

CULTURAL AWARENESS AND PROVIDER BASED CARE FOR REFUGEE WOMEN

A Dissertation
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

Andrea Jean Middlestead

In Partial Fulfillment of the Requirements
for the Degree of
DOCTOR OF NURSING PRACTICE

Major Department:
Nursing

March 2013

Fargo, North Dakota

North Dakota State University
Graduate School

Title

Cultural Awareness and Provider Based Care for Refugee Women

By

Andrea Jean Middlestead

The Supervisory Committee certifies that this *dissertation* complies with North Dakota State University's regulations and meets the accepted standards for the degree of

DOCTOR OF NURSING PRACTICE

SUPERVISORY COMMITTEE:

Dr. Tina Lundeen

Chair

Dr. Norma Kiser-Larson

Dr. Molly Secor-Turner

Dr. Gina Aalgaard-Kelly

Approved:

4/6/2013

Date

Dr. Carla Gross

Department Chair

ABSTRACT

This dissertation aimed to improve the cultural education of nurse practitioner's (NP's) related to female refugee populations. The ultimate goal was to improve health care outcomes and decrease disparities for refugee women by focusing on increasing cultural understanding, enhancing education, and providing a framework which NP's can utilize in daily practice. An online educational module was created and offered on the American Association of Nurse Practitioners Continuing Education website.

Traditional cultural health care practices for the top 10 refugee populations in the United States in 2011 were compiled, compared with current cultural competence and awareness of primary care providers and formulated into an educational module. A 1.25 hour long PowerPoint accompanied by audio, pretest, posttest, and evaluation were created for members of the American Association of Nurse Practitioners. Participants were able to receive 1.25 continuing education units upon completion of the entire module and evaluation.

Purposes from the educational module evaluation questions included: (a) perceived educational preparation during graduate education and at the postgraduate level, and (b) the perceived effectiveness of the educational method. Both purposes were supported through NP evaluation responses (n=85). There was a lack of graduate education on cultural awareness and implementation into practice found in literature. The evaluation results from this project conflicted with the literature by demonstrating 90% of participants felt adequately prepared during graduate education. The majority (94%) of respondents specified that the module "completely" or "quite a bit" promoted learning for each participant free of commercial bias. Educational modules using PowerPoint with audio appeared to be an acceptable educational strategy for NPs regarding cultural awareness based on survey evaluation data.

As the culture of the patient population within the United States continues to evolve and change, it is of vital importance that NP's stay up to date on current practice and treatment changes that are culturally appropriate and sensitive. An educational framework to maintain cultural awareness, enhance understanding, and increase communication becomes a forefront issue. In order to assist with the coordination of care in the hopes to diminish health care related disparities, continued research is needed in the delivery of educational modules.

ACKNOWLEDGEMENTS

I would like to acknowledge the genuine support and continued guidance of my committee members during this practice improvement project: Dr. Tina Lundeen, Dr. Norma Kiser-Larson, Dr. Molly Secor-Turner and Dr. Gina Aalgaard-Kelly. I would like to extend a heartfelt thank you to Dr. Lundeen who not only assisted with the inspiration and expansion of this project but also guided me during each phase of development and implementation. Without her support this project would not have been possible.

Additionally, I would like to thank my husband, Greg Middlestead, and our families who have continued to support my desire to pursue my Doctor of Nursing Practice despite missed gatherings, holidays, and family events. Without your continued encouragement, this project would not have been possible, and for that I am eternally grateful.

PREFACE

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

- Martin Luther King, Jr., 1966

TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	iv
PREFACE.....	v
LIST OF TABLES	ix
LIST OF FIGURES.....	x
CHAPTER ONE. INTRODUCTION.....	1
Background.....	1
Purpose.....	3
Significance of the Study.....	3
CHAPTER TWO. LITERATURE REVIEW AND THEORETICAL FRAMEWORK.....	5
Review of Literature.....	5
Cultural Awareness and Competence.....	6
Nurse Practitioner Cultural Education.....	7
Cultural Awareness Transformation.....	10
Refugee Cultures, Backgrounds, and Traditional Health Beliefs.....	12
Burma.....	12
Bhutan.....	13
Iraq.....	14
Somalia.....	15
<i>Female Genital Mutilation</i>	17
Cuba.....	18
Eritrea and Ethiopia.....	19
Iran.....	21
Democratic Republic of Congo.....	22
Afghanistan.....	23
Theoretical Framework.....	25

CHAPTER THREE. METHODOLGY.....	29
Design.....	29
Setting.....	31
Population and Sample.....	31
Data Collection Methods and Procedures.....	31
Evidenced Based Intervention Plan.....	32
Instrumentation and Methods of Evaluation.....	32
Timeline for Project Completion.....	32
Ethical Issues and Measures to Protect Human Subjects.....	33
Data Analysis.....	33
CHAPTER FOUR. RESULTS.....	34
Introduction.....	34
Demographic Information.....	34
Assessment of Learning.....	34
Program Evaluation.....	36
Perceived Educational Preparedness.....	36
Perceived Effectiveness of Educational Module.....	37
CHAPTER FIVE. INTERPRETATION OF FINDINGS.....	42
Analysis and Project Purposes.....	42
Interpretation of Results.....	42
Perceived Educational Preparedness.....	42
Perceived Effectiveness of Educational Module.....	44
Limitations	45
CHAPTER SIX. DISCUSSION AND CONCLUSION.....	48
Discussion.....	48
Recommendations for Nursing Practice and Future Projects.....	49
Conclusion.....	53
REFERENCES.....	55

APPENDIX A. INSTITUTIONAL REVIEW BOARD LETTER.....	64
APPENDIX B. CORRESPONDENCE WITH THE AANP.....	65
APPENDIX C. EDUCATIONAL MODULE LETTER OF ACCEPTANCE	66
APPENDIX D. AANP COPYRIGHT TRANSFER AGREEMENT	67
APPENDIX E. PERMISSION TO REPRINT PURNELL’S MODEL FOR CULTURAL COMPETENCE	68
APPENDIX F. EDUCATIONAL MODULE SCRIPT.....	69
APPENDIX G. EDUCATIONAL MODULE POWERPOINT HANDOUT.....	88
APPENDIX H. EDUCATIONAL MODULE PRETEST	107
APPENDIX I. EDUCATIONAL MODULE POSTTEST	109
APPENDIX J. EVALUATION QUESTIONS OF EDUCATIONAL MODULE	111
APPENDIX K. EDUCATIONAL MODULE RESULTS	113

LIST OF TABLES

<u>Table</u>	<u>Page</u>
1. United States Refugee Arrival by Country of Nationality: Fiscal Year 2011.....	2
2. Pretest and Posttest Responses.....	35
3. Program Objectives.....	38

LIST OF FIGURES

<u>Figure</u>	<u>Page</u>
1. The Purnell Model for Cultural Competence.....	26
2. Percent of Refugee Population in Practice.....	37
3. Cohesiveness of Individual Objectives/Content to One Another.....	39
4. Format Appropriateness	40
5. Would You Recommend Program to Colleagues?.....	40
6. Level of Content.....	41

CHAPTER ONE. INTRODUCTION

Background

Travel and technology have dramatically changed the idea of relocation for most of the world's citizens. These luxuries are not a choice but, rather, a necessity for individuals who live in countries where landscapes have become playgrounds for warlords and corruption leaving behind paths of devastation, persecution, destruction, and death. Seeking refuge in countries outside their homeland has become the only available option. With an ever-increasing mix of diversity in the United States, cultural disparities in refugee health care continue to rise.

The 1951 United Nations Refugee Agency defined a refugee as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (p. 3). Asylum seekers have submitted a claim for refugee status and are waiting for this claim to be accepted or rejected. Refugees and asylees comprise the majority of displaced persons resettled to the United States. An immigrant is an alien admitted to the United States as a lawful permanent resident. The Immigration and Nationality Act (INA) define immigrants, commonly referred to as permanent residents, as any alien in the United States, except one legally admitted under specific nonimmigrant categories (INA, 2010).

