = 584)</p>	<p>cultural competence level? Cross- sectional descriptive design. To examine the self- reported individual assessment of cultural competence among expatriate nurses, and to evaluate if there was an improvement after educational training provided by nurse educators.</p>	<p>Individual Assessment of Cultural Competence.</p>	<p>The data revealed that there was no significant difference between the pre-test mean score and post-test mean score (<i>p</i>- value = 0.488). Nurses' self- reported cultural competence was improved (<i>mean post-test gain</i> = 0.020).</p>
---------------------------------------	---	--	--	---

Importance of Cultural Competence

De Beer and Chipps (2014) highlighted the importance of healthcare workers to integrate culture and language for better health outcomes of healthcare consumers from diverse cultural backgrounds. The study was designed to explain and report the self-rated levels of CC in CCNs (Critical Care Nurses) working in critical care units in a public hospital in South Africa. The key findings of the study found that the majority of CCNs were culturally aware but not competent. There were differences between the constructs of cultural competence, and how non-English speaking CCNs graded themselves higher on all the specific constructs than English speaking CCNs.

A study by Eche and Aronowitz (2017) showed that nurses were motivated to engage in the process of becoming CC. The majority of nurses were culturally aware even though scores were low on the subscales of cultural knowledge and skill. The nurses wanted to learn and were motivated to engage in the process of CC. Nurses did not perceive themselves to be knowledgeable in navigating the healthcare experience of patients from diverse backgrounds.

Berlin et al. (2010) evaluated the extent to which specific CC training affected how nurses rated their CC, difficulties, and concerns. The nurses' level of cultural awareness was not changed, but several other statistically significant improvements were revealed: cultural knowledge, cultural skills, cultural encounters, and difficulties and concerns were lessened. These effects were presumed to contribute to a better quality of the health services, with a reduction in the risk for healthcare disparities among children of immigrant parents.

Delgado et al. (2013) emphasized that educational intervention positively affected the level of self-reported CC within the category range of cultural awareness over time ($p = 00$). Baseline CC results according to the IAPCC-R, indicated that the majority of participant scores (91%) were in the category range of cultural awareness, but only 9% reached the level of CC. The mean IAPCC-R baseline score was 65.4. At 3 months, the majority of participants (88%) again scored within the category range of cultural awareness with a mean of 67.8, and the level of CC increased to 12.5%. Riley et al. (2012) showed a significant, weak, and negative relationship between IAPCC-R total scores and years of experience ($r = -.294, p = .05$). Moderate, negative correlations were found between years of experience and both the cultural knowledge construct ($r = -.342, p = .05$) and the cultural skill construct ($r = -.347, p = .05$). The participants in this sample achieved an overall mean score of 75.3 on the IAPCC-R; 50.9% to be CC.

Brathwaite (2005) emphasized the importance of including the cultural courses in undergraduate and graduate nursing programs to equip nurses with knowledge and skills to provide CC care to clients. The mean score at T2 ($M = 2.82$), the mean score at T3 ($M = 3.37$) and the comparison between the mean scores at T3 and T4 ($M = 3.51$) were statistically significant, indicating that the level of CC continued to increase at a 3-month follow up. The study results highlighted that short-term cultural immersion experiences helped participants develop CC. The mean scores implied that the course was effective in increasing the participants' overall CC and that the level of it increased over time.

Bunjitpimol et al. (2018) explained how the demographic characteristics and work-related factors of the samples showed the age and level of seniority significantly different in control and intervention hospitals. However, marital status, sex, highest education

attained, monthly salary, religion, and current responsibilities were found to be statistically nonsignificant in both hospitals. Cultural knowledge, cultural awareness, cultural skills and willingness to provide patients with healthcare from different cultures could be improved by gaining experiences with people from diverse cultures.

Mahabeer (2009) highlighted the importance of nurses having a passion for gaining new insight and knowledge in the area of CC. The nurses demonstrated cultural awareness and were motivated in the process of becoming CC exhibited a higher mean score in cultural desire. The study results showed, 52.6% of the hemodialysis nurses revealed that their educational level influenced their CC level. Whereas 86.2% indicated that their work involvement influenced their CC level. Healthcare professionals who lack CC might put patients at risk for treatment delays, inappropriate diagnosis, and noncompliance with treatment protocols (Seright, 2012). A CC nurse should assess each patient individually and not make assumptions about a patient's beliefs or health practices, develop a cultural sensitivity that involves being aware, and utilize knowledge relating to culture, gender, or sexual orientation (Jirwe et al., 2009).

Aboshaigah et al. (2017) highlighted that through educational training programmed and administered by nurse educators, nurses' CC was enhanced. Aboshaigah et al. (2017) observed an improvement in scores from a baseline (pretest) to end of study (posttest), overall, (pretest = 3.15, posttest = 3.17 and a mean posttest gain = 0.020). The study emphasized CC nursing care as an essential component in a multicultural environment to improve the quality of care and protect the safety of patients and nurses alike from potential risks.

An Introduction to South Asia

South Asia is a region of differences, ranging from the world's tallest point, Mount Everest in Nepal, to the country with the lowest 'high' point on the island nation of the Maldives. Located in the Indian Ocean off the southwest coast of India, the Maldives reaches only eight feet above sea level at its highest point. South Asia has deserts in the northwest and dense rain forests in the eastern regions. South Asia is composed of eight countries (see Figure 2) with a wide variety of demographic features. India is by far the most populous nation in the region (see Table 3). India is the second largest populous country in the world, whereas the Maldives ranks as the 176th country by population, with not quite 400,000 inhabitants. Literacy ranges from almost 94% in the Maldives to barely 28% in Afghanistan. Afghanistan and Nepal are the most impoverished nations, based on the gross domestic product per capita. Their mountainous terrains made everything from transport to education and developing initiatives more difficult. The small nations of Bhutan and the Maldives are the most prosperous, the former because of its hydroelectric dams, and the latter due to tourism. A total of 22 constitutionally recognized languages in 18 different scripts, with two official languages (Hindi and English) is the most basic summary of the languages of India (Waldley, 2014).

Table 3*South Asian Countries and Capital Cities*

South Asian Countries	Capital	Population & % of World Population (1,940,605,118 & 24.89%)	Land in Square Miles
India	Delhi	1,380,004,385 & 17.7%	1,147,955 sq. miles
Pakistan	Islamabad	220,892,340 & 2.83%	297,638 sq. miles
Bangladesh	Dhaka	164,689,383 & 2.11%	50,259 sq. miles
Afghanistan	Kabul	38,928,346 & 0.5%	252,071 sq. miles
Nepal	Kadmantu	29,136,808 & 0.37%	55,348 sq. miles
Sri Lanka	Colombo, Sri Jayawardenepura Kotte	21,413,249 & 0.27%	24,212 sq. miles
Bhutan	Thimphu	771,608 & 0.01%	14,717 sq. miles
Maldives	Male	540,544 & 0.01%	116 sq. miles

Note: Worldometer (2020)

Figure 2

Picture of South Asia



Note: Boston University Henry M. Goldman School of Dental Medicine. (2015).

India

Religion and Rituals

In India, 82% of the population self-identified as Hindu (Kumar & Singh, 2017; Sharma, 2017). Muslims consisted of 12% of the population, making India one of the largest Islamic nations worldwide (Torrecillas et al., 2020). Christianity consisted of 2% of the population, with Shikhs having about the same percentage (Verghese, 2018). Buddhists represented less than 1%, and Jains consisted of 1% of the total population (Power, 2018; Tarabout, 2004).

The majority of Hindus are vegetarians (Kumar & Singh, 2017) and the taboo within the Hindu religion against the consumption of cow's flesh, which, in the 19th century, was used as a rallying point in northern India (Sarkar and Sarkar, 2016). Fasting

is an integral part of most holy days (Power, 2018). Muslims, on the other hand, consume beef but refrain from eating pork (Shoup, 2019; Srinivasan et al., 2012).

Treatments and Medications

There are four main medical systems in the country as of today (Sarkar, 2020). There are also several other medical systems, both localized and tribal, that rely on herbal treatments (Ansari, 2016). Of the four systems, *Ayurveda*, dates back the farthest. It means science of long life (Philips et al., 2018). It is a very elaborate system comprising of clinics, hospitals, medical textbooks, and even pharmaceutical factories (Porter & Grills, 2016). It relies mainly on herbal treatments that are non-invasive and accentuates the significance of a holistic approach in diagnosis and treatment (Ansari, 2016). *Sidda*, is another unique tradition developed in South India, which emulates the doctrine of physiology similar to those of Ayurveda. Meticulous reading of the pulse is the basis of diagnosis, and subsequent treatment is mainly through psychological and herbal methods (Porter & Grills, 2016). *Unani*, is the third medical tradition worthy of note. It was developed under the guidance of Mughals, although it arrived in India through Muslim travelers (Das et al., 2016). Although it reiterates the importance of holistic diagnosis and treatment, it also accentuates the theory of human physiology (Ansari, 2016). An imbalance between vital constituents is associated with disease in the three systems mentioned above. The fourth system is biomedicine or scientific medicine. It is the most widely preferred of all the systems (Pinto, 2017). Its use in the cities dates back to three centuries, and it is commonly practiced in the best hospitals and training colleges (Weber and Kelley, 2014). The number of medical colleges that teach medicine in India is around 542 (Medical Council of India, 2017).

End of Life

It is believed that the soul has no beginning nor end; hence death is an indication of its transition (Iyer & Shah, 2019). At death, one's karma from a previous life can be carried to the next one even though the soul can be reborn as another person (Inbadas, 2017). It is not uncommon to see sacred threads tied on the neck or wrists as well as Holy water and basil leaves placed on the body. The arms of the deceased should be straightened. Hindus' ideas about the afterlife are quite unlike those of Muslims, Jews, and Christians. The latter pray that their souls go to paradise after death. Cemeteries are the commonplace of burial for Muslims, Jews, and Christians, and even most Zoroastrians (Harvey, 2016). Zoroastrians, however, are well known in Bombay and a few other cities for their Towers of Silence (Ashtiani, 2019). In these stone towers, the corpses are left to the open air, especially to the vultures that converge up there (Weber & Kelley, 2014).

Reincarnation is an intrinsic belief in the majority of the Hindu communities. It is believed that although a person's soul can reincarnate for an unknown number of rebirths, the equilibrium of the person's iniquities and good deeds in past lives, however, will determine what the soul will be in the reincarnation (Mills, 2019). It is on this belief that the injustices of the caste system are rationalized; that the particular caste, high or low, that one is born into is determined by the culmination of good deeds or transgressions of one's soul from a past life. Belief also reiterates that there is no hope moving out of one's caste in a lifetime, but it may happen upon reincarnation. Especially malevolent individuals may reincarnate as animals. Hindus normally cremate the dead on a pile of logs. However, burial is sometimes done by the poor. Burying in a sitting

position is reserved for saint-like persons who go above and beyond, as seen in members of the Lingayat sect (Weber & Kelley, 2014).

Attitudes Towards Healthcare Providers

If a nurse obtains information directly from the wife and ignores the husband, this may cause the husband to start harboring feelings of disrespect and humiliation in the eyes of his family (Poreddi et al., 2017). Gaining the husband's confidence is pertinent to establishing and sustaining an effective nurse-client relationship. This way, the husband views the nurse as a healthcare advocate and not a trespasser (Poreddi et al., 2017). In a large majority of households (91.2%), males are considered the head (Census India, 2011). Non-acceptance of sterilization by Indian men seems to be both on psychological and religious grounds (McKay et al., 2007).

The first resort for older Asian Indian women is home treatments and remedies like massage and herbal medicines. Physicians are usually only needed upon the occurrence of serious ailments (Solomon, 2018). Ayurvedic medicine, the traditional Indian system of medicine, may be adopted by many elderly Asian Indians as a method of prophylaxis and therapy of illnesses (Mills et al., 2019). The prevalence rate of coronary heart disease, noninsulin-dependent diabetes, lower high-density lipoprotein (HDL) cholesterol levels, and hypertriglyceridemia among Asian Indian male immigrants in the United States is high. The prevalence rate of coronary artery disease in Asian Indian women is three times higher than the prevalence rate in white women (Emmanuel, 2019).

Asian Indian women have a risk of osteoporosis, similar to other Asian women. Amongst Asian Indian immigrants, the most prevalent cancers are prostate, lung, and

colorectal cancer. Due to their dietary habits, lactose intolerance is prevalent among older Asian Indians, deficiency of Vitamin D, B6, B12, and pantothenic acid is common in Asian Indian immigrants. One of the factors of Diabetes prevalence rates among Asian Americans is different by countries of origin. Asian Indians have the highest diabetes prevalence rate (14.2%; Spanakis & Golden, 2013).

Pakistan

Religion and Rituals

Sunni Muslims make up about 75% of the Pakistani population, and the remaining are Shia Muslims (Erdal & Borchgrevink, 2017). The holy book they use is the Quran (Asad, 2017). The house of worship for Muslims is the mosque (Blashfield, 2012). The Sindhi people are Hindus. The Kalash tribe, which is part of the Hindu Kush, worship many gods. The biggest Christian church in Pakistan, St Patrick's Cathedral, is located in Karachi. Muslim prayer starts at dawn through sunrise, noon, afternoon, sunset, and evening totalling five times a day. Prayers are usually done on a prayer rug facing east in the direction of the sacred place in Mecca after the ritual washing of the hands, face, and feet. Modesty is required of women, and they do not see any man apart from their husbands, naked. Both males and females commonly wear salwar kameez and it is comprised of loose pants and a long top. A long matching scarf or *dupatta*, for the head and shoulders, completes the outfit for women. In more traditional homes, it is still considered disgraceful for a woman to work. However, many women have professional careers in the cities (Blashfield, 2012). Although most Muslims are not vegetarians, they do not eat pork. Fasting is part of most holidays (Sheehan et al., 2015).

Treatments and Medications

Pakistanis have access to good doctors and hospitals. In Pakistan, there are eight doctors for every 10,000 people compared to 27 doctors per 10,000 in the United States and 21 per 10,000 in the United Kingdom. There are shortcomings in the Pakistani healthcare system with regards to servicing the enormous number of refugees living in the rural and tribal areas. These refugees are particularly susceptible to diseases due to poor living conditions and the inability to obtain clean drinking water (Blashfield, 2012). Questioning healthcare providers is regarded as an indication of lack of trust, and as such most families and clients are unlikely to ask questions. It is important that dying clients face east and that they die facing east. Prayers could be done by someone other than the Imam (Sheehan et al., 2015). Food shortages and malnutrition are also some issues and several Pakistani children do not get the nutrition they need. According to the Pakistan Medical Association, there are 25 million out-of-school children, and clean drinking water is unavailable to 90% of the population. (Rodriguez, 2019).

Bangladesh

Religion and Rituals

In Bangladesh, 90% of the population is Muslim, while about 10% are Hindu. The number of meals served are three per day for Bangladeshis (Whyte et al., 2019). The main beverage consumed is water. Before a meal, the washing of the right hand is done using water above the eating bowl. The inside of the bowl is rubbed using the recently washed knuckles of the right hand. Food is put in the bowl after the water has been thrown away. When the meal is over, the right hand is rewashed above the emptied bowl. Visitors are galvanized to imbibe as much as possible during holidays or formal

occasions. A cow or goat is usually killed during Eid celebrations, and curries are made from the meat. In Islam, prayer is expected to be done five times daily. Knowledge of the Quran, and the capacity to commit phrases in Arabic to memory is the basis of an Imam's (important religious person) power. Several gods and goddesses are associated with Hinduism, including Krishna, Ram, Durga, Kali, and Ganesh. However, rituals dedicated to the female goddess Durga are the most widely celebrated, and the holidays are mostly religious. The main Muslim festivals are eid-ul-Fir and eid-ul-Adha. These festivals are usually marked by visits from family, friends, food, and gifts. Sinking statues into rivers at night is part of the Hindu festival of autumn called Durga Puja (Adamson, 2016).