According to the Migration Information Source, in 2008, more than 60,100 people sought refuge in the United States (Batalova, 2009). In 2011, The Office of Homeland Security reported that 56,000 refugees were admitted in 2011, which reflected a change in both the diversity of refugees entering the United States and an increase in the security procedures required prior to entry (Martin & Yankay, 2012). The United States is among the highest recipients of refugees in the world and allows up to 80,000 refugees into the country annually (Haadal, 2009). In 2005, over 2.6 million people sought refuge in the United States, approximately 7% of the total U.S. population. Currently, the predicted foreign-born population comprises approximately 13.5% (Grantmakers Concerned with Immigrants and Refugees, 2012). The top countries whose citizens are seeking refugee status in the United States in 2011 were Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia and Afghanistan (Table 1) (Martin & Yankay, 2012).

This dissertation emphasizes refugees from the preceding 10 countries, discussing the background, cultural norms and taboos, and health care for women within each culture with the hope that increased knowledge will translate to practice and eventually decrease disparities. The state in which the refugee resides is “obligated to provide law-abiding admitted refugees with many of the same rights and privileges that citizens enjoy, such as access to courts, the right to pursue gainful employment, public education, medical access, artistic expression, and the like” (Haadal, 2009, p. 2). Despite being geographically displaced and exposed to a new health system, many refugees maintain their cultural and traditional health beliefs. Incorporation of traditional health beliefs in to the U.S. health system by providers may diminish refugees’ health disparities.

Table 1

United States Refugee Arrival by Country of Nationality: Fiscal Year 2011

Country of Nationality	Number	Percentage
Total	56,384	100
Burma	16,972	30.1
Bhutan	14,999	26.6
Iraq	9,388	16.7
Somalia	3,161	5.6
Cuba	2,920	5.2
Eritrea	2,032	3.6
Iran	2,032	3.6
Democratic Republic of Congo	977	1.7
Ethiopia	560	1.0
Afghanistan	428	0.8
All other countries including unknown	2,915	5.2

(Adapted from Martin & Yankay, 2012)

Purpose

The purpose of this dissertation was to provide an educational module for nurse practitioners (NPs) and to assess if NPs gained knowledge regarding cultural awareness, competence, and refugees' traditional health beliefs. The educational module was designed to promote culturally sensitive health care. In order to formulate practical culturally sensitive care, professionals need to be aware of the barriers that prevent refugees from seeking care or continuing care after encountering the U.S. health care system. As refugees continue to seek shelter from persecution in the United States, the need to provide culturally sensitive health care and education has become increasingly pertinent. How will practitioners provide culturally sensitive care that addresses the physical and emotional needs of refugees? Questions that specifically need further investigation include: (a) what barriers to health care access exist that prevent female refugees from seeking care or continuing to seek care?, (b) what educational methods are effective to enhance provider knowledge about cultural beliefs and health care customs of female refugees?, (c) will increased provider education improve health outcomes for refugee women within the primary care setting?, (d) is there a gap between provider knowledge and the application of culturally sensitive health care for refugee?, and (e) do health care disparities continue to rise despite current efforts to diminish cultural differences for female refugees?

Significance of the Study

Refugee populations displaced in foreign countries experience changes in health and health practices exacerbating health care disparities. As refugees continue to seek safety within the U.S. borders, the diversity in health care expands due to the exposure of traditional health beliefs and practices. Article 25 of the Universal Declaration of Human Rights states that, "health care is an essential right for everyone regardless of their social, cultural, and economic status" (United Nations Human Rights, 1948). Barriers to health care include language and direct access to care. Perceived and actual access barriers result in adverse health consequences (Agency for Health Care Research and Quality [AHRQ], 2003). Barriers for access to care, quality of care, and practitioners' lack of knowledge about traditional health beliefs exemplify health care disparities and lead to higher rates of morbidity and mortality (Egede, 2006).

Health related barriers need to be addressed locally, nationally and at practitioner levels. The Nursing and National Priorities Partnerships' strategies include a goal to increase patient and family engagement honoring individuals including their differing cultural backgrounds, languages, and social customs (Johnson, 2009). Diversity in health care is evolving, and practitioners need to improve knowledge by incorporating cultural sensitivity in education, knowledge, and practical application. Additionally, practitioners need to be able to translate knowledge into practice by incorporating refugee health beliefs. If there is to be a reduction in health care disparities, barriers need to be addressed and rectified.

Nurse practitioners need to develop rapport with patients, regardless of the patients' cultural background, in order to provide consistent and culturally competent care. Enhancement of rapport can occur through increased NP knowledge of traditional health beliefs and practices. Without cultural awareness, approaches to health promotion and disease prevention cannot meet the expanding diversity of health care needs of refugees'. Because NPs fill a leadership role within today's health care system, implementing policies, organizational effectiveness, and applying newly designed models of care, including those models that consider cultural sensitivity, are particularly important. The Doctor of Nursing Practice degree focuses on integration, application, and teaching evidenced-based guidelines, and it is particularly suited to meet the demanding and changing needs of refugee women (Chism, 2013). Goals for NPs specific to this dissertation include the potential to improve health care outcomes and to lessen health care disparities for refugee women by focusing on increasing the cultural understanding and knowledge of NPs who are caring for refugee women.

CHAPTER TWO. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Review of Literature

Refugees are particularly vulnerable to multiple health disparities due to inadequate access, a lack of insurance coverage, poverty, little-to-no social or cultural support, experiences of previous trauma, and difficulties understanding the health system, leading to inadequate access to care or unequal quality of care (AHRQ, 2011; Vasey & Manderson, 2012). Disparities are defined as racial or ethnic differences in quality of health care (Egede, 2006). Determination of health are influenced by “pre-migration circumstances and experiences, factors precipitating flight, differences in selection criteria, and the resettlement process including an often extended period of detention” (Vasey & Manderson, 2012, p. 49). In order to formulate practical solutions that incorporate a culturally sensitive approach to health care, professionals need to be aware of the barriers that may prevent refugee populations from seeking care or continuing care after encountering the U.S. health system.

An extensive literature review was performed. Owing to an overall abundance of research articles available that relate to cultural sensitivity, the established period of published articles was condensed to include articles from 2001 to 2012 in order to have the most up-to-date information. An exception to this was made for articles providing information about female genital mutilation, in which the timeframe was extended from 1994 to 2012). Inclusion criteria for the literature review were: research that sought both refugees’ and provider’s knowledge and opinions about health care provisions related directly to primary care, graduate education, relevance towards culturally sensitive health practices, barriers toward refugee health care, a lack of provider knowledge, and either evidence-based or research-based data collections and analysis that augmented inadequacies in refugee care or treatment. Exclusion criteria included any article that did not meet the inclusion criteria. Published research articles appeared in peer-reviewed journals and/or were data compiled from legitimate internet websites that specifically had information regarding the top 10 refugee cultures in the United States, traditional health practices, and provider education. Journals and reference materials were analytically searched using CINAHL, MEDLINE, Alt Health Watch, EBSCO Mega FILE, Health Source, Google, and Google Scholar using the following keywords: cultural awareness, cultural competence, provider knowledge, cultural health guidelines, health care professionals, perceptions, education, graduate nurse practitioner

education, access to health care, medical complications, health care beliefs, refugee cultures within the United States, cultural health practices/care, traditional health beliefs/practices, refugees within the United States, female refugees, refugee women's health, Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan. Countries outside of the United States were included because this evidence further elaborates how traditional health care contributes to the survival of the refugee transition.

Cultural Awareness and Competence

In order to properly assess and evaluate NP familiarity with cultural practices, there must be a common definition of cultural competence. Cultural competence, as defined by the National Center for Cultural Competence, Georgetown University, and the U.S. Department of Minority Health is as follows:

“A set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. “Competence” implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices and needs presented by patients and their communities” (California Endowment, 2002, p. v).

Culturally and Linguistically Appropriate Services (CLAS) has expanded the definition of culture to include the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (U.S. Department of Health and Human Services Office of Minority Health [DDHS OMH], 2001a, 2001b, 2007). Culture defines how information is received, how rights and protections are exercised, how health information is processed, how symptoms and problems are expressed, who should provide treatment for the problem, and what the treatment should entail. Cultural issues are central in the delivery of health care due to beliefs about nature, the human body, and the disease process. With this understanding and continuing education, providers can meet the unique needs and respond appropriately to cultures that may be different from the prevailing culture. Culture is largely unconscious but has a powerful effect on health and illness (Purnell & Paulanka, 2008).

Benkert, Tanner, Guthrie, Oakley and Pohl state that “providing culturally competent care requires that health care providers respond to individuals in a way that is sensitive to and respectful of culturally rooted ideas and behaviors” (2005, p. 225). Cultural competence should assist the NP in

making a shift from teacher to learner in cross-cultural situations (Taylor, 2005). Cultural understanding should be ongoing and continually incorporate awareness of self, awareness of others, development of relationships, knowledge, and interpersonal skills (Benkert et al., 2005). Cultural awareness is the ability to understand one's own culture and perspective in addition to the stereotypes and misconceptions with other or less-known cultures (California Endowment, 2002). Competence should be a goal or a process where one continually strives toward obtaining a greater understanding of refugee cultures, languages, beliefs, practices, habits, and values while avoiding false awareness and skill. It is an important step in improving culturally competent care and reducing health care related disparities. Knowledge without understanding, self-reflection, and application is not sufficient for NPs to provide culturally sensitive care. Providers need to be responsive to cultural needs and practices in order to make every effort to provide care that incorporates each refugee culture (Benkert et al., 2005). Cultural competence can change the one size fits all health care system to meet the needs of a progressively diversified population (Betancourt, Green, Carrillo, & Park, 2005).

Recommendations for practice based on various sources include learning about the cultures from which your patients come, recognizing ethnocentricity, becoming familiar with traditional health care practices and beliefs, providing care and modesty, performing cultural and physical assessments, and conversing with colleagues and people from the particular culture (Betancourt et al., 2005; Hess, Weinland, & Saalinger, 2010). While these recommendations are a starting point for addressing conversations about cultural awareness, they are neither research nor evidence based at this time.

Nurse Practitioner Cultural Education

Clinical cultural competence is the ability of a health care provider to “communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds” (Betancourt & Green, 2010, p. 583). Professional standards for education and practice require culturally competent care (Benkert et al., 2005), but how often are competencies assessed? Ramona Benkert and colleagues (2005) discuss a need for improvement within NP education of cultural competence and awareness that stresses a deep understanding for clinical practice and coincides with a multicultural learning experience. Unified cultural competence education needs focus on improvement of quality and consistency related to providers' cultural competence (Betancourt et al., 2005). Few studies that incorporate multicultural

learning experiences that coincide with the educational process of NP students exist (Benkert et al., 2005).

Providing culturally competent care necessitates that health care providers respond to individuals in a way that is sensitive to and respectful of culturally rooted ideas and behaviors in order to assess, diagnosis, treat, and implement a plan for follow-up and evaluation (American Association of Nurse Practitioners [AANP], 2010; Benkert, et al., 2005). According to The National Institute of Nursing Research, areas to emphasize include the promotion of health and prevention of disease (Burns & Grove, 2009). Nurse practitioners specifically emphasize both health promotion and disease prevention. An effort to increase NP education and cultural sensitivity about refugee cultures contributes to the promotion of health and the prevention of disease by creating an open forum for communication within the newly settled community.

The Liaison Committee on Medical Educations (LCME) and the Association of American Medical Colleges (AAMC) require all medical schools to have an integrated cultural competence component in the curriculum (Betancourt et al., 2005). According to Benkert et al. (2005), "Nurse practitioner programs may be too short in length to ensure competence; developing a provider group who seeks a lifelong discovery of cultural uniqueness and community justice may be a more realistic and appropriate goal for NP educators" (p. 232). Continuing medical education (CME) plays an important role because dissemination of information occurs through continuing education (Like, 2011). In order to eliminate health care disparities, CME needs to be developed, implemented, and evaluated with a focus on evidence-based cultural competence, health promotion, and prevention, and diagnosis and treatment for patients from varying backgrounds throughout the life span (Like, 2011). Additionally, Robert Like (2011) writes that the formation of educational programs should instill self-reflection, critical thinking, and humility.

The literature demonstrates a need to increase quality-improvement interventions to diminish disparities (The Johns Hopkins University Evidence-Based Practice Center, 2004). Health disparities disproportionately affect minority, ethnic, and lower socioeconomic status individuals (Like, 2011). According to the Agency for Healthcare Research and Quality (2011), racial and ethnic minorities are more likely to be poor non-Hispanic than whites in the United States. Exposure to the English language prior to arriving in the United States is limited. Some refugees are not literate in their own language (U.S.

Department of Health and Human Services [DHHS], 2010) which compounds the difficulty in assessing, treating, and referring for health care when dealing with acute and chronic health issues. The difficult component is determining the cause, diagnosis, and treatment of health related illnesses because cultural beliefs influence a refugee's response to health and illness (Broome, 2006). Health care in the United States should be a bridge that connects what a refugee is familiar with regarding health care to how health care functions in the country of refuge.

Recently, policy makers, providers, insurance companies, and educators have taken note of cultural competence as a way to help eradicate disparities (Betancourt et al., 2005). The provider-patient relationship has demonstrated adherence to the mutually agreed-upon goals of health promotion, prevention, and improved outcomes based on patient satisfaction (Betancourt et al., 2005). Previous research validates that a strong association between comfort with cultural assessments and previous multicultural learning or life experiences exists (Benkert et al., 2005). Refugee and minority care based on the provider-patient relationship directly relates to positive health outcomes (Betancourt et al., 2005). Of particular importance to refugees are language barriers and direct access (i.e. cost, insurance, and transportation) to health care (AHRQ, 2003).

The government views cultural competence as a way of improving access to care for refugee populations (Betancourt et al., 2005). General knowledge related to refugee cultures' could assist in opening communication with a particular refugee woman during provider-patient interactions. The difficult part of creating educational materials is that not all refugees from a specific culture have the same traditional health beliefs nor have they been acculturated at the same level generalizing difficult (Egede, 2006). Finding a broad population that will allow for overall generalization of findings is problematic because not all women have the same interpretations of cultural or religious health care traditions. There is significant variation within each refugee group meaning that diversity exists within diversity (Jenks, 2011; Parker, 2010). Culture is not static and is similar to a website template with numerous options from which to choose (Jenks, 2011).

Numerous facilities lack adequate resources and funding to allow refugees to properly communicate and discuss their health concerns. Resource deficiencies include structural access, geographic barriers and access, time, variation in care, a lack of translators, and a lack of female

providers (Carroll, Epstein, Fiscella, Gipson, Volpe, & Jean-Pierre, 2007; Hess et al., 2010; Thierfelder, Tanner, & Kessler Bodiang, 2005). Refugees fear mistreatment, lack of level of comfort, and the perception of lack of empathetic care (Carroll et al., 2007; Hess et al., 2010; Thierfelder et al., 2005). Well-structured continuing education materials require a provider to change attitudes and perceptions towards refugee health care practices (Ogunsiji, Wilkes, & Jackson, 2007), create a redirection to find and utilize existing education in practice, and create evidence-based guidelines.