Treatments and Medications

A pluralistic healthcare system consists of different groups of healers; physicians, Ayurvedic practitioners, non-professionally trained doctors, fakirs, homeopaths, and naturopaths (Whyte et al., 2019). The type of healer consulted is dependent upon reputation of the local healer in rural areas if the condition is non-life threatening or acute. Patients consult with nonprofessional doctors or homeopathic healers who are familiar with the local remedies as well as modern medicine. The educated clients prefer professional physicians. In addition, professional physicians are used by others who have not received relief by using other means. Alternative medical treatments can be visiting a fakir for an amulet, an Imam for blessed oil, and/or a physician for homeopathic or traditional western medicine. Prevalent among both Hindus and Muslims are Ayurvedic beliefs, which are based on humoral beliefs (Whyte et al., 2019). Humoral beliefs are expressed in the intrinsic characteristics of hot or cold foods. Sickness is believed to be

due to an imbalance of hot or cold food intake and counteracting this imbalance through dietary means restores health (Whyte et al., 2019).

Muslims believe that after death their soul is judged and moved to either heaven or hell. The body of the deceased is washed, and the nostrils and ears are plugged with cotton or cloth. The body is then wrapped in a white clean shroud. The last part of the burial rite is that the body is buried or entombed in a structure made of brick or concrete. It is believed that the presence of women in graves during burial or burial prayers contaminates the sacred ground; therefore, women are neither allowed to participate in prayers nor do they visit graves (Whyte et al., 2019). Meanwhile, Hindu worshippers believe in reincarnation; therefore, it is expected that one's actions throughout life determine one's future lives. During funerals, close relatives shave their head and mourn. The site of the funeral where prayers are recited is by the bank of a river. The body is placed on a pyre and cremated, and the ashes are thrown into the river (Whyte et al., 2019).

Attitude Towards Healthcare Providers

The basic healthcare system in Bangladesh is grossly inadequate for its vast population. The objective of the government is to provide minimum healthcare services for all. Poverty is a significant cause of health problems. As a result of this, they are less productive as adults, remaining vulnerable to health problems for the rest of their lives. The bride's father or another male guardian usually arrange marriages. Polygamous marriage is allowed by Muslims, although it is rare. This, however, is dependent on the male's ability to provide for many households. Divorce is perceived as a source of social stigma. Women perform household work while men are income earners. A man can

decide the dowry he received was inadequate and demand more. If the in-laws refuse to pay he and his family might resort to threats, extortion, beating, and abusing the woman, and sometimes even kill her. The child marriage rate in Bangladesh is the highest in the world (Whyte et al., 2019).

Sri Lanka

Religion and Rituals

As of the 2011 census, 70.2% of Sri Lankans were Theravada Buddhists, 12.6% were Hindus, 9.7% were Muslims, and 7.4% Christians (Spilling, 2012). There is the freedom to choose religion in Sri Lanka. Muslims worship in the mosques while Buddhists and Hindus have temples where they worship. Buddhists and Hindus celebrate the new year in April and the festival of the tooth in July and August. Tamils have a 4-day festival of thanking sun God in January (Sullivan, 2020).

Beverage and Food

Sri Lanka's staple meal is a large serving of rice accompanied by up to 12 different side dishes of vegetables, eggs, meat, or fish stewed together with peppers, spices, and often coconut milk (Sullivan, 2020). Sri Lankan's midday meal usually consist of rice and curry, although it can also be eaten in the evening. The traditional morning and evening meals are usually composed of a traditional starchy staple, such as string hoppers (fresh rice noodles), hoppers (cup-shaped pancakes), roti (coconut flatbread), orthosai (sourdough pancakes), served with asambol (a mixture of hot peppers and other vegetables, served cold) and one or two curries (Sullivan, 2020). Sri Lankans also eat snacks through the day, consist of finger foods, sweets, and strong and sweet tea

with milk. Curd, a yogurt made from the milk of buffaloes or cows, is often served as a dessert with palm syrup or sugar (Sullivan, 2020).

Muslims avoid pork, while Hindus are often vegetarians. The Sinhala and Tamil people also eat food according to hot and cold energies. They will not eat food prepared by those who they consider a lower caste status. Alcoholic beverages are equally condemned in Islam, Buddhism, and Hinduism, and it is not used in their formal rituals. However, alcohol is an ever-present component in men's social gatherings (Sullivan, 2020).

Treatments and Medications

Theravada Buddhists believe in supernatural powers secondary to Buddhist beliefs. Some feel that belief in supernatural powers will hinder their spiritual growth. In Theravada Buddhism, attainment of self-liberation is through one's efforts. Enlightenment comes from meditation and concentration (British Broadcasting Company, 2002). In Sri Lanka, funerals are usually conducted elaborately by the family of the deceased in conjunction with the religious officiants. The funeral process involves initial embalmment of bodies. This secular, medical process occurs, and the body is then returned to the family for the gathering of the funeral rites, which can either be burial or cremations. Both Buddhists and Hindus believe that for a good rebirth, the body is to be kept in the home of ancestors for a week. At this time, various rituals are performed to honor the dead where a variety of rituals are performed to give honor to the deceased. The family members are protected from pollution from the body through a series of purification rituals. The color of white is associated with funerals except yellow is used

for monks. Following a death, white banners, flags, and other decorations are put up according to the status of the deceased (Spilling, 2012).

Attitudes Towards Healthcare Providers

In Sri Lanka, *Dosha*, which loosely translates as troubles, is the central common concept among the various health systems. The concept of Dosha within Ayurveda refers to the physical and emotional problems because of imbalances in body heat, coolness, and wind. In the folk system, the concept of Dosha is much broader. Dosha can also include financial, social, or academic problems. Sri Lankans believe that imbalances are a result of food, spirit attacks, or encountering other extremes. They believe that these imbalances require different types of treatments from different types of health providers. Executive-level employment, good command of English, network of international contacts, access to education in elite schools, and possession of valued commodities are associated with the elite classes. Manual labor is performed by lower castes. They are given minimal comforts and do not have social contacts with those of higher castes. While women may have a great deal of power within a family, ultimate authority belongs to the oldest male member of a household, whether that is the father, husband, brother, or son (Spilling, 2012).

Nepal

Religion and Rituals

Nepal historically operates a single caste hierarchy, which consists of Hindu castes and the Buddhist and animist ethnic groups (Burbunk & Elias, 2014). Hindus, who are considered at the top of the caste system, are followed by Mongolian ethnic groups. Untouchable Hindu castes occupy the bottom level. Jobs that the lower castes provide

are considered demeaning by higher castes. The caste system of the Newars of the Kathmandu Valley has been absorbed into the national caste hierarchy (Burbunk & Elias, 2014). The conventions of food and alcohol consumption are tied to the caste system. Hindus who are considered to be orthodox high caste are strict vegetarians and do not drink alcohol. People from other castes may drink and eat pork and beef. Caste rules also determine who a person may eat with or accept food from whom. Members of the higher castes were particularly reluctant to eat food prepared by strangers (Sullivan, 2020).

Treatments and Medications

Nepalis combine Ayurvedic, shamanic, biomedical, and other systems (Mills et al., 2019). The meditation of a priest is not required with many forms of Hinduism. For weddings and funerals, Brahmin priests will read Vedic scriptures. This ensures that the performance of rituals is correct (Burbunk & Elias, 2014). Religious icons are cared for by the priest in the temples because they are believed to embody the essence of the deities they represent (Burbunk & Elias, 2014). Buddhists and Hindus believe in reincarnation (Burbunk & Elias, 2014). If an individual is considered to have had worthy actions, they will be given a higher rebirth. In both religions, the goal is to live a virtuous life and move through higher births. This brings higher states of consciousness. The ultimate goal is to attain enlightenment. Enlightenment stops the cycle of rebirth (Burbunk & Elias, 2014).

Generally, the son performs the funeral rites. Buddhists can either be buried or cremated. Others perform sky burials, in which corpses are cut up and left at sacred sites for vultures to carry away (Burbunk & Elias, 2014). Western biomedical practices have

social prestige, but many poor people cannot afford this type of healthcare (Burbunk & Elias, 2014).

Shamans and other types of religious specialists can be consulted. Others look to Ayurvedic medicine, in which illness is thought to be caused by imbalances in bodily humors (Mills et al., 2019). Treatment involves correcting these imbalances, principally through diet. Arranged marriages are the norm in mainstream culture. A dowry is given to the groom's family from the bride's family. Women consider themselves to be a part of a lower caste when it comes to men and often are seen in a subordinate social position. However, the opportunities and freedoms for women vary widely by ethnic group and caste (Mills et al., 2019). Women who are in the highest castes are scrutinized publicly for their mobility because reputation is crucial to the honor of family and caste. Women of lower castes and classes often play a more significant wage-earning role, have greater mobility, and are more outspoken around men (Burbunk & Elias, 2014).

Bhutan

Religion and Rituals

A significant ethnic conflict in Bhutan between the mostly Hindu Nepalese population and the Buddhist majority occurred at the end of the 20th century. This was due to the rapid growth of the largely Hindu Nepalese population (Cooper & Lin, 2011).

Treatments and Medications

Terminal illnesses are believed to be a unique opportunity to reflect on the ultimate meaning of life and one's connection with the world. Prayer and meditation are considered as means for cleaning and healing. Medication should not interfere with consciousness. The traditional family structure is responsible for the care of the sick,

indigent, and aged. Life is considered as an opportunity to cultivate understanding, compassion, and joy for self and others, while death is associated with rebirth. Serene surroundings are important to the dignity of dying. The concept of karma and reincarnation is strong with both Hindus and Buddhists. Marriages may be arranged either by parents or the individuals entering the marriage (Cooper & Lin, 2011).

The Maldives

Religion and Rituals

In the Maldives, it is forbidden to practice any religion other than Islam. Islam is the official religion, and all citizens must be Muslims. In the Maldives, daily life is regulated according to the tenets of Islam, and only Muslims can become citizens, marry, or own properties. Even though, Hindus of Nepalese origin do exist as minorities.

Their cuisine often consists of the chilies of the Tibetan area. Spices are grown in abundance and other foods include apricots, asparagus, and mushrooms. Vegetables, spices, and fruits are cooked with pork, chicken, dried yak, and beef. Their food resembles those of the Chinese and Indian cuisines. A typical meal consists of dried meat, rice, and chilies. Sometimes soft, white cheese is included. Beverages such as tea are served in many ways. Any meat other than pork is used for special occasions. Alcohol is permitted only in tourist resorts. Raa is a local brew that is a sweet drink made from the crown of the coconut palm. The Islamic lunar calendar is used to determine most holidays. In addition to the Golden Grand Friday mosque, 20 other mosques are scattered around Male (Grahame-Smith & Pee, 2011).

End of Life

The people of Maldives who follow the Islamic faith, believe that they either go to heaven or hell after death. This is dependent upon how strictly they followed the five tenets of Islam while still alive. Believers who faithfully repeat the creed “There is no God but Allah, and Muhammad is the prophet of Allah;” fast during the month of Ramadan; pray five times every day; give alms to the poor; and, if possible, make a pilgrimage to the holy city of Mecca sometime during their lifetime are considered worthy to enter heaven (Grahame-Smith & Pee, 2011).

Treatments and Medications

Family health workers stationed on every inhabited island are the providers of healthcare. Their job includes the provision of vaccinations to children and pregnant women and controlling communicable diseases such as tuberculosis and viral epidemics. One vital aspect of their mission is to educate the island population about healthy practices and the importance of hygiene in their daily activities. For more serious medical treatment, islanders go to the atoll health center where there is at least one doctor. Many Maldivians also consult a local medicine man or woman called *hakim*. These traditional practitioners believe that good health depends on the balance between the hot, cold, dry, and wet properties of the body. Thus, when someone has a fever, the hakim recommends cold foods and herbal remedies. The hakim is treated with great respect in the island communities. Maldivians are brought to conform with the strong Islamic code of conduct and a strict respect for elders. Strong loyalties tie the individual to the extended family (Grahame-Smith & Pee, 2011).

Under Islamic law, a man is entitled to four wives at any time provided he can support them financially. Sex before marriage is a punishable offense, and marriages can take place only between Muslims. The Maldives has one of the highest divorce rates in the world. There have been reports of societal abuses and discrimination based on religious affiliation, belief, or practice, including incidents against Maldivians who did not want to conform to a strict, conservative interpretation of Islam (Global Security, 2019).

Afghanistan

Religion and Rituals

Virtually, the entire population is Muslim. Between 80 and 85% of Muslims are Sunni and 15 to 19%, Shia. The minority Shia are economically disadvantaged and frequently subjected to discrimination (Library of Congress, 2008). With an estimated 2.5 million registered refugees from Afghanistan, they comprise the largest refugee population in Asia, and the second largest population in the world (UNHCR, 2020). A burka is mandatory for women and can cause accidents involving vehicles and pedestrians due to limited vision. The most important religious holidays in Afghanistan are the Muslim religious holidays. The month-long holiday referred to as Ramadan features fasting in the daytime, followed by a celebration, Eid-al-Fitr, in the evening. Eid-al-Fitr lasts 1 to 3 days following Ramadan, marking the end of the fast. Eid-al-Adha is a festival remembering the sacrifice of Ishmael, a story told in the Koran. Lambs or cows are sacrificed during the festival, and the meat is shared among family and friends. Muslims also celebrate Maulud-Sharif, the birth of the Prophet Muhammed (Wittekind, 2013).

Mutton is preferred, but beef, camel, and chicken also are eaten. Foods can be fried crepes with ravioli, leeks, and noodles in a soup form. Spinach, turnips, peas, cucumber, beans, zucchinis, and tomatoes are types of vegetables that are eaten. Dessert consists of fresh fruits but are also eaten throughout the day. Pilau rice is served with meat, raisin, peas, pistachios, and carrots on special occasions. Men and women are not allowed to sit together during formal situations. Before dinner drinking tea and eating chickpeas or pistachios is common. Food is not served until later in the evening. The dishes are placed on a cloth on the floor. Eating amply shows a person's pleasure. Tea is consumed all day, but sugar is only used in the first cup. Sweets are eaten and kept in the mouth while tea is being sipped. Other common beverages are water and buttermilk (Ali & Eliyas, 2014).

When a person dies, they are quickly buried in a shroud in the countryside. Graves are marked with stones with no names on them. People who are wealthier may have a tombstone with a prayer written on it. After the burial, the relative of the deceased receive condolences in their homes for the next 3 days. Relatives and friends may meet and visit the grave to pray for the forty days after the burial. A formal ceremony takes place one year after the death to mark the end of a period of mourning. Many believe that the ghost of the dead will return to torment the living if the funeral is not carried out correctly (Ali & Eliyas, 2014).