Cultural Awareness Transformation

Disparities are defined as unequal, having a “difference in access or availability of facilities and services” (AHRQ, 2003; HSRIC, 2012, para 1). The *National Healthcare Disparities Report* lists seven areas of improvement for all populations:

1. Inequity in quality exists in health care as minorities and the financially poor may receive lower quality care;
2. Inequalities pay both a personal and societal cost;
3. There are differences in access to care that may contribute to overall quality;
4. Preventative care opportunities are frequently missed;
5. There is limited knowledge of why disparities exist and more research in this area is needed in order to develop plans and policies that may affect disparities;
6. Improvement is needed and is possible if everyone plays a part in advocacy for patients, holds coworkers accountable and participates in ongoing education;
7. Additional research is needed. (AHRQ, 2003)

The goal of the Patient Protection and Affordable Care Act (ACA) in relation to refugees is to increase access to health care, to increase quality of care, and to decrease disparities (U.S. Department of Health and Human Services, 2011). The Affordable Care Act lists several provisions directly related to cultural competence and health care disparities, specifically addressing language services, community outreach, and cultural competence training. The provisions place emphasis on the “development and evaluation of model cultural competence curricula, dissemination of cultural competence curricula through an online clearinghouse, cultural competency training for primary care providers and home care aides,

and collaborative research on topics including cultural competence” (Like, 2011, p. 197). The Affordable Care Act mentions cultural competence 19 separate times in the document, emphasizing the need for change. According to Section 5208, the reform bill will authorize “grants for Nurse Managed Health Centers that provide comprehensive primary care or wellness services without regard to income or insurance status for patients” (American Nurses Association [ANA], 2011, p. 8).

As grant funding for primary care services becomes available, the ability to provide care to all patients, regardless of cultural background or financial status, increases. A provision of the bill includes \$200 million for educating more NPs who will work in primary care to provide preventative care and management of chronic conditions (ANA, 2011). Health care provider education takes a prominent position within the cultural competence movement (Jenks, 2011).

Organizations such as the Culturally and Linguistically Appropriate Services (CLAS), the Joint Commission, the National Committee for Quality Assurance, and several others encourage and often require the development of clinical and organization cultural competence training and implementation (Like, 2011). The CLAS is a department within the Office of Minority Health, which addresses culturally competent care, language-access services, and organizational support for services related to cultural competence. The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. The CLAS has identified 14 standards or activities recommended by the Office of Minority Health for adoption as mandates by federal, state, and national accrediting agencies to address health disparities. The CLAS standards address inequities in current health care provisions to make services more responsive to the consumer. The CLAS recommends that health care organizations verify that all staff members, at all levels and in all disciplines, participate in continuing education that is based on educational learning principles, includes pretest and posttest evaluations, and is conducted by appropriately trained individuals (U.S. DHHS OMH, 2001a, 2001b, 2007). Ongoing staff education and training may be the most important area to assure cultural and linguistic competence.

Refugee Cultures, Backgrounds, and Traditional Health Beliefs

In the United States, ethnic minorities including refugees are projected to comprise 40% of the population by 2035. Due to the large number of current refugees living in the United States, the focus of this dissertation is limited to refugees identified in the 2011 refugee census (Martin & Yankay, 2012). The following sections of the literature review focus on basic cultural information for Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, the Democratic Republic of Congo, Ethiopia, and Afghanistan. A brief rationale is provided regarding the pursuance of refugee status, traditional health practices, and female specific health care. The educational module covers the majority of health related education (Appendixes F and G).

Burma. Burma is largely comprised of two ethnic groups, the Karen and the Chin. Both ethnic groups in Burma have been oppressed by the military regime (Neiman, Soh, & Sutan, 2008). The regime has maintained power since 1962 and has imprisoned numerous political leaders who have pursued elimination of the regime (Neiman et al., 2008).

“Burma ranks among the poorest countries in the world; its schools and health system have collapsed; and it is home to a rapidly escalating HIV/AIDS epidemic- thanks in part to the fact that Burma has become one of the largest producers of heroin in the world. Ongoing internal skirmishes, military repression of ethnic minorities, forced relocations based on economic strategy, and pervasive poverty have resulted in a constant exodus of political and economic Refugees” (Neiman et al., 2008, para 13).

Traditional Burmese beliefs include the view that health is a relationship among the body, mind, soul, and universe. Illnesses are hot or cold, with hot illnesses treated with cold therapies and cold illnesses treated with hot therapies (Barron et al., 2007; Bodeker, Neumann, Lall, & OO, 2005). Spiritual possession is the most common form of illness. Burmese refugees come from an agriculture society with little to no technology. Marriages are arranged, parents are considered sacred, and disobeying is considered a sin. Burmese believe that the health care providers should avoid touching the head as it is sacred, should sit above or at a level equal to an elder, and pointing a finger towards another person is rude (Jewish Vocational Service, 2006).

For Burmese women, the amount of menstrual flow indicates the level of health (Jewish Vocational Service, 2006). During pregnancy, Burmese society admires and respects women except when pregnancy occurs outside marriage (Neiman et al., 2008). A midwife traditionally provides prenatal and neonatal care. Imposed dietary restrictions may potentially lead to malnutrition for both the fetus and

the mother (Jewish Vocational Service, 2006). Women typically choose home births, especially when living in Thai refugee camps. Women in Thai refugee camps have undergone forced sterilization after childbirth due to “health” related reasons. Women view childbirth in a hospital as shameful due to the lack of respect for modesty, and the presence of male health care staff during delivery (Neiman et al., 2008).

Burmese women have a high incidence of Hepatitis B, and thus, a high prevalence of perinatal transmission of the disease to their infants (Neiman et al., 2008). The mother is protected for one-month following delivery due to the belief that postpartum the body is cold secondary to blood loss and, therefore, at the highest risk of developing an illness. The treatment of a cold illness is through the ingestion of sour or bitter foods (Jewish Vocational Service, 2006; Neiman et al., 2008). Infants are usually breastfed up to three years of age. Interest in birth control has increased by some Burmese women. However, the topic of contraception is difficult to discuss because sexual health is considered a taboo subject. Burmese women may prefer natural birth control methods, such as lactational amenorrhea (Neiman et al., 2008).

Bhutan. In the early 1990s, Bhutanese faced human-rights violations, torture, imprisonment, and detention without trial (CDC, 2012a; Maxym, 2010). Requirements forcing Bhutanese to prove their citizenship were stringent, and regardless of proof, Bhutanese have been denied citizenship within Bhutan (CDC, 2012a). During this period, hundreds of thousands of Bhutanese were forced to leave Bhutan and were placed in Nepalese refugee camps (CDC, 2012a; Maxym, 2010). Less than 65% of Bhutanese have access to health care due to the uprisings in Bhutan. The leading causes of death include dysentery, diarrhea, respiratory illnesses, malaria, and parasitic infections (EveryCulture, 2013).

Traditional health practices vary based on region, religion, and economic status. Both an imbalance of passion and the presence of an evil spirit can cause illness (Maxym, 2010). The use of home remedies and religion to cure illness is a common practice. Often several remedies and the advice of traditional healers are sought prior to utilizing western medicine (CDC, 2012a; Maxym, 2010). Traditional healers attempt to restore balance through incantations, reading of rice, and prescribing a special diet. Basil treats colds, coughs, and pain. Garlic, turmeric, ginger, and cardamom cure stomach discomfort (Maxym, 2010). Most Bhutanese people need assurance that a provider understands, and

does not condemn, traditional health practices before they feel comfortable sharing past medical history. When an illness becomes severe, western medicine becomes an option. Preventative medicine is an uncommon concept in Bhutan, with the exception of protective home remedies (CDC, 2012a). Common health concerns include malnutrition, depression, and female reproductive health care (Maxym, 2010).

Sexual practices, sexual health, and gynecology are uncomfortable subjects for Bhutanese women regardless of the provider's gender. It is unlikely that elderly Bhutanese women will discuss sexual health concerns. Younger generations who have lived in refugee camps and have been exposed to American society are more likely to speak with close female friends and family members than health care providers. Use of contraception is common and widely accepted. Access to prenatal care is often inadequate; although for women living in refugee camps, prenatal care is required. The Bhutanese prefer childbirth in a hospital with western technology, if accessible; otherwise, home birth with or without a midwife is common practice (Maxym, 2010). Infant mortality is high at 118 deaths per 1,000 live births (EveryCulture, 2013). After delivery, the mother's focus is on the infant and bed rest. There is an 11-day period after delivery when the mother does no household chores. Completion of a naming ritual occurs on the eleventh day followed by the mother returning to work. It has been common practice for the mother to leave the infant at home alone while she goes to work. Infants are exclusively breastfed for the first six months, followed by the introduction of cow's milk and solid food (Maxym, 2010).

Iraq. Since the early 1980s, Iraq has been in turmoil. The most recent war began in 2003 and ended in 2011. War has led to the displacement of more than 4.2 million Iraqi people (International Rescue Committee [IRC], 2009; Mateen et al., 2012; Queensland Health and Multicultural Society, 2011). Oppression, political sanctions, and economic sanctions have led to a humanitarian crisis (Queensland Health and Multicultural Society, 2011). Iraqis who have found refuge seek both humanitarian assistance and medical aid. Approximately 10-15% of Iraqis have had access to adequate health care (IRC, 2009; Mateen et al., 2012). A lack of adequate health care is due, in part, to the prevalence of physician homicide. The remaining physicians seek refuge to protect their lives (IRC, 2009).

Most Iraqi refugees are Sunni or Shiite Muslims. Sunni Muslims are less restricted in traditional practices, especially in the United States (Texas Department of State Health Services [TDSHS], 2009). Shiite Muslims follow a strict religious code that dictates religious practices, food, and the treatment of

women (Jewish Vocational Service, 2006; TDSHS, 2009). Another Muslim must slaughter meat in order for the meat to be pure and edible. Pork and alcohol are taboo (TDSHS, 2009). Segregation of women occurs even in their own homes. Women wear black clothing that covers the entire body and face (Jewish Vocational Service, 2006; Stratis Health, 2012; TDSHS, 2009). A Shiite woman's hand should not be touched (TDSHS, 2009). Women are often considered subservient to men, although Iraqi women tend to have higher levels of education than women in the surrounding areas (Jewish Vocational Service, 2006).

Iraqi refugees are at risk for developing thalassemia, schistosomiasis, parasites, anemia, typhoid, leprosy, tuberculosis, and Post-Traumatic Stress Disorder (IRC, 2009; TDSHS, 2009). Men and women tend to be modest and may refuse health care from someone of the opposite gender. The required holiday of Ramadan typically starts in July and lasts for 30 days. During Ramadan, all Muslims, except for pregnant and lactating women, fast. Muslims may refuse to take medications during Ramadan. Conservative Iraqi Muslims may avoid preventative health care due to the belief that Allah has predetermined an individual's lifespan (Jewish Vocational Service, 2006). Family members discuss all medical decisions with family prior to decision making (Queensland Health and Multicultural Society, 2011). Traditional health remedies include cures and treatments for common conditions (Stratis Health, 2012; TDSHS, 2009). Stomach pain is treated with a mixture of cumin powder, caraway herb, and water. A cough is treated with honey and lemon juice. A 24-hour steam tent is often used for common colds (TDSHS, 2009).

The belief that contraception interferes with Islamic law is common (Jewish Vocational Service, 2006; TDSHS, 2009). During pregnancy, women are relieved of typical household duties, and other female household members do chores. Sonograms may be refused due to the belief that determining the child's gender pre-birth is against Allah's will. Iraqi women receive minimal prenatal care, and midwives typically assist with home births. Circumcision of boys occurs within the first few days of birth, and piercing of girls' ears occurs at one week of age. Breastfeeding is very common for up to one year (Jewish Vocational Service, 2006).

Somalia. Somali refugees are the largest population granted asylum in U.S. history. Approximately 55,000 Somali have immigrated to the United States since 2001 (U.S. Census Bureau,

2011). In the 18th century, Italians colonized and enslaved Somalia. It was not until the 1930s that Somalia received emancipation, but Somali were still treated harshly by warlords, militia, and government officials (Lloyd, 2009). In the 1990s, civil war in Somalia placed numerous Somali in refugee camps or allowed them to gain asylum in foreign countries.

Most Somali believe in treating health care as a legacy, one that incorporates traditional prayer, religious ceremonies, spirits, herbal medicines, various foods, and home remedies (Carroll et al., 2007). Illness is due to unwarranted flattery brought on by the evil eye, or angry spirits. With all health concerns, traditional healers are consulted. When seeking western medical care, Somali expect to receive a treatment for every illness (CDC, 2012b). Somali believe in a strict separation of the sexes. Most women cover their bodies when in public and prefer a health care provider who is the same gender (CDC, 2012b; TDSHS, 2009). Preventative medicine is an unfamiliar concept, and adherence is typically low (CDC, 2012b). Somali may be at risk for malnutrition, parasites, filariasis, leishmaniasis, Hepatitis B, tuberculosis, dental caries, typhoid fever, malaria, trachoma, syphilis, dengue fever, HIV, and Hansen's disease (TDSHS, 2009).

Before a female child's tenth birthday, female genital mutilation is performed on approximately 98% of the girls in Somalia (CDC, 2012b; Culture Profiles, 2007). In this dissertation, a general definition of female genital mutilation (FGM), the history of FGM practice, and common justifications for the continuation of the practice are expanded upon because FGM applies to not only Somali refugees, but also numerous refugee cultures. The origin of FGM is poorly documented, but it is believed to have been practiced for over 5,000 years (Kontoyannis & Katsetos, 2010).

In the United States, two laws exist in relation to FGM: The U.S. Federal Prohibition of Female Genital Mutilation Act of 1995 (which prohibits FGM under the age of 18) and The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Title 6, Subtitle D, Section 645 (which also prohibits FGM under the age of 18). However, no law prevents females from leaving the country to have the procedure performed. In the United States, repairing FGM after delivery is not a federal crime. In Sweden and Great Britain, laws consider FGM a crime punishable by law. Other countries, including Africa, are following suit (Jaeger Caffisch, & Hohlfeld, 2009). Hess et al. (2010) found that many U.S. midwives are aware of FGM, but lack the medical knowledge to provide quality care. Hess et al. said,

“the low percent of correct responses by midwives who care for women with a history of FGM indicate that they may lack adequate education to care for FGM women in a culturally competent manner” (2010, p. 50). Switzerland continues to work on addressing the needs of FGM women but does not have laws banning its practice, and most health practitioners lack experience and guidance; instead, they utilize assumptions to make judgment calls about treatment for FGM women (Thierfelder et al., 2005). There is an overall lack of research regarding provider knowledge about the care of FGM women (Lavender, 2009).

Female Genital Mutilation. The first mention of a documented female circumcision was in 450 B.C. by the Greek historian Herodotus (Ogunsiji et al., 2007). Ancient Egyptian female mummies were found to be circumcised; possibly indicating that FGM was a sign of merit (Little, 2003). During the Victorian period, FGM was used to treat various psychological disorders and masturbation in women (Little, 2003). “In ancient Rome slaves had metal rings passed through the labia minora to prevent procreation and women in medieval England wore chastity belts” owing to the thought that women were unable to control their sexual activity and promiscuity (Parekh, 2000, p. 275). Western medicine advocated clitoridectomy as a treatment for hysteria, melancholy, epilepsy, lesbianism, and masturbation as well as control sexual desire well into the 20th century, and the father of gynecology, J. Marion Sims, endorsed the practice (Ball, 2008; Little, 2003). U.S. physicians and surgeons have incised the clitoral prepuce to treat frigidity and perform “aesthetic vaginal labioplasties to reduce the size of the clitoris and labia” (Horowitz & Jackson, 1997, para 9).