Treatments and Medications

Physical ailments are categorized as warm or cold and restoring the cure. People go on a pilgrimage to cure a disease. These pilgrims get a pinch of sand from their pilgrimage to the holy place and put it in their tea. They may also keep a scrap of cloth

from the banners on the tomb. The waters of certain springs considered holy are believed to be able to cure illnesses. Talismans (Koranic verse in a cloth folder) are also sewed onto clothing or hats to protect against the evil eye or treat an illness. Under Soviet and Taliban rule, many educated Afghans left the country, leaving few trained medical workers. This has plunged the healthcare system in crisis for several years. Women are not allowed to work under Taliban rule (Ali & Eliyas, 2014).

In Afghanistan, only female doctors or nurses can treat women in need of care. The World Health Organization (2016) lists life expectancy 61 for males and 64 for females. Child mortality is also high; under five mortality is listed as 60.3% (UNICEF, 2019). In clinics and hospitals, there is a dire lack of access to clean water supply, reliable electricity, and modern medical equipment. Medicines are also rarely available, and family members must purchase medicines elsewhere and bring it to the hospitals for the patients. Curable diseases go untreated, and this is more common in the villages. Roads are bad, so transportation to medical centers is difficult (Bjorklund, 2012). There were also almost weekly executions or amputations of criminals in the Kabul stadium before November 1999 (Ali & Eliyas, 2014).

Summary

Organizations must focus on promoting diversity within the workforce and provide necessary support structures that are in place to promote the integration of nurses from diverse linguistic and cultural backgrounds into cohesive nursing teams. CC is an essential factor for better patient outcomes. Based on this literature review, CC is affected by many factors: cultural competency training, years of experience, and experience with a diverse population. This integrative review has a few limitations. In

general, the studies showed great heterogeneity regarding research designs and methodology (qualitative, $n = 2$; quantitative, $n = 9$). Another limitation was the terminology. The terms were culture, cultural competence, nursing, caregiving, ethnic differences, nurses, nursing competence, and intervention. Although numerous relevant synonyms of the searched terms were used, some studies using different terms may have been overlooked. Lastly, this integrative review was limited to the English language, and studies written in other languages other than English were not included.

CHAPTER III
METHODOLOGY

Research Design

A correlational descriptive study design was used to examine the relationship between CC and knowledge of South Asian culture of RNs working in an urban hospital setting. The purpose of descriptive studies is to observe, describe, and document aspects of a situation as they naturally occur and sometimes serve as a starting point for hypothesis generation or theory development. Descriptive correlational research aims to describe relationships among variables rather than to support inferences of causality (Polit & Beck, 2012). The primary investigator's (PI) Institutional Review Board (IRB) approved the study as exempt. RNs' self-ratings of CC and knowledge of South Asian culture were assessed in an urban acute care hospital in the Houston metropolitan area using a demographic data form, South Asian Knowledge Survey, and the IAPCC- R via PsychData survey link (Campinha-Bacote, 2003). The affiliated institute also approved the study.

Setting

The setting of the study was an acute care urban hospital in the Houston metropolitan area in Texas, USA. The urban hospital provides services to a wide variety of diverse populations. There were more than 900 RNs at the selected urban hospital (Harris Health System, 2018).

Sample Population

The sample population was recruited from RNs working in an acute care urban hospital in the Houston metropolitan area. The inclusion criteria for the sample were the following 1) be a registered nurse, 2) at least 18 years or older, and 3) currently working in an urban hospital setting. The sample size set for the original study was $N = 250$, based on the following: effect size 0.25 with the power of 0.80 and alpha level of 0.05 (216 participants + 15% incomplete or invalid data = 250; 10% of the sample size ($N = 25$)). The power calculations needed for the estimated sample size was based on an assumed small effect (0.25). With a power of .80 and alpha of .05, the power analysis indicated the need for 86 to 216 participants. The PI had planned to recruit 250 participants for the study considering incomplete or invalid data (15%). Only 10% of the sample size ($N = 25$) was used for the pilot study. A total of 129 RNs participated in the study. But, six participants' data were not included since they had already participated in the pilot study. Another participant's data were also excluded due to having missed more than 50% of the data. Only 122 RN participant's data were entered into SPSS for data analysis. RNs would be at least 18 years or older as per the Texas Board of Nursing (2020).

Protection of Human Subjects

The study had been approved by Texas Woman's University IRB and the affiliated institute. All data have been kept confidential. The data have been stored in a locked cabinet in the PI's home. Only the PI and her adviser would have access to the data. The pilot study paper with the responses would be destroyed within 3 years after the study was finished. The electronic data have been saved on a password-protected computer and hard drive. Survey packets from the pilot study did not contain any names

of participants. While a pilot study participant may be viewed dropping off the packet and collecting the gift card, there was no identifying data in the packet. The study was conducted using a PsychData survey link due to COVID-19 data collection restrictions. The recruitment email (see Appendix F) contained contact information and a link to the study survey. The PI created the study survey in PsychData, which included the cover letter (see Appendix G), the Demographic Data Form, the South Asian Knowledge Survey, and the IAPCC-R tool. All data from the PsychData survey were downloaded into an SPSS database on the PI's personal computer that was password protected.

Instruments

The IAPCC-R (Campinha-Bacote, 2003) was used to measure five constructs of CC. The IAPCC-R is a well-developed pencil/paper self-assessment tool. This determines one's level of CC in healthcare delivery and was used for the pilot study. Data collection was done electronically using a PsychData survey link (Zygar-Hoffmann et al., 2020) due to COVID19 restrictions in summer 2020 for the final study. The recruitment email contained contact information and a link to the study survey.

The IAPCC-R tool consists of 25 items to measure five cultural constructs: cultural awareness, cultural desire, cultural skills, cultural knowledge, and cultural encounters. A 4-point Likert scale is used in scoring the IAPCC-R. The response categories are 1) strongly agree, agree, disagree, and strongly disagree; 2) strongly disagree, disagree, agree, and strongly agree; 3) very aware, aware, somewhat aware, and not aware; 4) very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable; 5) very comfortable, comfortable, somewhat comfortable, not comfortable; 6) very involved, involved, somewhat involved, and not involved. The time

to complete IAPCC-R was 10-15 minutes (Campinha-Bacote, 2007). The scores range from 25 to 100 and are categorized as follows: culturally proficient (91-100), culturally competent (75-90), culturally aware (51-74), and culturally incompetent (25-50). Higher scores mean higher CC. This instrument demonstrated sound psychometric measures (CampinhaBacote, 2003; Kawashima, 2008).

The PI designed the South Asian Knowledge survey (see Appendix D), which was also administered for data collection. The South Asian Knowledge survey had 11 items with 32 possible points. Each correct response had one point. The South Asian Knowledge survey addressed the following: Eight nations of South Asia; most common languages spoken in India and Pakistan; most common religion of South Asia; religious and cultural accommodations of South Asia. Reliability statistics showed a Cronbach's alpha of .618 (see Table 8) for the South Asian knowledge survey. The demographic form had 22 items. The items were gathered from the previous 5 years asked about gender, race, ethnicity, nationality, languages known, religious affiliation, education, experience as an RN, date of the last training in CC, and the participant's zip code. The zip codes were collected to determine the population and ethnicity percentages in those locations. Race and ethnicity of those zip codes were analyzed to find the mean percentage race and mean percentage ethnicity of the participants' neighborhood in which they had lived for the previous 5 years. This is to find out if being in a diverse neighborhood has any correlation with cultural competence scores.

Data Collection Procedures: Pilot Study

The PI presented to staff and leadership meetings to explain the study *Cultural*

Competence and Knowledge of South Asian Culture of RNs Working in an Urban Hospital Setting to RNs in the urban hospital setting. A hard copy of a flyer describing the study was provided to the participants (see Appendix E). The flyer illustrated the purpose of the study, title of the study, nature of the study (voluntary, confidential, and anonymous), and the researcher's contact information. The PI gave participants survey packets containing hard copies of the cover letter, the demographic data form, the South Asian knowledge survey, and the IAPCCR. Participants were briefed about the purpose and procedure of the study. Participants had been informed that the study was voluntary and anonymous throughout and after the study. Permission had been obtained from Dr. Camipnha-Bacote for the use of the instrument (see Appendix H). The RNs were instructed to complete the surveys and return the packet to the PI. The time needed to complete all materials in the packet was 15 to 20 minutes. Once completed, the RNs sealed the packet and returned it to the PI. The participants also had the option of texting or calling the PI to arrange to pick up the packet. The PI provided the participants with a \$10 Starbucks gift card after receiving the packets. The PI reviewed each demographic data form for inclusion criteria. If the information indicated that the participant met inclusion criteria, the data were entered into a Statistical Package for Social Sciences (SPSS) 25 database.

Data Collection Procedures

The data collection for the study was done electronically due to COVID-19 restrictions in the summer of 2020. The study survey had been created in PsychData, which included the recruitment email, cover letter, the Demographic Data Form, South Asian Knowledge Survey, and the IAPCCR-R tool. Permission had been obtained from Dr.

Campinha-Bacote to use the IAPCC- R tool for the data collection (see Appendix I). The original protocol, which included gathering data in-person, had been changed due to COVID-19 restrictions. The PI had to make the modification request to change data collection using electronic format. All study instruments had been converted to an electronic PsychData format. The Administrative Director of Research and Sponsored Programs assisted in sending out the recruitment email to potential participants. A second reminder email was sent out by the Administrative Director of Research and Sponsored Programs after 2 weeks of sending out the initial recruitment email. The time needed to complete all materials was 10-15 minutes. Once completed, the participants had the option to put their email address on a second link to collect the \$10 Starbucks gift card electronically. All data from the PsychData survey were downloaded into an SPSS database on the PI's personal computer that has been password protected. No data were associated with any personal information.

Data Analytic Techniques

Data were entered into the SPSS version 25.0 (IBM Corp., 2017). Statistical analysis was conducted using SPSS. For analysis purposes, all data sets were complete for all variables. Descriptive statistics were used to calculate the scores on the IAPCC-R and South Asian Knowledge survey. Each question was coded, and frequencies of responses to each question were tabulated. Correlations between all variables were performed to identify relationships. Descriptive statistics and scale reliabilities were analyzed. Mean scores and standard deviations were calculated for all individual variables as well as the participants' CC scores. Relationships between binary demographics and cultural competence score or South Asian knowledge were analyzed

using an independent *t*-test. A one-way ANOVA was utilized to analyze relationships between specific demographics and the CC scores of South Asian knowledge scores of the participant. Cronbach's alpha for scale and sub-scale reliabilities were calculated. An alpha level of .05 was utilized to determine significance for the one-way ANOVA and correlation tests.

Pilot Study Findings

RNs working in an urban hospital setting had been recruited to participate in the study. A total number of 25 RNs ($N = 25$) participated in this study without any attrition (see Table 4). The cultural makeup of RNs who participated in the study was as follows: Black or African Americans- 36%; White or Caucasians- 24%; Asians- 20%; Other- 12%, More than One Race- 4%, with 4% choosing not to fill in that information. The majority ($N = 17$, 68%) of the participants were not Hispanic/Latino, whereas 20% ($N = 5$) of them were Hispanic/Latino. RN participants 12% ($N = 3$) did not enter that information. The mean age of the RNs was 36 years old, ranging from 22 to 60. There were 22 females and three male participants. 76% ($N = 19$) of the RNs were baccalaureate prepared, and 16% ($N = 4$) of the participants held master's degrees. RN participants 8% ($N = 2$) had an associate degree in nursing. The number of years of experience of the RNs varied from less than a year to more than 10 years. RN participants 20% ($N = 5$) had experiences of 1-2 years, 3-5 years, and 10 plus years respectively. RN participants 16% had 6-10 years of experience. RN participants 12% had less than a year's experience. Data were missing for three RNs. All the participants had a full-time job status during the time of the pilot study.

Table 4*Demographic Data (n = 25)*

Variable		<i>N %</i>
Age in years	Mean	36.96
	SD	12.25
	Median	35.50
	Mode	22
	Range	22 – 60
Gender	Female	22 (88%)
	Male	3 (12%)
Race	Black or African American	9 (36%)
	White or Caucasian	6 (24%)
	Asian	5 (20%)
	Other	3 (12%)
	More than one race	1 (4%)
	Missing	1 (4%)
Ethnicity	Not Hispanic/Latino	17 (68%)
	Hispanic/Latino	5 (20%)
	Missing	3 (12%)
Country Born	USA	15 (60%)
	Nigeria	4 (16%)
	India	2 (8%)
	Eritrea	1 (4%)
	Mexico	1 (4%)
	Nepal	1 (4%)
	Vietnam	1 (4%)

Table 4	African American	4 (16%)
(continued)	Caucasian	4 (16%)
Nationality	Mexican American	3 (12%)
	Nigerian/American	3 (12%)
	Indian	2 (8%)
	Vietnamese American	2 (8%)
	Eritrean	1 (4%)
	Hispanic	1 (4%)
	Ibo	1 (4%)
	Mexican	1 (4%)
	Native American	1 (4%)
	Nepali	1 (4%)
	Persian American	1 (4%)
Primary Language at Home as a Child	Not English	13 (52%)
	English	12 (48%)
Primary Language at Home as an adult	English	16 (64%)
	Not English	9 (36%)
Religion as a Child	Christian	19 (76%)
	Buddhist	2 (8%)
	Hindu	2 (8%)
	Hindu/Buddhist	1 (4%)
	None	1 (4%)
Religion Today	Christian	18 (72%)
	Hindu	2 (8%)
	Buddhist	2 (8%)
	None	2 (8%)
	Hindu/Buddhist	1 (4%)

Table 4

(continued)

Number of Years as RN	1-2 years	8 (6.6%)
	3-5 years	23 (18.9%)
	6- 10 years	36 (29.5%)
	10+ years	47 (8.5%)
	Missing	8 (3.3%)
Highest Nursing Degree	Baccalaureate	19 (76%)
	Masters	4 (16%)
	Associate degree	2 (8%)
Start working at your current job	3-5 years	7 (28%)
	Less than a year	6 (24%)
	1-2 years	5 (20%)
	6-10 years	5 (20%)
	10+ years	2 (8%)
	Missing	0 (0%)
Current Position	Staff nurse	20 (80%)
	Management/ administration	3 (12%)
	Educator	1 (4%)
	Other	1 (4%)
Specialty Area	Med/Surg	20 (80%)
	Missing	2 (8%)
	Administration	1 (4%)
	Cardiac IMU	1 (4%)
	Neurology	1 (4%)
Current Job-status	Full time	25 (100%)
Last year of training in Cultural Competence	2019	10 (40%)
	2018	5 (20%)
	2016	2 (8%)
	2015	2 (8%)
	Missing	6 (24%)

Table 4
(continued)

Home Zip Code	Race White	(48.93%)
Diversity 2019	Mean	(50.50%)
	Median	
Ethnicity	Hispanic	(30.39%)
	Mean	(24.80%)
	Median	

Home zip codes showed the following results for diversity: Race-mean = 48.93% and median = 50.50%. The Hispanic percentage had a mean = 30.39% and median = 24.80%. The maximum score in South Asian Knowledge survey was 32 points. The actual scores ranged from 5-23. The mean score was 14.08 (see Table 5). The standard deviation was 4.462. The mean total CC scores were 72.12 ranging from 60-88 (see Table 6).