FGM has been linked to cultural factors such as tradition, religion, economics, and ethnic identity (Williams, Acosta, & McPherson, 2002). FGM is believed to have been developed as a means to control fertility and depending upon the source, may or may not be directly linked to religious beliefs and practices (Momoh, 2004). Many Muslim, Jewish, and Christian religions have supported the practice even though neither the Koran nor the Bible endorses FGM; in fact, Islam belief prohibits the cutting of female organs (Epstein, Graham, & Rimsza, 2001; Kontoyannis & Katsetos, 2010; Momoh, 2004). According to Deborah Byrne (2006), FGM is considered a cultural practice but religion is often used to legitimize the practice of FGM. Islamic religion is the most frequently cited reason for FGM practices even though FGM predates Islam (Horowitz & Jackson, 1997; Williams et al., 2002). Islamic law requires

a female to be a virgin in order to be married. FGM is believed to insure abstinence prior to marriage (Williams et al., 2002). Other rationales for FGM include preserving family honor, improving fertility, assuring cleanliness, and providing increased sexual pleasure to the male partner (Ogunsiji et al., 2007). The World Health Organization (WHO) indicates that FGM reduces libido, prevents illicit premarital sexual intercourse, and maintains the cultural ideals of femininity and social pressures to conform to one's cultural society's beliefs and practices (WHO, 2010c).

FGM is illegal in the United States prior to age 18 and at any age in the United Kingdom. Although FGM is illegal for women in the United States who are under the age of 18, practitioners care for patients who have undergone the procedure. Not until after 1979 did WHO formally recognize FGM (Althaus, 1997). Since 1979, there has been a progressive movement to educate about FGM, teach prevention for future generations, and enforce laws prohibiting its practice. In 1997, the WHO, the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA) denounced the practice of FGM (WHO, 2010c). The World Health Organization has developed educational programs for prevention, increased international involvement, revised legal statements, and increased political support for abolishing the practice. The WHO has three major focuses: advocacy, research, and guidance for health systems to continue to increase societal awareness of FGM practices (WHO, 2010c). Whether health care providers are aware of the World Health Organization's education programs is unknown and beyond the scope of this dissertation.

Cuba. Since Fidel Castro gained control of the Cuban government in 1959, Cubans have fled the country. The Cuban culture is difficult to define due to the extreme deviations of class, ethnicity, and rural or urban upbringing. Regardless of class, most Cubans come from a large extended family (TDSHS, 2009). Cuban society is typically patriarchal (Jewish Vocational Service, 2006). Life expectancy is 77 years (Belanger, 2011).

Health is a "sense of well-being, freedom from discomfort, and a robust appearance" where mind, body, and spirit are entwined (TDSHS, 2009, p. 621). Free health care is provided to every individual in Cuba (Belanger, 2011; TDSHS, 2009). The United Nations has rated Cuban health care amongst the top three nations (EveryCulture, 2013). However, due to a shortage of medications, poor diet, and other confounding factors, most chronic diseases are untreated. Cuban refugees are at risk for malnutrition,

tuberculosis, and dengue fever (TDSHS, 2009). Obesity is an indication of good health. Spiritual faith is viewed as the cause of an illness and then often used as the overriding treatment in coordination with herbal medicines (Jewish Vocational Service, 2006; Kemp, 2006; Stafford, 2010). Upon arriving in the United States, most Cubans have a difficult adjustment due to the cost of health care, and the differences in the provider-patient relationship (TDSHS, 2009). Health care providers are highly regarded in Cuba and typically direct all health care treatments whereas in the United States, providers and patients partner together to improve health (Jewish Vocational Service, 2006; TDSHS, 2009). Respected family members and the patient make joint health related decisions. Traditionally the family is informed prior to the patient if the diagnosis is terminal. Direct eye contact is common in all interactions (Jewish Vocational Service, 2006).

Pregnant women are protected from negative conversations that have the potential to increase stress. In addition, they remain indoors to avoid exertion and to evade contact with people who have deformities or other illnesses during the entire pregnancy. Traditionally, the husband is not present at childbirth; rather, the woman's mother is involved in the labor-and-delivery process. After childbirth, women and infants remain at home for 41 days due to the belief of susceptibility to supernatural-caused illnesses. The woman's mother and other female members of the family are expected to care for the woman and her infant during this time. Most Cuban mothers breastfeed their infants and believe in the practice of FGM (Jewish Vocational Service, 2006; Kemp, 2006).

Eritrea and Ethiopia. Eritrea and Ethiopia are discussed as a single culture due to their long history of rule by a single government, and their similar health beliefs and practice. The government was overthrown in the 1970s by an oppressive regime, which has maintained control since that time (Duncan & Hayden, 2008). Ethnic conflicts and wars have continued, forcing Ethiopians and Eritreans to seek refuge from a devastated country (Cooper & Underwood, 2010; Duncan & Hayden, 2008). In 1962, Ethiopia annexed Eritrea, and it took approximately 30 years before Eritrea was able to rid Ethiopian forces from its land (Commonwealth of Australia, 2006; EveryCulture, 2013). The countries are economically underdeveloped and ruled by a few large proprietors. Additionally, Ethiopia and Eritrea face annual floods and ongoing conflict with neighboring Somalia (EveryCulture, 2013). Most Eritreans and

Ethiopians seek refuge due to political reasons. Average life expectancy is 56 years (Queensland Health Multicultural Services, 2011).

An extended patriarchal family structure is considered ideal. Women tend to be soft spoken with direct communication. If translation is needed, preference for someone from his or her ethnic group is preferred (Jewish Vocational Service, 2006).

Health is the equilibrium among the body, the outside world, and the supernatural world (Jewish Vocational Service, 2006). A lack of balance or angering God is believed to cause illness. Treatment for illness includes herbal medicines, prayer, and spiritual healing (Duncan & Hayden, 2008; Jewish Vocational Service, 2006; Queensland Health and Multicultural Services, 2011). Eritreans tend to seek western medicine before Ethiopians, but only once an illness is severe (Commonwealth of Australia, 2006; Cooper & Underwood, 2010). Access to medical care is limited, and private health care can be very expensive (Commonwealth of Australia, 2006). Medications are highly regarded. Injected medications are seen as providing greater therapeutic effect than oral medications, and individuals are dissatisfied if medication is not given when seen by a health care provider. Providers are expected to know and educate patients about what is best for the patient at each visit. If a poor prognosis or terminal illness is suspected, it is preferable for news to be relayed to a male family member first. Traumatic news needs to be given with care to protect the patients' mental health (Queensland Health and Multicultural Services, 2011; Jewish Vocational Services, 2006).

FGM is a common practice in both Eritrea and Ethiopia (Cooper & Underwood, 2010; Duncan & Hayden, 2008; Jewish Vocational Service, 2006; Queensland Health and Multicultural Services, 2011). Traditionally, sex education was taught at home, however, many schools now incorporate sex education into their curriculums (Cooper & Underwood, 2010). Contraception is not typically available in Eritrea and Ethiopia. However, contraception is widely accepted by refugees in the United States (Cooper & Underwood, 2010; Duncan & Hayden, 2008; Jewish Vocational Service, 2006). Contraception can be considered a taboo subject to discuss openly although most Eritreans and Ethiopians see the benefit of having a smaller family size. Pregnancy is not openly discussed until the woman is noticeably showing, and prenatal care starts at that time (Cooper & Underwood, 2010; Duncan & Hayden, 2008). Pregnancy is thought to increase the risk of susceptibility to disease for both the mother and the fetus. Most Eritrean

and Ethiopian women reject the fetus prior to delivery to prepare for the pain and discomfort caused by delivery (Jewish Vocational Service, 2006). Women prefer that female providers deliver their children and traditionally deliver at home with a midwife (Cooper & Underwood, 2010; Duncan & Hayden, 2008; Jewish Vocational Service, 2006). Breastfeeding is common but, typically, for a shorter duration than in the United States. There is a push to introduce solid foods at four months of age (Cooper & Underwood, 2010; Jewish Vocational Service, 2006). Post-delivery, the mother and infant remain at home for 2 to 6 weeks and often up to six months to accommodate breastfeeding and disease prevention (Cooper & Underwood, 2010).

Iran. In 1979, “The Revolution” began to overthrow the Pahlavi Dynasty (EveryCulture, 2013; Lewis, 2003). During the next 30 years, Iranian rulers liquidated agricultural and industrial assets for personal profit (EveryCulture, 2013). In 2009, Mahmud Ahmadinejad, the newly elected president, continued the Pahlavi dynasty. He ruled with violent enforcement to silence protest movements (Arjomand, 2010; Lewis, 2003).

Children are a blessing and a top-priority life task for Iranians. Girls are less indulged than boys (Jewish Vocational Service, 2006). The woman of the house arranges marriages, whereas the father is the disciplinarian. Men and women do not communicate in public settings despite women’s role in Iranian society. Men and women often dress modestly to avoid sexual desires (Jewish Vocational Service, 2006; Lewis, 2003). Men traditionally are sensitive, artistic, and aware of aesthetic appearances, whereas women are emotionally distant and detached. Crying in public is normal in either gender, and affection in public between same gender individuals is common. Public affection between members of the opposite gender is not acceptable except for between family members (Jewish Vocational Service, 2006).

Life expectancy is 70 years of age, and health care in Iran is generally very good (EveryCulture, 2013). Common belief stresses the creation and maintenance of balance among blood, phlegm, and yellow and black bile through the ingestion of hot and cold foods. Very little information related to Iranian health, traditional health beliefs, and practices for women’s health care could be found (EveryCulture, 2013; Jewish Vocational Service, 2006). The mother’s role is extremely important in Iranian society. Breastfeeding is expected of all new mothers to prevent children from being remorseless in the future. Commonly, older children assist the mother in raising younger siblings (Jewish Vocational Service, 2006).

Democratic Republic of Congo. The Democratic Republic of Congo is home to over 62 million people from 200 varying ethnic groups with customs that differ according to tribe, region, and social position (Culture Profiles, 2007; Refugee Council, 2004). A violent civil war disrupted the country from 1996 to 2003. Despite resolution of the civil war, the country remains in turmoil due to continued persecution by rebel forces forcing approximately 3.6 million Congolese citizens to abandon their homes (Refugee Council, 2004). This uprising is just one in a violent history of the country, which has led to more deaths than any war since World War II. The United Nations has called the Democratic Republic of Congo one of the worlds' largest humanitarian disasters (Refugee Council, 2004).

Most Republic of Congo men and women are at risk of developing malaria, parasites, tuberculosis, schistosomiasis, diarrhea, AIDS, and malnutrition, mainly due to living conditions and poor access to clean water (EveryCulture, 2013). Malaria remains the highest cause of mortality (Culture Profiles, 2007). However, approximately 33% of the population has HIV/AIDS (Culture Profiles, 2007). Life expectancy is 49 years of age (WHO, 2010b). Appearance and living conditions dictate Congolese health status; if Congolese people appear healthy, then they are healthy. A good appetite and being well fed signify health. Medications are available at local pharmacies and markets without prescriptions. Often the Congolese will self-diagnose and treat themselves with medications including antibiotics. Herbal medicines treat common illnesses such as the flu, back pain, and asthma.

Illnesses that are not immediately symptomatic do not create a cause for concern, and rarely is medical attention sought in these circumstances. Only after an unusual or prolonged course of symptoms is medical attention pursued (Culture Profiles, 2007). If a cause cannot be found, a spiritual healer is consulted to confirm a supernatural cause, and herbs, plants, and prayer are used to cure the ailing patient (Culture Profiles, 2007; StudentsFIRST, 2012). Physical and mental illnesses are curses or punishments from God (StudentsFIRST, 2012). Most Congolese seek care at hospitals or clinics when they are sick and usually pay for services prior to appointments or procedures (Culture Profiles, 2007; Refugee Council, 2004). At the clinic visit, Congolese typically expect an exact diagnosis and treatment, preferably with intravenous or intramuscular medication. Congolese tend to have a strong belief that talking about a disease will cause a person to develop the disease. Thus, dialogues regarding health promotion and prevention are often difficult (Culture Profiles, 2007). Mental health issues are viewed as a

course, and the acceptance of available assistance is often avoided (Culture Profiles, 2007; Refugee Council, 2004). No preference has been demonstrated about the gender of the provider (Refugee Council, 2004). Sexual relations are a taboo topic, and most men and women are unwilling to discuss sexual health. Sexual intercourse prior to marriage is a sin. However, depending upon the tribe, pre-marital sexual relations may be acceptable for men (Refugee Council, 2004).

Women often have varying degrees of freedom based on their area of residence. Freedom and social norms are typically restricted (Refugee Council, 2004). Domestic violence is common in this patriarchal society, and women tend to view it as an “extension of male authority” (Refugee Council, 2004, p. 6). “Rape, deliberate infection with HIV/AIDS, abduction, and sexual slavery were widely reported” and have been used as a weapon of war by both rebels and soldiers during wartime (Refugee Council, 2004, p. 6). Teenage pregnancy is extremely common, and maternal death rates continue to be high due to a lack of prenatal care. Death during childbirth is approximately three times higher in Congo than other areas of Africa (Culture Profiles, 2007). The belief that children are a gift from God and that the use of contraception is selfish, inhibits acceptable use (Culture Profiles, 2007; Refugee Council, 2004). The most commonly used contraception is natural family planning (Culture Profiles, 2007).

Numerous hospitals have been closed due to poor care, lack of funding, or the constraints of war (EveryCulture, 2013). Despite inadequate hospital facilities, women choose to deliver in available hospitals. Society often views women who have had C-sections as failures; therefore, they avoid C-sections at all costs. The infant mortality rate is 94.5 per 1,000 live births. The mother rests for up to three months after delivery and the family provides support during that time. Male circumcision occurs within three weeks of delivery, whereas females undergo FGM around the time of puberty (Culture Profiles, 2007).

Afghanistan. Afghanistan has faced continued conflict due to its clan-based society (Culture Profiles, 2007). In the 20th century, Afghanistan gained independence but has not been able to become politically stable. The Taliban had control of the country and enforced strict Islamic practice until 2001 (Culture Profiles, 2007; EveryCulture, 2013). In 2001, the United States declared war on terrorists and began to attack Afghanistan terrorist groups. This war resulted in high civilian loss and numerous Afghani sought refuge as the country attempted to recreate political stability (Culture Profiles, 2007).

Afghanis often utilize tribal affiliations for societal organization and follow a patriarchal lineage. Most of them live in extended family units due to polygamy. Society accepts men having multiple wives as long as they are able to support each wife and family. Women have less freedom than their male counterparts. Typically, families arrange marriages. Generally, Afghani women have adapted to the United States, and they are able to work and contribute to the family income. Men suffer a loss of leadership due to wives working and children becoming a crutch for translation (Jewish Vocational Service, 2006).

Taliban law prevents delivery of care by female practitioners, which, limits access to health care and health care providers. Because of limited health care access, illnesses are often treated with non-western, traditional health practices (Culture Profiles, 2007; EveryCulture, 2013). Life expectancy is only 46 years of age (Culture Profiles, 2007). Most Afghani believe that health requires regular exercise, fresh food and a balanced diet, keeping the body warm, and getting enough rest. Strict adherence to Islamic law can prevent most common illnesses because it stresses cleanliness and personal hygiene. Many Afghanis believe Evil spirits cause atypical illnesses and therefore, only a curing ritual can treat the person. Health maintenance demands a balance between hot and cold (EveryCulture, 2013; Jewish Vocational Service, 2006; Queensland Health and Multicultural Services, 2011). Home remedies include herbs and roots (Jewish Vocational Service, 2006). Health care decisions involve all family members, with particular emphasis on the elders who prefer traditional therapies (Culture Profiles, 2007; Queensland Health and Multicultural Services, 2011).