Table 5*Knowledge of South Asian Culture*

Range 5-23

Mean 14.08

SD 4.462

Table 6*Cultural Competence Scores (N = 25)*

Subscales	Mean (SD) Range	IAPCC-R Levels
Cultural Awareness	14.48 (1.686) 10-18	Items 1, 2, 3, 15, 18
Cultural Knowledge	11.60 (2.217) 8-16	Items 6, 8, 10, 11, 12
Cultural Skill	14.56 (2.181) 10-20	Items 5, 9, 20, 21, 22
Cultural Encounters	13.44 (1.685) 10-17	Items 14, 16, 17, 23, 25
Cultural Desire	18.04 (1.744) 15-20	Items 4, 7, 13, 19, 24
Total Score	72.12 (7.096) 60-88	Culturally Proficient 91-100 Culturally Competent 75-90 Culturally Aware 51-74 Culturally Incompetent 25-50

The standard deviation was 7.096. The subscale cultural awareness mean score was 14.48 ranging from 10-18 with a standard deviation of 1.686. The cultural awareness scores were measured using items 1, 2, 3, 15, and 18 on the IAPCC-R. The subscale cultural knowledge mean score was 11.60 ranging from 8-16 with a standard deviation of

2.217. The cultural knowledge subscale was measured using items 6, 8, 10, 11, and 12 on the IAPCC-R. The cultural skill mean score was 14.56, ranging from 10-20 with a standard deviation of 2.181. The cultural skill subscale was measured using items 5, 9, 20, 21, and 22 on the IAPCC-R. The cultural encounters mean score was 13.44 ranging from 10-17 with a standard deviation of 1.685. The cultural encounters subscale was measured using the items 14, 16, 17, 23, and 25 on the IAPCCR. Finally, the cultural desire subscale mean was 18.04, ranging from 15-20 with a standard deviation of 1.744. The cultural desire subscale was measured using items 4, 7, 13, 19, and 24 (see Table 6).

Pearson correlations showed a moderately positive relationship between awareness and knowledge ($r = 0.555$ and $p = 0.004$): 1) There was a strong positive relationship between skill and knowledge ($r = 0.617$ and $p = 0.001$): 2) There was a moderately positive relationship between encounter and knowledge ($r = 0.529$ and $p = 0.007$): 3) There was a moderately positive relationship between skill and desire ($r = 0.531$ and $p = 0.006$): 4) There was a strong positive relationship between the total competency score versus awareness ($r = 0.660$ and $p < .001$) and 5) There was a strong positive relationship between the total competency score versus knowledge ($r = 0.843$ and $p < .001$).

The PI performed two independent sample *t*-tests were performed for all bivariate analyses. The South Asian Knowledge and ethnicity comparison yielded a statistically significant difference amongst the groups ($p = 0.027$). The total CC score and ethnicity comparison yielded a statistically significant difference amongst the groups ($p = 0.046$). The results showed that Hispanics had higher CC (76.40) scores than non-Hispanics (69.82). A study by Alejandro (2015) found that Hispanic nurses show a high level of

CC. Participants, including by subgroups, scored over 90% cumulatively on the Self-Assessment Checklist. The results showed a trend that participants with a master's degree had lower CC scores than participants with baccalaureate and associate degrees.

Instrument Reliability and Validity

The measurement tool for identifying dependent variables was the IAPCC-R developed by Campinha-Bacote (1999). The IAPCC-R instrument was used to measure the levels of CC among nurses in an urban hospital setting (Campinha-Bacote, 1999). A literature search was conducted using the key terms: CC, IAPCC-R, and/or nurses. The databases CINAHL, MEDLINE/PubMed, Medline with full text, health, and psychosocial instruments, and nursing and allied health databases were used. These yielded 249 articles that illustrated the use of IAPCC-R among nurses, nursing students, and other healthcare professionals.

The five constructs of this model were interrelated and needed to achieve CC, which was essential in providing culturally responsive services (Campinha-Bacote, 2002, 2003). Several studies were conducted to test the validity and reliability of the IAPCC-R (Campinha-Bacote, 1999, 2009; Doutrich & Storey, 2004; Tinsley, 2000; Wilson, 2002). Researchers used the IAPCC-R to measure the level of self-reported CC (Kardong-Edgren, 2007; Nokes et al., 2005; Sargeant et al., 2005). The IAPCC-R has been used in clinical settings to find the effectiveness of educational trainings on CC in research studies concerning healthcare providers' levels of CC (Brathwaite, 2005; Chipps et al., 2008). The instrument was field-tested in 1999, using 15 RNs (Campinha-Bacote, 1999). The Cronbach's Alpha was used to assess the inter-rater reliability of the constructs concerning the items in the IAPCC-R. A Cronbach's alpha of at least 0.7 indicated

consistency within the items that were derived from each construct. The reliability analysis showed a Cronbach's alpha of .790 for IAPCC-R in this pilot study.

The cultural awareness construct had a lower reliability statistic at 0.594 than the other constructs. The cultural desire construct had the highest reliability at 0.783. Reliability subscales showed a Cronbach's alpha of 0.651, 0.712, and 0.746 for cultural encounters construct, cultural knowledge construct, and cultural skill construct, respectively (see Table 7). Cronbach's alpha based on the standardized items was .618 (see Table 8). The number of items on the South Asian Knowledge Survey was 11. The South Asian Knowledge survey and CC scores had negative correlations and were not significant. An independent *t*-test showed that gender, South Asian Knowledge scores, and CC scores were not significant. An independent *t*-test showed ethnicity and South Asian Knowledge scores with the CC score were not significant. A one-way ANOVA showed a race and South Asian Knowledge score. The CC score was not significant. There was a trend that Asians and Whites had higher CC compared to African Americans, who represented 36% of the participants. A one-way ANOVA showed years of experience, the South Asian Knowledge scores, and CC scores were not significant.

Table 7*Reliability Analysis (N = 25)*

	Cronbach's alpha
Cultural Awareness	0.594
Cultural Knowledge	0.712
Cultural Skill	0.746
Cultural Encounters	0.651
Cultural Desire	0.783
Total Score	0.790

Table 8*Reliability Statistics*

Cronbach's Alpha	N of Items
.618	11

Recommendations for Revisions

This study can be replicated in the same healthcare setting using a larger sample size or replicated in several different healthcare settings with a larger sample size to compare CC levels based on the IAPCC-R. Findings from such a study would be likely to be more representative and accurately reflect the general population of RNs in Houston, Texas area. There are several recommendations for revision including the study should be repeated with additional RNs from the South Asian population. It would be

good to analyze the differences between races/ethnicities to accurately respond to the proposed research questions.

Conclusions

The purpose of this study was to explore the relationship between CC and the knowledge of the South Asian culture of RNs working in an urban hospital setting. A significant finding of this study was that the RNs were culturally aware and were highly motivated in the area of cultural desire but required more cultural knowledge. The results showed there was an opportunity to improve RNs' cultural knowledge. As Houston's population becomes more culturally diverse, RNs need to achieve cultural knowledge so that they can meet the needs of patients from diverse cultures.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this correlational descriptive study was to examine the relationship between CC and knowledge of South Asian culture of RNs working in an urban hospital setting in Houston, Texas. A final convenience sample of 122 RNs from different departments of the specific urban hospital was used in the analysis. A description of sample characteristics, study variables, and presentation of study findings are presented in this chapter.

Description of the Sample

RNs working in an urban hospital setting were recruited to participate in this study using convenience sampling. A total of 129 RNs in the study with an attrition of seven. The PI did not include 6 of the participants' data in the data analysis due to prior participation in the pilot study along with an RN participant's ($N = 1$) data due to missing more than 50% of data. RN participants' ($N = 122$) data were downloaded into SPSS 25 for data analysis. The inclusion criteria for the sample were the following: 1) be a registered nurse, 2) at least 18 years or older, and 3) currently working in an urban hospital setting.

The cultural characteristics of the RNs (see Table 9) who participated in the study were as follows: Asians- 41.8%; Black or African Americans- 23%; White or Caucasians- 22.1%; American Indian or Alaska Native- 0.8%; More than One Race- 0.8%; Others- 7.4%, with 4.1% chose not to fill in that information. The majority ($N =$

93, 76.2%) of the participants were not Hispanic/Latino, whereas 18.9% ($N = 23$) were Hispanic/Latino. 4.9% ($N = 6$) did not enter that information. The mean age of the RNs was 38.68 years old, ranging from 21 to 65. There were 103 female participants and 13 male participants; RN participants ($N = 5$) marked their gender under others, and one participant choosing not to enter that information. RN participants (69.7%; $N = 85$) were baccalaureate-prepared, and 20.5% ($N = 25$) of the participants held master's degrees. RN participants (6.6%; $N = 8$) had an associate degree in nursing. Whereas one (0.8%) person had a diploma in nursing. RN participants (2.5%; $N = 3$) of the participants chose not to fill in that information. The number of years of experience of the RNs varied from 1 to 2 years to more than 10 years. The RNs had experiences of 1-2 years ($N = 6.6\%$), 3-5 years (18.9%; $N = 23$), and 10 plus years (38.5%; $N = 47$), respectively. RN participants (29.5%; $N = 36$) had 6-10 years of experience. Data were missing for eight RNs (3.3%; $N = 8$). RN participants (91%; $N = 111$) had full-time job status while 7.4% ($N = 9$) of the participants had part-time job status during the study. Current job status data was missing for (1.6%; $N = 2$) of the participants (see Table 9).

Table 9*Demographic Data (n = 122)*

Variable		N (%)
Age in years	Mean	38.68
	SD	11.58
	Median	36.00
	Mode	30
	Range	21-65
Gender	Female	103 (84.4%)
	Male	13 (10.7%)
	Others	5 (4.1%)
	Missing	1 (0.8%)
Race	Asian	51 (41.8%)
	Black or African American	28 (23%)
	White or Caucasian	27 (22.1%)
	Others	9 (7.4%)
	American Indian or Alaska Native	1 (0.8%)
	More than one race	1 (0.8%)
	Missing	5 (4.1%)
Ethnicity	Not Hispanic/Latino	93 (76.2%)
	Hispanic/Latino	23 (18.9%)
	Missing	6 (4.9%)
Country Born	USA	60 (49.2%)
	India	20 (16.4%)
	Philippines	12 (9.8%)
	Nigeria	8 (6.6%)
	Mexico	4 (3.3%)
	Vietnam	4 (3.3%)
	Nepal	3 (2.5%)
	Saudi Arabia	1 (0.8%)
	Uruguay	1 (0.8%)
	Antigua	1 (0.8%)
	Canada	1 (0.8%)
	El Salvador	1 (0.8%)
	Eritrea	1 (0.8%)
Japan	1 (0.8%)	

Table 9 (Continued)	Missing	4 (3.3%)
Nationality	USA	41 (33.6%)
	Asian	18 (14.8%)
	African American	13 (10.7%)
	Filipino	7 (5.7%)
	Mexican American	7 (5.7%)
	Caucasian	5 (4.1%)
	Hispanic	3 (2.5%)
	Vietnamese American	3 (2.5%)
	Indian American	2 (1.6%)
	Mexican	2 (1.6%)
	Vietnamese	2 (1.6%)
	American/Uruguayan	1 (0.8%)
	Antiguan	1 (0.8%)
	Asian American	1 (0.8%)
	Canadian	1 (0.8%)
	English	1 (0.8%)
	Eritrean	1 (0.8%)
	Fil- American	1 (0.8%)
	Hispanic American	1 (0.8%)
	Ibo	1 (0.8%)
	Latin American	1 (0.8%)
	Mixed with European de	1 (0.8%)
	Native American	1 (0.8%)
	Orthodox, well rooted	1 (0.8%)
	Persian American	1 (0.8%)
	Salvadoran	1 (0.8%)
	Missing	4 (3.3%)
Primary Language at Home as a Child	Not English	64 (52.5%)
	English	54 (44.3%)
	Missing	4 (3.3%)
Primary Language at Home as an adult	English	78 (63.9%)
	Not English	41 (33.6%)
	Missing	3 (2.5%)

Table 9 (Continued)

Religion as a Child	Christian	107 (87.7%)
	Non-Christian	10 (8.2%)
	None	2 (1.6%)
	Missing	3 (2.5%)
Religion Today	Christian	98 (80.3 %)
	Non-Christian	15 (12.3 %)
	None	5 (4.1%)
	Missing	4 (3.3%)
Number of Years as RN	10+ years	47 (38.5%)
	6-10 years	36 (29.5%)
	3-5 years	23 (18.9%)
	1-2 years	8 (6.6%)
	Missing	8 (6.6%)
Highest Nursing Degree	Baccalaureate	85 (69.7%)
	Masters	25 (20.5%)
	Associate degree	8 (6.6%)
	Diploma	1 (0.8%)
	Missing	3 (2.5%)
Start working at your current job	3-5 years	41 (33.6%)
	10+ years	29 (23.8%)
	6-10 years	25 (20.5%)
	1-2 years	20 (16.4%)
	Less than a year	1 (0.8%)
Current Position	Staff nurse	95 (77.9%)
	Management/Administration	17 (13.9%)
	Others	3 (2.5%)
	Nurse Practitioner/ Nurse Clinician	3 (2.5%)
	Educator	2 (1.6%)
	Missing	2 (1.6%)

Table 9 (Continued)

Specialty Area	Med/Surg & IMU	47 (38.5%)	
	Critical Care	23 (18.9%)	
	Maternal and Child Services	13 (10.7%)	
	Operating room & PACU Services	17 (13.9%)	
	Others	8 (6.6%)	
	Administration/Management	9 (7.4%)	
	Missing	5 (4.1%)	
	Current Job-status	Full time	111 (91%)
	Part time	9 (7.4%)	
Missing	2 (1.6%)		
Last year of training in Cultural Competence	This year (2020)	32 (26.2%)	
	In the past 2 years (2018-2019)	64 (52.5%)	
	More than 2 years	14 (11.5%)	
	Missing	10 (8.2%)	
	None	2 (1.6%)	
Home Zip Code Diversity 2020	Race White		
	Mean	(54.28%)	
	Median	(53.60%)	
	Ethnicity Hispanic		
	Mean	(27.41%)	
	Median	(19.40%)	
Home Zip Code Diversity 2019	Race White		
	Mean	(51.97%)	
	Median	(52.65%)	
	Ethnicity Hispanic		
	Mean	(29.59%)	
	Median	(21.95%)	

Table 9 (Continued)

Home Zip Code Diversity 2018	Race White	
	Mean	(52.10%)
	Median	(53.60%)
	Ethnicity Hispanic	
	Mean	(29.57%)
	Median	(21.30%)
Home Zip Code Diversity 2017	Race White	
	Mean	(51.66%)
	Median	(51.30%)
	Ethnicity Hispanic	
	Mean	(29.54%)
	Median	(21.30%)
Home Zip Code Diversity 2016	Race White	
	Mean	(52.09%)
	Median	(51.70%)
	Ethnicity Hispanic	
	Mean	(30.13%)
	Median	(19.80%)

Home zip codes showed the following results for diversity 2020: White Race-mean = 54.28% and median = 53.60%. The Hispanic percentage had a mean = 27.41% and median = 19.40%. Home zip codes showed the following results for diversity 2019: White Race-mean = 51.97% and median = 52.65%. The Hispanic percentage had a mean

= 29.59% and median = 21.95 %. Home zip codes showed the following results for diversity 2018: White Race-mean = 52.10% and median = 53.60%. The Hispanic percentage had a mean = 29.57 % and median = 21.30%. Home zip codes showed the following results for diversity 2017: White Race-mean = 51.66% and median = 51.30%. The Hispanic percentage had a mean = 29.54% and median = 21.30%. Home zip codes showed the following results for diversity 2016: White Race-mean = 52.09% and median = 51.70%. The Hispanic percentage had a mean = 30.13% and median = 19.80%.

The maximum score in South Asian Knowledge survey was 32 points. The actual scores ranged from 2-23. The mean score was 12.09 (See Table 10). The standard deviation was 4.446. The mean total CC scores were 71.9705 ranging from 57- 88 (see Table 11). The standard deviation was 6.47168. The mean scores of the participant's cultural awareness subscale were 13.7918 ranging from 9-18. The standard deviation was 1.87147. The cultural awareness scores were measured using items 1, 2, 3, 15, and 18 on the IAPCC-R.

Table 10*Knowledge of South Asian Culture*

Knowledge of South Asian Culture (maximum score 32)	
Range	2-23
Mean	12.09
SD	4.446

The subscale cultural knowledge mean score was 12.1672 ranging from 8-18 with a standard deviation of 2.13408. The cultural knowledge subscale was measured using items 6, 8, 10, 11, and 12 on the IAPCC-R. The cultural skill mean score was 14.1566, ranging from 9-20 with a standard deviation of 1.83470. The cultural skill subscale was measured using items 5, 9, 20, 21, and 22 on the IAPCC-R. The cultural encounters mean score was 14.4877 ranging from 10-19 with a standard deviation of 1.76099. The cultural encounters subscale was measured using the items 14,16, 17, 23, and 25 on the IAPCC-R. Finally, the cultural desire subscale mean score was 17.3672, ranging from 13-20 with a standard deviation of 1.91270. The cultural desire subscale was measured using items 4, 7, 13, 19, and 24 (see Table 11).

Table 11*Cultural Competence Scores (N = 122)*

Subscales	Mean (SD) Range	IAPCC-R Levels
Cultural Awareness	13.7918 (1.87147) 9 - 18	Items 1, 2, 3, 15, 18
Cultural Knowledge	12.1672 (2.13408) 8 - 18	Items 6, 8, 10, 11, 12
Cultural Skill	14.1566 (1.83470) 9 - 20	Items 5, 9, 20, 21, 22
Cultural Encounters	14.4877 (1.76099) 10 -19	Items 14, 16, 17, 23, 25
Cultural Desire	17.3672 (1.91270) 13 - 20	Items 4, 7, 13, 19, 24
Total Score	71.9705 (6.47168) 57-88	Culturally Proficient 91-100 Culturally Competent 75-90 Culturally Aware 51-74 Culturally Incompetent 25-50

Pearson's Correlation was used to determine the relationships between scaled measurements or interval data. Pearson Correlation (see Table 12) showed a weak positive relationship between 2017 White race and cultural encounters ($r = .219, p = .029$). 1) There was a moderate positive relationship between Cultural Knowledge and Cultural Encounters ($r = .438 p$ -value = 0.00). There was a moderate positive relationship between cultural desire and cultural encounters ($r = .368 p$ -value = 0.00). There was a moderate positive relationship between cultural skill and cultural encounters ($r = .318 p$ -value = 0.00). There was a moderate positive relationship between cultural awareness and cultural desire ($r = .372 p$ -value = 0.00). There was a moderate positive relationship between cultural skill and cultural desire ($r = .455 p$ -value = 0.00). There is a

strong positive relationship between cultural desire and CC total score ($r = .701$ p -value = 0.00). There is a strong positive relationship between cultural awareness and CC total score ($r = .585$ p -value = 0.00). There is a strong positive relationship between cultural knowledge and CC total score ($r = .680$ p -value = 0.00).

There is a strong positive relationship between cultural skill and Cultural Competence Total Score ($r = .775$ p -value = 0.00). There is a strong positive relationship between cultural encounters and CC total score ($r = .662$ p -value = 0.00). There is a weak positive relationship between South Asian Knowledge score and cultural awareness ($r = .209$ p -value = .021). The PI performed two independent sample t -tests for all bivariate analyses. Ethnicity is not statistically significant with regards to cultural competency, cultural knowledge, cultural desire, cultural skill, cultural awareness, or cultural knowledge. Language at home as an adult (English/not English speaking) is statistically significant with regards to cultural awareness ($df = 117$, Sig. (2-tailed) = .000; see Table 13). The groups are not even in group 1 and group 2 (group 1, $N = 78$, & group 2, $N = 41$, t value = 4.356). Language at home as an adult (English/not English speaking) is not statistically significant with regards to cultural competency, cultural encounters, cultural desire, cultural skill, or cultural knowledge.

Table 12*Pearson Correlation*

Pearson Correlation	<i>r</i>	<i>p</i>
South Asian knowledge score and cultural awareness	.209	.021
2017 White race and cultural encounters	.219	.029
2016 White race and cultural awareness	-.050	.624
2016 White race and cultural knowledge	-.068	.505
2016 White race and cultural skill	-.117	.249
2016 White race and cultural encounters	.152	.133
2016 White race and cultural desire	.067	.513
2016 White race and Culturalcompetence	-.010	.920
TotalScore		
2017 White race and cultural awareness	-.021	.839
2017 White race and cultural knowledge	-.091	.372
2017 White race and cultural skill	-.099	.329
2017 White race and cultural encounters	.219	.029
2017 White race and cultural desire	.098	.334
2017 White race and CulturalCompetence	.024	.817
TotalScore		
2018 White race and cultural awareness	-.030	.767
2018 White race and cultural knowledge	-.047	.642
2018 White race and cultural skill	-.060	.549
2018 White race and cultural encounters	.161	.107
2018 White race and cultural desire	.047	.640
2018 White race and CulturalCompetence	.016	.873
TotalScore		

Table 12 (Continued)

2019 White race and cultural awareness	-.095	.338
2019 White race and cultural knowledge	-.043	.663
2019 White race and cultural skill	-.088	.373
2019 White race and cultural encounters	.091	.358
2019 White race and cultural desire	.022	.826
2019 White race and CulturalCompetence	-.036	.716
TotalScore		
2020 White race and cultural awareness	-.067	.532
2020 White race and cultural knowledge	.033	.756
2020 White race and cultural skill	-.103	.356
2020 White race and cultural encounters	.067	.529
2020 White race and cultural desire	.062	.559
2020 White race and CulturalCompetence	-.002	.985
TotalScore		
Cultural awareness and cultural encounters	.160	.079
Cultural awareness and cultural knowledge	.108	.236
Cultural awareness and cultural desire	.372	.000
Cultural awareness and cultural skills	.377	.000
Cultural awareness and CulturalCompetence	.585	.000
TotalScore		
Cultural knowledge and cultural awareness	.108	.236
Cultural knowledge and cultural encounters	.438	.000
Cultural knowledge and cultural desire	.207	.022
Cultural knowledge and cultural skills	.488	.000
Cultural knowledge and CulturalCompetence	.680	.000
TotalScore		
Cultural encounters and cultural knowledge	.438	.000

Table 12 (Continued)

Cultural encounters and Cultural desire	.368	.000
Cultural encounters and Cultural skills	.318	.000
Cultural encounters and CulturalCompetence	.662	.000
TotalScore		
Cultural skills and cultural awareness	.377	.000
Cultural skills and cultural encounters	.318	.000
Cultural skills and cultural desire	.455	.000
Cultural skills and CulturalCompetence	.775	.000
TotalScore		
Cultural desire and CulturalCompetence	.701	.000
TotalScore		
Cltural awareness and South Asian knowledge score	.209	.021
Cultural knowledge and South Asian knowledge score	.038	.680
Cultural skill and South Asian knowledge score	.052	.568
Cultural encounters And South Asian Knowledge score	-.123	.176
Cultural desire and South Asian knowledge score	.128	.159
CulturalCompetence TotalScore and South Asian knowledge score	.092	.314

Table 13*T-Test*

Language at home as adult (English/not English speaking)	<i>df</i>	<i>Sig. (2- tailed)</i>	<i>t value</i>
<i>Group 1, N = 78</i> <i>Group 2, N = 41</i>	117	.000	4.356
CulturalCompetenceTotalScore (Hispanic/Latino/ Not Hispanic/Latino) <i>Group 1, N = 23</i> <i>Group 2, N = 93</i>	114	.221	1.232
Cultural Knowledge (Hispanic/Latino/ Not Hispanic/Latino) <i>Group 1, N = 23</i> <i>Group 2, N = 93</i>	114	.501	.675
Cultural Awareness (Hispanic/Latino/ Not Hispanic/Latino) <i>Group 1, N = 23</i> <i>Group 2, N = 93</i>	114	.219	1.236
Cultural skill	114	.911	.112

Table 13 (continued)

(Hispanic/Latino/Not Hispanic/Latino)

Group 1, N = 23

Group 2, N = 93

Cultural encounters 114 .472 .722

(Hispanic/Latino/

Not Hispanic/Latino)

Group 1, N = 23

Group 2, N = 93

Cultural desire 114 .177 1.358

(Hispanic/Latino/

Not Hispanic/Latino)

Group 1, N = 23

Group 2, N = 93

CulturalCompetenceTotalScore 117 .106 1.628

(English/Not English)

Group 1, N = 78

Group 2, N = 41

Cultural knowledge 117 .117 -1.581

(English/Not English)

Group 1, N = 78

Group 2, N = 41

Cultural skill 117 .872 -.161

(English/Not English)

Group 1, N = 78

Group 2, N = 41

Cultural desire 117 .112 1.603

(English/Not English)

Group 1, N = 78

Group 2, N = 41

Table 13 (continued)

CulturalCompetenceTotalScore	117	.106	1.628
(English/Not English)			
Group 1, <i>N</i> = 78			
Group 2, <i>N</i> = 41			

Instrument Reliability and Validity

The Cronbach's Alpha was used to assess the inter-rater reliability of the constructs concerning the items in the IAPCC-R. A Cronbach's alpha of at least 0.7 indicated consistency within the items that were derived from each construct. The reliability analysis showed a Cronbach's alpha of .770 for IAPCC-R in this study (see Table 14). The cultural awareness construct had a lower reliability statistic at 0.594 than the other constructs. The cultural desire construct had the highest reliability at 0.783. The number of items on the IAPCC-R scale was 25. Reliability subscales showed a Cronbach's alpha of 0.738, 0.651, and 0.712 for cultural skill, cultural encounters, and cultural knowledge, respectively (see Table 14). Literature showed the individual constructs ranged from poor (0.304 for cultural knowledge) to moderate (0.671 for cultural encounters; Beer & Chipps, 2014). The reliability analysis showed a Cronbach's alpha of .596 for the South Asian Knowledge survey (see Table 15). The number of items on the South Asian Knowledge Survey was 11 (see Appendix D).

Table 14*Reliability Analysis (N = 122)*

	Cronbach's alpha
Cultural Awareness	.594
Cultural Knowledge	.712
Cultural Skill	.738
Cultural Encounters	.651
Cultural Desire	.783
Total Score	.770

Table 15*Reliability Statistics*

Cronbach's Alpha Based on Standardized Items	N of Items
.596	11

Conclusions

This chapter presented the data analysis and findings of a correlational descriptive study that examined the relationship between cultural competence and knowledge of South Asian culture of RNs working in an urban hospital setting. RN participants' (N = 122) data were downloaded into SPSS 25 for data analysis. The maximum score in South Asian Knowledge survey was 32 points. The actual scores ranged from 2-23. The mean

score was 12.09. The standard deviation was 4.446. The mean total CC scores were 71.9705 ranging from 57-88. The standard deviation was 6.47168. A Cronbach's alpha of at least 0.7 indicated consistency within the items that were derived from each construct. The reliability analysis showed a Cronbach's alpha of .770 for IAPCC-R in this study (see Table 14). The cultural awareness construct had a lower reliability statistic at 0.594 than the other constructs. The cultural desire construct had the highest reliability at 0.783.

CHAPTER V

SUMMARY OF THE STUDY

The purpose of this correlational descriptive study was to explore the relationship between cultural competence and knowledge of South Asian culture of RNs working in an urban hospital setting in Houston, Texas. The data collection for the study was done electronically due to COVID- 19 changes in summer 2020. The study survey had been created in PsychData, which included the recruitment email, cover letter, the Demographic Data Form, South Asian Knowledge survey, and the IAPCC- R tool.

The study gave light on the factors that RNs saw as important when taking care of South Asian patients in an urban hospital setting. The study measured the knowledge of RNs' South Asian culture, and different religions from different regions of South Asia. This study allowed the RNs an opportunity to document various accommodations like diet, fasting, caregiver preferences, and end of life rituals, they practice based on the religion of patients from a South Asian culture. Examples of those religions are Buddhist, Christian, Hindu, Muslim, Jain, and Sikh.

Research Question 1

What is the relationship between the cultural competence of urban hospital registered nurses and their South Asian knowledge?

The data analysis showed there was a weak positive relationship between South Asian knowledge score and Cultural Awareness ($r = .209$ p value = .021).

Research Question 2

What is the relationship between the cultural competence of urban hospital registered nurses and their exposure to diverse cultures?

The Pearson Correlation showed a weak positive relationship between the White race and cultural encounters ($r = .219, p = .029$).

Research Question 3

Is there any difference in the CC of registered nurses by their demographics?

Ethnicity is not statistically significant with regards to cultural competency, cultural knowledge, cultural desire, cultural skill, cultural awareness, or cultural knowledge. Language at home as an adult (English/not English speaking) is statistically significant with regards to cultural awareness ($df = 117, \text{Sig. (2- tailed)} = .000$) (see Table 13). The groups are not even in group 1 and group 2 (group 1, $N = 78$, & group 2, $N = 41, t \text{ value} = 4.356$). Language at home as an adult (English/not English speaking) is not statistically significant with regards to cultural competency, cultural encounters, cultural desire, cultural skill, or cultural knowledge.

Discussion

The key finding of the study was that majority of the RNs were culturally aware; however, they were not culturally competent as seen in the scores on the IAPCC- R. The mean score on the IAPCC- R was 71.97%. This result, compared to the two previous studies, also demonstrated that RNs scored in the range of being culturally aware (Mahabeer, 2009; Salman et al., 2007). The participants scored lowest (12.1672) in the subscale cultural knowledge. This was consistent with the findings of other studies (Mahabeer, 2009; Songwathana & Siriphan, 2015).

Most of the RNs felt they were not highly knowledgeable in the area of biological variations among the different ethnic groups. Campinha-Bacote (2003) stresses the importance of having knowledge about biological, physical, physiological differences and its influence on the ability to perform an accurate nursing assessment. A common finding of inverted T waves shown on the precordial leads of the electrocardiogram in African American males is considered normal, whereas the same finding may be considered as an unusual result in other cultural groups (Campinha-Bacote, 2003). This was consistent with the previous study by Mahabeer (2009). Mahabeer (2009) highlighted a cultural desire area that required the most improvement. These results also stressed that the nurses had a passion for achieving new insights and knowledge in the area of CC. Healthcare professionals should know how biological, physical, and physiological differences might influence the ability to perform an accurate nursing assessment (Campinha-Bacote, 2003). Asian-Indians (28%) had difficulty communicating with doctors, and 43% of Asian-Indians felt their doctors did not understand their background or values (Hughes, 2002).

The participants scored highest in the subscale cultural desire (17.3672), suggesting that the nurses were motivated to become more CC. Participants scored cultural awareness (13.7918), cultural skill (14.1566), and cultural encounters (14.4877) in the second, third, and fourth place, respectively. These results showed that RNs demonstrated cultural awareness and were motivated in the process to be CC with a higher mean of 17.3672%. This was consistent with a previous study conducted by Mahabeer (2009). The results were promising because they highlighted an area that requires the most improvement (cultural knowledge). They also reflected that RNs have a

desire for gaining new understanding and knowledge in the area of CC. The findings highlight that there needs to be a variety of educational interventions used to improve cultural competence.

Mareno and Hart (2014) noted that nurses with an undergraduate education scored lower on CC scores than nurses with graduate degrees. Riley et al. (2012) showed a significant, weak, and negative relationship between IAPCC-R scores and years of experience ($r = -.294$, $p = .05$). Mahabeer (2009) stated that the majority of hemodialysis nurses (52.6%) indicated that their educational level influenced their CC level. Most hemodialysis nurses (86.2%) indicated that their work experience influenced their CC level.

Spanakis and Golden (2013) reported the self-rated levels of CC of critical care nurses (CCNs) working in a public hospital in South Africa. The key findings of the study found that the majority of CCNs were culturally aware but not competent, the differences between the different constructs of cultural competence, and the evidence that non-English-speaking CCNs self-rated higher on all the individual constructs than English speaking CCNs. RNs scored highest in the cultural desire subscale. Cultural desire is one of the major components to become culturally competent (Campinha-Bacote, 2002).

The purpose of this correlational descriptive study was to explore the relationship between cultural competence and knowledge of South Asian culture of RNs working in an urban hospital setting. Significant findings were that the RNs were culturally aware, required more cultural knowledge, and were highly motivated in cultural desire. There is an opportunity for educators to improve RN's level of cultural knowledge. As the United

State's population becomes more culturally diverse, it is most important for RNs to gain cultural knowledge to meet the needs of patients from diverse cultures.

Theoretical Framework, Study Findings, and Relations

This study's results are supported by the CC model (see Table 16). Cultural desire is one of the major components to become culturally competent (CampinhaBacote, 2002). It mainly revolves around the eagerness and willingness of healthcare providers to interact with people from other cultural background and learn about their different cultural perspectives (Campinha-Bacote, 2002). Nurses have opportunities to engage and learn different cultures through education and learning activities, self- learning, and interaction with colleagues from other cultures. This process can shape their understandings and perceptions around other cultures (Aboshaigah et al.,2017).

Table 16

Study Findings and Conceptual Model

<i>Study Findings</i>	<i>Conceptual model of CC (Campinha-Bacote, 2002)</i>
Scored second in the subscale cultural awareness (13.7918).	Cultural awareness involves self-examination of one's cultural background and recognition of biases and prejudice.
Scored highest in the subscale cultural desire (17.3672). This reflected that RNs have a desire for gaining new understanding and knowledge in the area of CC.	Cultural desire involves caring and engaging in the process of cultural competence.
Scored third in the subscale cultural skill (14.1566).	Cultural skills involve collecting relevant cultural data and utilizing information to perform culturally based assessments.
Scored lowest in in the subscale cultural knowledge (12.1672). The results highlighted this area that required most improvement.	Cultural knowledge involves seeking and obtaining a broad knowledge base of diverse populations.
Scored fourth in the subscale cultural encounters (14.4877).	Cultural encounters involve face-to-face interactions with patients of diverse backgrounds to prevent stereotyping (Campinha-Bacote, 2002).

A definition of CC in nursing needs to include parts of the culture's affective, cognitive, and practical/skill dimensions defining CC as a dynamic, continuous, and developing process to provide culturally congruent and competent healthcare for a culturally diverse population (Shen, 2015). Research has also shown that the more CC the healthcare provider is, the better the patient outcomes (Betancourt et al., 2014). The goal of CC in healthcare is to create a system and a workforce that can provide the highest quality care to all patients regardless of race, ethnicity, culture, or language

(Betancourt et al., 2014). The concept in this model is that the five constructs are interrelated and are essential to achieve culturally competent responsive services (Campinha-Bacote, 2002, 2003).

Implications for the Nursing Practice

The findings of the study suggest important implications for education and research. The study could be replicated at different healthcare facilities, or in other areas of practice, with a larger sample size, using an intervention study based on the IAPCC-R tool. Future research is essential to evaluate cultural competence in different regions of the United States, including registered nurses from diverse backgrounds at different healthcare organizations with larger sample sizes to detect statistically significant differences to make inferences about cultural competence to add to the scientific knowledge. Conducting a qualitative study would have helped to get cultural competence perspectives of RNs.

Recommendations for Further Research

There is a gap in research regarding cultural competence and knowledge of South Asian culture of RNs working in an urban hospital setting. Much of the current research explores the CC of RNs in different settings. Several recommendations for future research arise from this study, including:

1. An intervention study to measure the cultural competence scores of the RNs
2. Replication of the study using larger and heterogenous sample
3. Replication of the study in different settings
4. Replication of the study using qualitative method

5. An exploration of additional factors that may impact cultural competence scores and South Asian Knowledge scores

Strengths and Limitations of the Study

The study represented a diverse population of registered nurses: African American, American/Uruguayan, Antiguan, Asian, Asian American, Canadian, Caucasian, English, Eritrean, Fil-American, Filipino, Hispanic, Hispanic American, Ibo, Indian American, Latin American, Mexican, Mexican American, Mixed with European, Native American, Orthodox well-rooted, Persian American, Salvadoran, Vietnamese, and Vietnamese American which was a strength of the study. The sample characteristics of the RNs did represent RNs from diverse background in the USA. The National Nursing Workforce study conducted by the National Council of State Board of Nursing (2017) showed that 19.2% of RN respondents were minorities. Whereas 18.9% of the participants self-identified as Hispanic or Latino in the study conducted by PI.

The study included a convenience sample of 129 participants. RN participants ($N = 7$) did not meet the inclusion criteria for the study. Only 122 participant's data were entered into data analysis. This was one of the limitations of the study. The study limitations included the convenience sampling design in only one hospital. A pretest and posttest using an intervention would have given a better picture of the cultural competence of these RNs in the urban hospital. The South Asian knowledge survey was developed by PI and this instrument was not tested prior to this study. A Cronbach's alpha of .596 of the South Asian knowledge survey indicates further development and testing is needed. This could be considered as a limitation of the study too. The study was conducted during the COVID-19 outbreak (summer 2020). The data collection was

conducted electronically using PsychData survey link instead of in-person data collection due to restrictions related to COVID-19.

REFERENCES

- Aboshaigah, A. E., Tumala, R. B., Inocian, E. P., Almutairi, A. E., & Atallah, M. (2017). Enhancing culturally competent nursing care in Saudi Arabia. *Journal of Cultural Diversity*, 24(1), 20-26. <https://ezp.twu.edu/login?url=https://searchproquest-com.ezp.twu.edu/docview/1885722741?accountid=7102>
- Adamson, H. (2016). *Exploring Countries Bangladesh*. Bellwether Media.
- Alejandro, J. L. (2015). *Cultural competence perceptions by Hispanic nurses* (Order No. 3682192). [Doctoral dissertation, Capella University]. Available from ProQuest Dissertations & Theses Global.
- Ali, S. E., & Eliyas, J. (2014). *Cultures of the world: Afghanistan* (3rd ed.). Cavendish Square Publishing.
- American Nurses Association. (2018). *Retired Position Statement: Cultural Diversity in Nursing Practice*, <https://www.nursingworld.org/practice-policy/nursing-excellence/offciail-positionstatements/>
- Ansari, S. H. (2016). Globalization of herbal drugs. *Annals of Phytomedicine*, 5(2), 1-5. <https://doi.org/10.21276/ap.2016.5.2.1>
- Asad, M. (2017). *Indian Muslim Festivals and Customs*. Publications Division Ministry of Information & Broadcasting.
- Ashtiani, A. N. (2019). *Creating shade in arid climates: A welcoming landscape based on Zoroastrian beliefs for the towers of silence*, <https://vtechworks.lib.vt.edu/handle/10919/95986> [Doctoral dissertation, Virginia Tech University]

- Bauce, K., Kridli, S. A., & Fitzpatrick, J. J. (2014). Cultural competence and physiological empowerment among acute care nurses. *Online Journal of Cultural Competence in Nursing and Healthcare*, 4(2), 27-38.
<https://dx.doi.org.ezp.twu.edu/ojccnh.org/v4n2a3>
- Berlin, A., Nilsson, G., & Tornkvist, L. (2010). Cultural competence among Swedish child health nurses after specific training: A randomized trial. *Nursing and Health Sciences*, 12(3), 381-391. <https://doi/10.1111/j.1442-2018.2010.00542.x>
- Betancourt, J. R., Corbett, J., & Bondaryk, M. R. (2014). Addressing disparities and achieving equity: cultural competence, ethics, and health-care transformation. *Chest*, 145(1), 143-148. <https://doi.org/10.1378/chest.13-0634>
- Bhopal, R. S. (2014). *Migration, ethnicity, race and health in multicultural societies* (2nd ed.). Oxford University Press.
- Bjorklund, R. (2012). *Afghanistan: Enchantment of the World*. Scholastic.
- Blashfield, J. F. (2012). *Countries around the world: Pakistan*. Oxford: Capstobe Global Library.
- Boston University Henry M. Goldman School of Dental Medicine. (2015). *South Asia Map*. <https://www.bu.edu/dental/south-asia-map/>
- Brathwaite, A. E. C. (2005). Evaluation of a cultural competence course. *Journal of Transcultural Nursing*, 16(4), 361-369. <https://doi.org/10.1177/1043659605278941>
- British Broadcasting Company. (2002). *Theravada Buddhism*.
https://www.bbc.co.uk/religion/religions/buddhism/subdivisions/theravada_1.shtml

- Brown, S. A., Garcia, A. A., Kouzekanani, K., & Hanis, C. L. (2002). Culturally competent diabetes self-management education for Mexican Americans: The Starr County border health initiative. *Diabetes Care*, 25(2), 259-268.
<https://doi.org/10.2337/diacare.25.2.259>
- Bunjitpimol, P., Kumar, R., & Somrongthong, R. (2018). Effectiveness of case based cultural competency among nurses working in private hospitals of Bangkok, Thailand: A Quasiexperimental study. *Pakistan Journal of Medical Sciences*, 34(1), 1-5. www.pmjs.com.pk
- Burbunk, J., & Elias, J. (2014). *Cultures of the world: Nepal* (3rd ed.). Cavendish Square Publishing.
- Cai, D. Y. (2016). A concept analysis of cultural competence. *International Journal of Nursing Sciences*, 3(3), 268-273. <https://doi.org/10.1016/j.ijnss.2016.08.002>
- Cai, D., Kunaviktikul, W., Klunklin, A., Sripusanapan, A., & Avant, P. K. (2017). Developing a cultural competence inventory for nurses in China. *International Nursing Review*, 64(2), 205-214. <https://doi.org/10.1111/inr.12350>
- Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in healthcare. *Journal of Nursing Education*, 38(5), 204-208.
<https://ezp.twu.edu/login?url=https://search-proquestcom.ezp.twu.edu/docview/69938401?accountid=7102>
- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, 13(3), 181-184. <https://doi.org/10.1177/10459602013003003>

- Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of healthcare services: A culturally competent model of care* (4th ed.). Transcultural C.A.R.E.
- Campinha-Bacote, J. (2007). *The process of cultural competence in the delivery of healthcare services: The journey continues* (5th ed.). Transcultural C.A.R.E. Associates.
- Campinha-Bacote, J. (2009). *Reported reliability and validity of the IAPCC- R*.
<https://www.transculturalcare.net/iapccr.htm>
- Census India. (2011). *Census of India*. <http://www.censusindia.net>
- Chipps, J., Simpson, B., & Brysiewicz, P. (2008). The effectiveness of cultural competence training for health professionals in community-based rehabilitation: A systematic review of the literature. *Worldviews on Evidence Based Nursing*, 5(2), 85-94. <https://doi.org/10.1111/j.1741-6787.2008.00117.x>
- Cooper, R., & Lin, Y. J. (2011). *Cultures of the world: Bhutan* (3rd ed.). Cavendish Square Publishing.
- Das, J., Holla, A., Mohpal, A., & Muralidharan, K. (2016). Quality and accountability in health care delivery: Audit-study evidence from primary care in India. *American Economic Review*, 106(12), 3765-3799. <https://doi.org/10.1257/aer.20151138>
- De Beer, J., & Chipps, J. (2014). A survey of cultural competence of critical care nurses in KwaZulu-Natal. *Southern African Journal of Critical Care*, 30(2), 50-54.
<https://doi.org/107.7196/SAJCC.188>
- de Sousa Santos B. (2006). Globalizations. *Theory, Culture & Society*, 23(2-3), 393-399.
<https://doi.org/10.1177/026327640602300268>

- Delgado, D. A., Ness, S., Ferguson, K., Engstrom, P. L., Gannon, T. M., & Gillett, C. (2013). Cultural competence training for clinical staff: Measuring the effect of a one-hour class on cultural competence. *Journal of Transcultural Nursing, 24*(2), 204-213. <https://doi.org/10.1177/1043659612472059>
- Doutrich, D., & Storey, M. (2004). Education and practice: Dynamic partners for improving cultural competence in public health. *Family & Community Health, 27*(4), 298-307. <https://doi.org/10.1177/1043659612472059>
- Eche, I. J., & Aronowitz, T. (2017). Evaluating cultural competence of pediatric oncology nurses at a teaching hospital: A pilot study. *Journal of Pediatric Oncology Nursing, 34*(6), 422-426. <https://doi.org/10.1177/1043454217713452>
- Emmanuel, C. S. (2019). *Conflict between new religious movements and African traditional religion in the Bafut Community: the clash between kingship international ministries and African traditional religion* [Master's thesis, MF Norwegian School of Theology, Religion, and Society].
- Erdal, M. B., & Borchgrevink, K. (2017). Transnational Islamic charity as everyday rituals. *Global Networks, 17*(1), 130-146. <https://doi.org/10.1111/glob.12137>
- Garneau, A. B., & Pepin, J. (2015). A constructivist theoretical proposition of cultural competence development in nursing. *Nurse Education Today, 35*(11), 1062-1068. <https://doi.org/10.1016/j.nedt.2015.05.019>
- Global Security. (2019). *Maldives Religion*. <https://www.globalsecurity.org/military/world/indian-ocean/mv-religion.htm>
- Grahame-Smith, D., & Pee, S. (2011). *Cultures of the world: Maldives* (3rd ed.). Michelle Bisson.

- Gray, D. P., & Thomas, D. J. (2006). Critical reflections on culture in nursing. *Journal of Cultural Diversity*, 13(2), 76-82. <https://pubmed.ncbi.nlm.nih.gov/16856694/>
- Harris Health System. (2018). *Ben Taub Hospital*.
<https://www.harrishealth.org/locations-hh/Pages/ben-taub.aspx>
- Harvey, G. (2016). Zoroastrians Jenny Rose. In *Religions in focus: New approaches to tradition and contemporary practices* (pp. 19-40). Routledge.
- Hemberg, J. A. V., & Vilander, S. (2017). Cultural and communicative competence in the caring relationship with patients from another culture. *Scandinavian journal of caring sciences*, 31(4), 822-829. <https://doi.org/10.1111/scs.12403>
- Hughes, D. L. (2002). *Quality of healthcare for Asian Americans* (Report No. Pub.#525). Commonwealth Fund.
- IBM Corp. (2017). *IBM SPSS Statistics for Windows, Version 25.0*. IBM Corp.
- Inbadas, H. (2017). The philosophical and cultural situatedness of spirituality at the end of life in India. *Indian Journal of Palliative Care*, 23(3), 338.
https://doi.org/10.4103/ijpc.ijpc_61_17
- Iyer, S., & Shah, J. (2019). End-of-life practices in India: An update. In S. Todi, S. Bhalchandra, K. Zirpe, & Y. Mehta (Eds.), *Critical care update 2019* (pp. 269-272). Jaypee Brothers Medical Publishers.
- Jan, S., & Ali, A. (2020). South Asian American Digital Archive: Exploring digital reflections of South Asian Americans. *World Digital Libraries-An International Journal*, 13(1), 43-50. <https://doi.org/10.18329/09757597/2020/13104>
- Jeffreys, M. R. (2010). *Teaching cultural competence in nursing and health care: Inquiry, action, and innovation* (2nd ed.). Springer Publishing.

- Jenks, A. C. (2011). From “lists of traits” to “open-mindedness”: Emerging issues in cultural competence education. *Culture, Medicine, and Psychiatry*, 35(2), 209-235. <https://doi.org/10.1007/s11013-011-9212-4>
- Jirwe, M., Gerrish, K., Keeney, S., & Emami, A. (2009). Identifying the core components of cultural competence: Findings from a Delphi study. *Journal of Clinical Nursing*, 18(18), 2622-2634. <https://doi.org/10.1111/j.1365-2702.2008.02734.x>
- Joanna Briggs Institute (2011). The systematic review and synthesis of quantitative data. In *2011 Reviewers' Manual* (pp. 62–76). https://joannabriggs.org/sites/default/files/2019-05/JBI_Critical_Appraisal-Checklist_for_Systematic_Reviews2017_0.pdf
- Khan, S. A. R., Jian, C., Zhang, Y., Golpîra, H., Kumar, A., & Sharif, A. (2019). Environmental, social, and economic growth indicators spur logistics performance: From the perspective of South Asian Association for Regional Cooperation countries. *Journal of Cleaner Production*, 214, 1011-1023.
- Kardong-Edgren, S. (2007). Cultural competence of baccalaureate nursing faculty. *Journal of Nursing Education*, 46(8), 360-366. <http://doi.org/10.3928/01484834-20070801-05>
- Kawashima, A. (2008). *Study on cultural competency of Japanese nurses* [Unpublished doctoral dissertation]. George Mason University.
- Kumar, S., & Singh, R. P. (2017). Ayodhya (India): A study of Ritual Landscapes. *Practicing Geographer*, 21(2), 171-180. https://www.researchgate.net/publication/319987855_Ayodhya_India_a_Study_of_Ritual_Landscapes.

- Leininger, M. M., & McFarland, M. R. (Eds). (2002). *Transcultural Nursing: Concepts, theory, research & practice* (3rd ed.). McGraw- Hill.
- Library of Congress. (2008). *Country Profile: Afghanistan*.
<https://www.loc.gov/rr/frd/cs/profiles/Afghanistan.pdf>
- Mahabeer, S. A. (2009). A descriptive study of the cultural competence of hemodialysis nurses. *The CANNT Journal*, 19(4), 30-33.
<https://pubmed.ncbi.nlm.nih.gov/20136033/>
- Mareno, N., & Hart, P. L. (2014). Cultural competency among nurses with undergraduate and graduate degrees: Implications for nursing education. *Nursing Education Perspectives*, 35(2), 83-88. <https://doi.org/10.5480/12-834.1>
- Markey, K., Tilki, M., & Taylor, G. (2018). Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. *Journal of Clinical Nursing*, 27(1-2), e259-e268. <https://doi.org/10.1111/jocn.13926>
- Medical Council of India. (2017). *List of Colleges Teaching MBBS*.
<https://www.mciindia.org/CMS/information-desk/for-students-to-study-in-india/list-ofcollege-teaching-mbbs>
- McKay, J., Hill, B., & Buckler, J. (2007). *A history of world societies* (7th ed.). Boston: Houghton Mifflin.
- Mills, A. (2019). A Fine Book on Reincarnation Studies. A Review of "I saw a Light and Came Here: Children's Experiences of Reincarnation" By Erlendur Haraldsson and James G. Matlock, *The Journal of Parapsychology*, 83(1), 107-111. <https://doi.org/10.30891/jopar.2019.01.11>

- Mills, P. J., Peterson, C. T., Wilson, K. L., Pung, M. A., Patel, S., Weiss, L & Chopra, D. (2019). Relationships among classifications of ayurvedic medicine diagnostics for imbalances and western measures of psychological states: An exploratory study. *Journal of Ayurveda and Integrative Medicine*, 10(3), 198-202. <https://doi.org/10.1016/j.jaim.2018.02.001>
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, 151(4), 264-269. <https://doi.org/10.1136/bmj.b2535>.
- National Council of State Board of Nursing. (2017). *National Nursing Workforce Study*. <https://www.ncsbn.org/workforce.htm>
- National Council of State Board of Nursing. (2020). *Definition of Terms*. <https://www.ncsbn.org/nursing-terms.htm>
- National League for Nursing Accrediting Commission. (2016). *Accreditation standards for nursing education programs*. <http://www.nln.org/accreditationservices/overview>
- Newhouse, R., Dearholt, S., Poe, S., Pugh, L. C., & White, K. (2005). *The Johns Hopkins nursing evidence-based practice rating scale*. The Johns Hopkins Hospital/ The Johns Hopkins University School of Nursing.
- Nokes, K., Nickitas, D., Keida, R., & Neville, S. (2005). Does service-learning increase cultural competency, critical thinking, and civic engagement? *Journal of Nursing Education*, 44(2), 65-72. <https://doi.org/10.3928/01484834-20050201-05>
- Oikarainen, A., Mikkonen, K., Tuomikoski, A. M., Elo, S., Pitkänen, S., Ruotsalainen, H., & Kääriäinen, M. (2018). Mentors' competence in mentoring culturally and

- linguistically diverse nursing students during clinical placement. *Journal of Advanced Nursing*, 74(1), 148-159. <https://doi.org/10.1111/jan.13388>
- Paik, S. J., Rahman, Z., Kula, S.M., R., Saito, L.E., & Witenstein, M. A. (2017). Diverse Asian American families and communities: Culture, structure, and education (Part 1: Why they differ)." *The School Community Journal* 27(2) 35-66. https://primo-tcna01.hosted.exlibrisgroup.com/permalink/f/110i679/TN_eric_sEJ1165621
- Philips, C. A., Paramaguru, R., Joy, A. K., Antony, K. L., & Augustine, P. (2018). Clinical outcomes, histopathological patterns, and chemical analysis of Ayurveda and herbal medicine associated with severe liver injury—A single-center experience from southern India. *Indian Journal of Gastroenterology*, 37(1), 9-17. <https://doi.org/10.1007/s12664-017-0815-8>
- Pinto, S. (2017). Pharmocracy: Value, Politics, and Knowledge in Global Biomedicine by Kaushik Sunder Rajan. *Anthropological Quarterly*, 90(4), 1257-1267. <https://doi.org/10.1353/anq.2017.0070>
- Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Lippincott, Williams & Wilkins.
- Poreddi, V., Thimmaiah, R., & BadaMath, S. (2017). Medical and nursing students' attitudes toward mental illness: An Indian perspective. *Investigación y Educación en Enfermería*, 35(1), 86-94. <https://dx.doi.org/10.17533/udea.iee.v35n1a10>
- Porter, G., & Grills, N. (2016). Medication misuse in India: A major public health issue in India. *Journal of Public Health*, 38(2), e150-e157. <https://doi.org/10.1093/pubmed/fdv072>

- Power, E. A. (2018). Collective ritual and social support networks in rural South India. *Proceedings of the Royal Society B: Biological Sciences*, 285(1879), 1-7. <https://doi.org/10.1098/rspb.2018.0023>
- Purdue Global University. (2020). *What is cultural diversity?* <https://www.purdueglobal.edu/blog/social-behavioral-sciences/what-is-cultural-diversity/>
- Riley, D., Smyer, T., & York, N. (2012). Cultural competence of practicing nurses entering an RN- BSN Program. *Nursing Education Research*, 33(6), 381-385. <https://doi.org/10.5480/1536-5026-33.6.381>
- Rodgers, G. (2019). *What is South Asia?* <https://www.tripsavvy.com/what-is-south-asia-4115497>
- Rodriguez, L. (2019). *Global Citizen, Pakistan's Supreme Court Urges Rule Limiting Families to 2 children.* <https://www.globalcitizen.org/en/content/pakistan-two-childlimit-population-control/>
- SAALT. (2019). *Demographic snapshot of South Asians in the United States.* <https://saalt.org/wp-content/uploads/2019/04/SAALT-Demographic-Snapshot-2019.pdf>
- Salman, A., McCabe, D., Easter, T., Callahan, B., Goldstein, D., Smith, T. D., ... & Fitzpatrick, J. J. (2007). Cultural competence among staff nurses who participated in a family-centered geriatric care program. *Journal for Nurses in Professional Development*, 23(3), 103-111. <https://doi.org/10.1097/01.NND.0000277179.40206.be>

- Sargeant, S. E., Sedlak, C. A., & Martsolf, D. S. (2005). Cultural competence among nursing students and faculty. *Nurse Educator Today*, 25(3), 214-221.
<https://doi.org/10.1016/j.nedt.2004.12.005>
- Sarkar, P. (2020). Cases of Contributory Negligence in relation to Medical Practice in India-An appraisal. *Journal of Law of Torts and Consumer Protection Law*, 2(2), 14-16.
- Sarkar, R, & Sarkar, A. (2016). Meat-eating in India: Whose food, whose politics, and whose rights? *Policy Futures in Education*, 0(0) 1–14,
<https://doi.org/10.1177/1478210318780553>
- Schim, S. M., & Doorenbos, A. Z. (2010). A three-dimensional model of cultural congruence: Framework for intervention. *Journal of Social Work in End of Life & Palliative Care*, 6(3-4), 256-270.
<https://dx.doi.org/10.1080/15524256.2010.529023>
- Seright, T. (2012). Perspectives of registered nurse cultural competence in a rural state-- Part II. *Online Journal of Rural Nursing and Health Care*, 7(1), 57-69.
<https://dx.doi.org/10.14574/ojrnhc.v7i1.144>
- Sharma, P. (2017). Change in rituals India. *International Refereed & Blind Peer-Reviewed Multidisciplinary Research Journal*, 4(3), 9-14.
<http://www.wellpress.in/rrssh/Download/WPP-RRSSH-Jan-Feb-Mar-2017.pdf#page=16>
- Sheehan, S., Samiuddin, S., & Nevins, D. (2015). *Cultures of the world* (3rd ed.). Cavendish Square Publishing.

- Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: A literature review. *Journal of Transcultural Nursing*, 26(3), 308-321. <https://doi.org/10.1177/1043659614524790>
- Shoup, K. (2019). *Exploring world cultures: Pakistan* (1st ed.). Cavendish Square Publishing.
- Solomon, C. S. (2018). Homeopathic remedies and dietary supplements in 2018: Weighing benefits and risks. *Primary Care Reports*, 24(12). <https://search.proquest.com/docview/2140825163?accountid=45853>
- Songwathana, P. & Siriphan, S. (2015). Thai nurses' cultural competency in caring for clients living in a multicultural setting. *Pacific Rim International Journal of Nursing Research*, 19(1), 19-31. <https://he02.tcithaijo.org/index.php/PRIJNR/article/view/18965>
- Spanakis, E. K., & Golden, S. H. (2013). Race/ethnic difference in diabetes and diabetic complications. *Current diabetes reports*, 13(6), 814–823. <https://doi.org/10.1007/s11892-013-0421-9>
- Spilling, A. (2012). *Cultures of the World: Sri Lanka* (3rd ed.). Cavendish Square Publishing, LLC.
- Srinivasan, R., Jermyn, L., & NgCheong-Lum, R. (2012). *Cultures of the World* (3rd ed.). Marshall Cavendish Corporation.
- Suk, M. H., Oh, W. O., & Im, Y. (2018). Factors affecting the cultural competence of visiting nurses for rural multicultural family support in South Korea. *BMC Nursing*, 17(1), 1-9. <https://doi.org/10.1186/s12912-012-017-0269>
- Sullivan, L. (2020). *Exploring World Cultures: Sri Lanka* (1st ed.). Cavendish Square.

- Tarabout, G. (2004). Theology as history. Divine images, imagination, and rituals in India. In G. Phyllis, & K. Shinohara (Eds.), *Images in Asian Religions. Texts and Contexts* (pp. 5684). University of British Columbia Press.
- Texas Board of Nursing. (2020). *Practice - Registered nurse scope of practice*.
https://www.bon.texas.gov/practice_scope_of_practice_rn.asp
- Texas Health and Human Services. (2017). *Uniform Hospital Rate Increase Program*.
<https://hhs.texas.gov/sites/default/files/documents/about-hhs/communicationsevents/meetings-events/council/82111-3f-1R065-Uniform-Hospital-Rate-Increase-Program.pdf>
- Tinsley, M. (2000). *A study of cultural competence in nursing students*. [Master's thesis, Pittsburgh State University].
- Torrecillas, J., Bjorck, J. P., Kamble, S. V., & Gorsuch, R. L. (2020). Religious support and emotional functioning in India across three major religions. *The International Journal for the Psychology of Religion*, 30(1), 18-34.
<https://doi.org/10.1080/10508619.2019.1614868>
- Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, 14(1), 99. <https://doi.org/10.1186/1472-6963-14-99>
- UNHCR. (2020). *Afghanistan*. <https://www.unhcr.org/afghanistan.html>
- UNICEF. (2019). *Afghanistan: Key Demographic Indicators*.
<https://data.unicef.org/country/afg/>
- Verghese, A. (2018). *Taking other religions seriously: A comparative survey of Hindus in India*. <https://ssrn.com/abstract=3249626>

- Waldley, S. S. (2014). *South Asia in the world: An Introduction*. M.E. Sharpe.
- Watters, A., Bergstrom, A., & Sandefer, R. (2016). Patient engagement and meaningful use: Assessing the impact of the EHR incentive program on cultural competence in healthcare. *Journal of Cultural Diversity*, 23(3), 114-120.
<https://ezp.twu.edu/login?url=https://search-proquestcom.ezp.twu.edu/docview/1795672461?accountid=7102>
- Weber, J. R., & Kelley, J. H. (2014). *Health assessment in nursing* (5th ed.). Wolters Kluwer.
- Whyte, M., Yong, J. L., & Nevins, D. (2019). *Bangladesh*. Cavendish Square Publishing.
- Wilson, A. (2002). *Cultural competency of nursing and allied health faculty*. Clayton College & State University.
- Wittekind, E. (2013). *Countries of the World: Afghanistan*. ABDO Publishing Company.
- Worldometer (2020). *Population*. <https://www.worldometers.info/population/>
- World Health Organization. (2016). *Afghanistan*.
<https://web.archive.org/web/20181018031423/http://www.who.int/countries/afghanistan/>
- Zygar-Hoffmann, C., Hagemeyer, B., Pusch, S., & Schönbrodt, F. D. (2020). A large longitudinal study on motivation, behavior and satisfaction in couples: Research data from a four-week experience sampling study with a pre-, post-, and one-year follow-up assessment. (Version 1.0. 0) [data and documentation]. *Trier: Center for Research Data in Psychology: PsychData of the Leibniz Institute for*

Psychology Information ZPID.

https://doi.org/10.5160/psychdata.zrcemo99_v20000

APPENDIX A
IRB Approval Letter



IRB Approval Letter

Texas Woman's University
Institutional Review Board (IRB)

irb@twu.edu

<https://www.twu.edu/institutional-review-board-irb/>

July 18, 2019

Nisha Cherian

Nursing - Houston

Re: Exempt - IRB-FY2019-314 Title: Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting.

Dear Nisha Cherian,

The above referenced study has been reviewed by the TWU IRB - Houston operating under FWA00000178 and was determined to be exempt on July 17, 2019. If you are using a signed informed consent form, the approved form has been stamped by the IRB and uploaded to the Attachments tab under the Study Details section. This stamped version of the consent must be used when enrolling subjects in your study.

Note that any modifications to this study must be submitted for IRB review prior to their implementation, including the submission of any agency approval letters, changes in research personnel, and any changes in study procedures or instruments. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems.

All modification requests, incident reports, and requests to close the file must be submitted through Cayuse.

On September 5, 2020, this approval will expire and the study must be renewed or closed. A reminder will be sent 45 days prior to this date.

If you have any questions or need additional information, please contact the IRB analyst indicated on your application in Cayuse or refer to the IRB website at <http://www.twu.edu/institutional-review-board-irb/>. Sincerely,

TWU IRB - Houston

APPENDIX B

Cover Letter to Participants

Cover Letter to Participants

You are invited to participate in a dissertation study, entitled *Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting*.

The purpose of this study is to examine the relationship between cultural competence and knowledge of the South Asian culture of registered nurses working in an urban hospital setting.

Your participation is completely voluntary and confidential. It will take about 15 to 20 minutes to complete the surveys. There are three surveys:

- 1.) Demographic Data Form will ask questions about you, such as age, gender, experience as a nurse, etc.
- 2.) Knowledge about South Asian Culture will have questions specific to South Asia.
- 3.) The Inventory for Assessing the Process of Cultural Competence- Revised tool will ask questions about cultural competence.

After you complete the surveys, seal the envelope and return to your unit educator or text/call the PI to arrange for pick up. You will receive a Starbucks card once you return the completed survey. Please complete it in 2 to 3 weeks.

To voluntarily agree to take part in this study, you must be a registered nurse and at least 18 years or older.

By completing all study instruments, you are providing informed consent to participate in this research voluntarily.

I thank you very sincerely for your participation. If you have any questions, please contact me.

Nisha Jobin Mathews, MSN, RN

Doctoral Nursing Student, Texas Woman's University

Cell Phone: 832-561-3763

APPENDIX C

Demographic Data Form

Demographic Data Form

What is your age in years? _____

Gender:

_____Female

_____Male

_____Transgender female

_____Transgender male

_____Other, please describe: _____

Race:

_____American Indian or Alaska Native

_____Asian

_____Black or African American

_____Native Hawaiian or Other Pacific Islander

_____White or Caucasian

_____More than one race, please list: _____

_____Other, please describe: _____

Ethnicity:

_____Hispanic/Latino

_____ Not Hispanic/Latino

In what country were you born? _____

How would you describe your nationality? _____

What primary language was spoken at your home as a child?

What primary language is spoken at your home today?

_____ What was your religious affiliation as a child?

What is your religious affiliation today? _____

What year did you first start working as a Registered Nurse (RN), the year of your first license? _____

What is your highest nursing degree?

_____ Diploma in nursing

_____ Associate degree in nursing

_____ Baccalaureate degree in nursing

_____ Master's degree in nursing

_____ Doctoral degree in nursing

_____ Other: please describe: _____

What year did you start working at your current RN job? _____

What is your current job title?

_____ Staff nurse

_____ Management/administration

_____ Educator

_____ Other: please describe: _____

What specialty area of nursing do you currently work in? _____

Current job status:

_____ Full time (more than 35 hours per week)

_____ Part time (less than 35 hours per week)

When was the last year you received training/education in cultural competence?

Please list the zip codes where you have lived for the past five years.

Year	Zip Code where you lived
2019	
2018	_____
2017	_____
2016	_____
2015	_____

APPENDIX D

South Asian Knowledge Survey

South Asian Knowledge Survey

1. What are the eight nations of South Asia? (**circle only eight answers**)

Afghanistan	India	Nepal	Sri Lanka
Bangladesh	Japan	Pakistan	Thailand
Bhutan	Korea	Philippine Islands	Turkey
China	Maldives	Singapore	Vietnam

2. What are the two most common languages spoken in India? (**circle 2**)

Arabic	Indian	Hindi	Sindhi
English	Islamic	Punjabi	Urdu

3. What are the two most common languages spoken in Pakistan? (**circle 2**)

Arabic	Indian	Hindi	Sindhi
English	Islamic	Punjabi	Urdu

4. What is the most common religion in South Asia? (**circle only 1**)

Buddhism	Hinduism	Jainism
Christianity	Islam (Muslim)	Sikhism

5. Below is a table referring to patients of different South Asian religions. As a nurse, place an

X in the box if you agree special accommodations **MAY need** to be provided for the patients.

Patient	Diet: vegetarian	Diet: no pork	Diet: no alcohol	Female patient wears headscarf	Female patient prefers female nurse	Strict fasting during religious events	End of life rituals
Buddhist							
Christian							
Hindu							
Muslim							
Jain							
Sikh							

APPENDIX E

Flyer with IRB Information

Flyer with IRB Information

Recruiting RNs for Research Study

Title of Study: Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting

Purpose: The purpose of this study is to examine the relationship between cultural competence and knowledge of South Asian culture of registered nurses working in an urban hospital setting.

Completely voluntary and confidential – no names collected

Takes about 15 to 20 minutes to complete survey packet

To obtain a survey packet:
Contact Unit Educator or
Text or call Nisha Mathews at 832-561-3763

After you complete the survey and seal the envelope, drop off in white box placed in the unit labelled “Research study by Nisha Jobin Mathews”

You will receive a Starbucks card for your completed survey.

For more information, please contact the Researcher:

Nisha Jobin Mathews, MSN, RN
Doctoral Nursing Student
PhD Nursing Science Program, Texas Woman’s University
6700 Fannin St, Houston, TX 77030
Email: NCherian@twu.edu
Phone: 832-561-3763

HARRISHEALTH SYSTEM IRB Number: IRB-FY2019-314
Approval Date: 08/07/2019
Expiration Date: 09/05/2020

Approval: TWU Institutional Review Board (IRB)

APPENDIX F

Recruitment Email

Recruitment Email

Hello,

My name is Nisha Mathews, and I am a doctoral nursing student currently working on my dissertation. I am conducting a research study entitled, “*Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting.*” The purpose of this study is to examine the relationship between cultural competence and knowledge of South Asian culture of registered nurses working in an urban hospital setting.

Your participation is completely voluntary and confidential. All responses to this survey are confidential. There are three parts to this survey:

- 1.) Demographic Data Form will ask questions about you, such as age, gender, experience as a nurse, etc.
- 2.) Knowledge about South Asian Culture will have questions specific to South Asia.
- 3.) The Inventory for Assessing the Process of Cultural Competence- Revised (IAPCC- R) tool will ask questions about cultural competence.

It will take about 10 to 15 minutes to complete all three surveys.

Once you complete the surveys, you will receive a \$10 Starbucks gift card electronically within 12 hours. You will be able to choose the option to provide your personal email address to allow the delivery of a \$10 Starbucks gift card.

To voluntarily agree to take part in this study, you must be a registered nurse and at least 18 years or older. *By clicking the link below and completing all study instruments, you are providing informed consent to participate in this research voluntarily.*

Link: <https://www.psychdata.com/s.asp?SID=189899>

I thank you very sincerely for your participation. If you have any questions, please contact me at NCherian@twu.edu or 832-561-3763.

Nisha Mathews, MSN, RN

(Cherian- Old last name)

Doctoral Nursing Student, Ph.D. Nursing Science Program

Texas Woman's University

6700 Fannin St, Houston, TX 77030

Approval: TWU Institutional Review Board (IRB) and Harris Health Research &

Sponsored

Programs Department.

APPENDIX G

Cover Letter

Cover Letter

Dear Nurse Participant,

You are invited to participate in a dissertation study entitled "Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting." The purpose of this study is to examine the relationship between cultural competence and knowledge of South Asian culture of registered nurses working in an urban hospital setting.

Your participation is completely voluntary and confidential. All responses to this survey are anonymous and confidential. Your identity will not be linked in any way to the research data. It will take about 10 to 15 minutes to complete the surveys. There are three surveys: 1.)

Demographic Data Form will ask questions about you such as age, gender, experience as a nurse, etc. 2.) South Asian Knowledge Survey will have questions specific to South Asia. 3.) The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals - Revised (IAPCC- R) tool will ask questions about cultural competence.

Once you complete the survey, you can click on another link that will direct you to a page that is not connected to your survey. This new page will allow you to receive a \$10 Starbucks gift card electronically within 12 hours. You will be able to choose the option

to provide your personal email address to allow the delivery of a \$10 Starbucks gift card.

I thank you very sincerely for your participation.

To voluntarily agree to take part in this study, you must be a registered nurse and at least 18 years or older. By completing all study instruments, you are providing informed consent to participate in this research voluntarily.

If you have any questions, please contact me:

NCherian@twu.edu or 832-561-3763.

Nisha Mathews, MSN, RN

Doctoral Nursing Student, Ph.D. Nursing Science Program

Texas Woman's University

6700 Fannin St, Houston, TX 77030

Approval: TWU Institutional Review Board (IRB) and Harris Health Research &

Sponsored

Programs Department

APPENDIX H

Permission Letter 1

Permission Letter 1



Clinical, Administrative, Research
& Educational Consultation
in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, PMHCNS-BC, CTN-A, FAAN
Transcultural Healthcare Consultant

☎ 513-469-1664
☎ 513-469-1764
meddir@aol.com

www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: April 11, 2019

To: Ms. Nisha Cherian
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: **Contractual Agreement for Limited Use of the IAPCC-R**

This letter grants permission to Ms. Nisha Cherian to use my tool, "Inventory for Assessing the Process of Cultural Competence Among Professionals-Revised (IAPCC-R) to submit to the Texas Woman's University and Harris Health Ben Taub Hospital IRB Committees. I have received payment of \$40 for 2 tools to be used in this electronic submission.

TIME FRAME: Permission to copy/use the IAPCC-R is granted for a one-time use before June 15, 2019. **Upon June 16, 2019, any copies must be destroyed.** If Ms. Nisha Cherian receives approval to use the IAPCC-R, another formal letter of request for permission to use the IAPCC-R in the actual study and payment for the cost of additional tools will be required.


ADMINISTRATION: This permission only grants submitting the IAPCC-R for her IRB proposal submissions and therefore does not grant any form of administration of the IAPCC-R to any individuals/participants.

RESTRICTIONS OF COPYING: Ms. Nisha Cherian agrees that the IAPCC-R cannot be copied or reproduced in its entirety nor can any of the 25 items of this tool be copied for any reason. This includes, but not limited to, being copied in formal or informal publications, in a dissertation or thesis, in an academic paper/project, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of submitting it to be reviewed the IRB Committees.

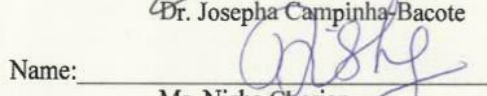
GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Thank you for complying with the requests of using this copyrighted tool. I look forward to the possibility of hearing from you if you're your proposal is accepted. Best of luck in your submission.

Name: 
Dr. Josepha Campinha Bacote

Date: 7/11/19

Name: 
Ms. Nisha Cherian

Date: 04/15/19

APPENDIX I

Permission Letter 2

Permission Letter 2



Clinical, Administrative, Research
& Educational Consultation
in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, PMHCNS-BC, CTN-A, FAAN
Transcultural Healthcare Consultant

☎ 513-469-1664
☎ 513-469-1764
meddir@aol.com

www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: June 17, 2020
To: Ms. Nisha Mathews
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Nisha Mathews to use the "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised" (IAPCC-R) in an online administration format to assess 225 registered nurses. I have received \$4,500 (i.e. 225 hits on this secure website) in this one-time assessment project. Ms. Nisha Mathews agrees to the following requirements regarding use of this copyrighted tool:

TIME FRAME: Permission to use the IAPCC-R, which is to be administered on a secure website, is only granted for the testing of 225 participants (225 hits) from June 18, 2020 through July 18, 2020. **Upon July 19, 2020, Ms. Nisha Mathews must remove the IAPCC-R off the secure web-based format and destroy any copies of the tool.**

ADMINISTRATION: This permission grants Ms. Nisha Mathews to administer the IAPCC-R on a secure online web-based format that has access to only 225 participants (225 hits). For online use, the tool must be copied verbatim in a secure online format as it appears on the hard copy that is enclosed in this letter and must use the citation on the top of the tool that reads:

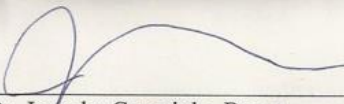
**Inventory for Assessing the Process of Cultural Competence
Among Healthcare Professionals –Revised (IAPCC-R)**
Copyrighted by Campinha-Bacote (2003)

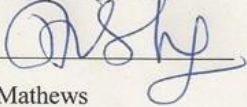
RESTRICTIONS OF COPYING: Outside of placing the IAPCC-R online on a secure a web-based format for 225 participants, Ms. Nisha Mathews **agrees that the IAPCC-R and its 25 items cannot be copied or reproduced for any other reason.** This includes, but not limited to, being copied in formal or informal publications, a dissertation, DNP capstone, or thesis, in an academic paper, handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. **The IAPCC-R is only to be used in the above project in which it is administered online for access to only 225 individuals/ subjects.**

PUBLICATIONS: Ms. Nisha Mathews agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Signature  Date 6/17/20
Dr. Josepha Campinha-Bacote

Signature  Date 06/19/2020
Ms. Nisha Mathews

APPENDIX J

TWU IRB Letter with Modification



Texas Woman's University

Institutional Review Board (IRB)

irb@twu.edu

<https://www.twu.edu/institutional-review-board-irb/>

June 5, 2020

Nisha Cherian
Nursing - Houston

Re: Modification - IRB-FY2019-314 Title: Cultural Competence and Knowledge of South Asian Culture of Registered Nurses Working in an Urban Hospital Setting.

Dear Nisha Cherian,

The modifications listed below have ~~have~~ been reviewed and approved on June 4, 2020 ~~by the TWU IRB - Houston.~~ If you made changes to your consent form, the newly approved form has been restamped by the IRB and uploaded to the Attachments tab under the Study Details section. This stamped version of the consent must be used when enrolling subjects in your study.

Modifications:

The original protocol included gathering data in-person that now needs to change due to COVID19 restrictions. This modification is requesting to change data collection to electronic format and all study instruments have been converted to ~~a~~ ~~an~~ electronic ~~PsychData~~ ~~PsychData~~ format. Dr. Thompson at Harris Health will assist in sending out the recruitment email to potential participants.

If you have any questions or need additional information, please contact the IRB analyst indicated on your application in Cayuse or refer to the IRB website at <http://www.twu.edu/institutional-review-board-irb/>.

Sincerely,

TWU IRB - Houston