Most Afghani women are not comfortable having a male health care provider. The majority of Afghani women are receptive to health promotion and education (Jewish Vocational Service, 2006). Contraception methods include the rhythm method and coitus interruptus as long as both the husband and the wife are agreeable to the same method. Usually contraception is only temporary (Queensland Health and Multicultural Services, 2011). Alternative forms of birth control are acceptable if there is a medical reason for pregnancy prevention. During Ramadan, pregnant and lactating women do not participate in fasting (Culture Profiles, 2007).

Theoretical Framework

In order to meet the multicultural health care needs of patients, practitioners should have a theory to follow which will assist them in learning and applying knowledge. Cultural awareness is an ongoing process that incorporates numerous aspects at different times and places in an attempt to view the entire picture of a patient. Dr. Larry Purnell's Model for Cultural Competence is based on 19 assumptions derived from numerous theories and research. Purnell's model is complex, much like cultural diversity within health care (Purnell, 2005).

The model's purpose is to provide a framework to learn concepts and characteristics, to define individual circumstances, to link cultural relationships and characteristics, to view individuals within unique ethnocultural environments, and to give a framework for the reflection of human traits (Purnell & Paulanka, 2008). The diagram (Figure 1) provides a way for nursing to organize assessment, intervention, and evaluation data (Higginbottom, Richter, Mogale, Ortiz, Young, & Mollel, 2011). The diagram, applicable in primary, secondary, or tertiary prevention, can be used in multiple health disciplines. The ability to explain health and illness, assess individuals, families, communities, and societies has allowed the model to be used in numerous research studies (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007; Higginbottom et al., 2006; Suh, 2004).

The diagram is represented by a circle with an outlying rim representing a global society, the second rim representing community, a third rim representing family, and an inner rim representing the person; each section is an integral part that together and separately affect a patient (Purnell & Paulanka, 2008). The 12 pie-shaped wedges depict cultural domains in relation to one another (Purnell, 2005). The domains are Overview and Heritage, Communication, Family Roles and Organization, Workforce, Biocultural Ecology, High-risk Behaviors, Nutrition, Pregnancy and Childbearing Practices, Death Rituals, Spirituality, Health Care Practices, and Practitioner Concepts. The saw-tooth line at the bottom of the diagram represents health care providers and organizations (Purnell & Paulanka, 2008). The diagram should translate to all cultural variations (Purnell, 2005).

The framework can assist all health care disciplines to provide holistic, culturally competent therapeutic interventions; health promotion and wellness; illness, disease, and injury prevention; health maintenance and restoration; and health teaching across all settings through inductive and deductive

reasoning in each cultural domain. Once cultural domain information is analyzed through a series of information-gathering questions, health care providers can adopt, modify, or reject health care interventions and treatments in a manner that continues to respect cultural differences (Purnell & Paulanka, 2008). An example would be if a provider were seeing a patient from Somalia for the first time. The provider would take into consideration how the refugee status and political situation in Somalia affected the patients' migration by asking about the motivation to come to the United States.

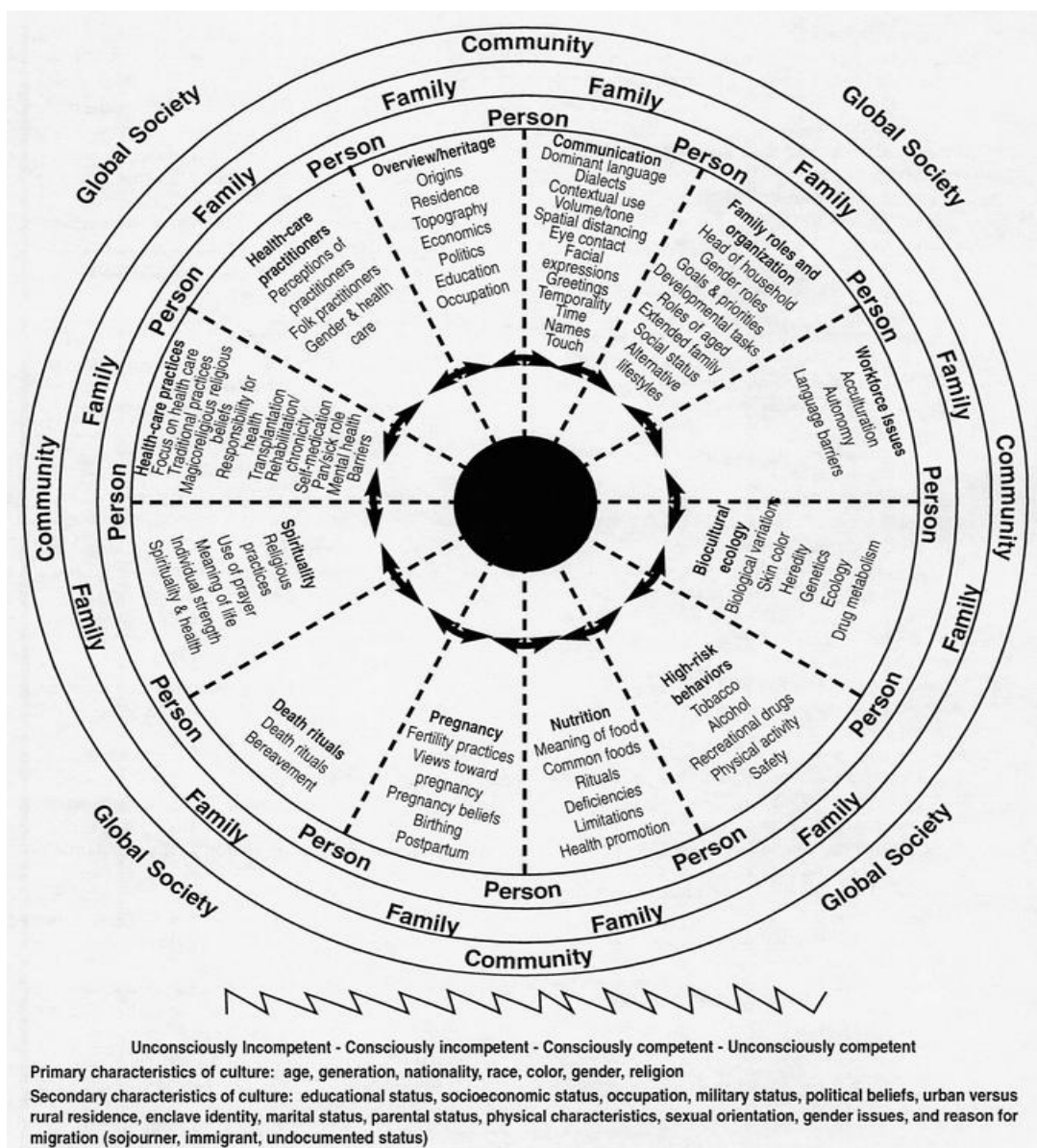


Figure 1. The Purnell Model for Cultural Competence. Reprinted with permission from Dr. Larry Purnell (Purnell, 2005). (Appendix E).

The provider could explore aspects such as economic or political reasons, and gather a deeper understanding of the transition period to take into account how the transition could influence current care perceptions. The information would give the provider a general overview of the patient's journey.

Next, other aspects would be analyzed such as communication style, dominant language, communication difficulties since transition, common expressions of thoughts, willingness to share personal information, and amount of personal space needed.

Communication is the most complex domain in Purnell's Model for Cultural Competence and is one of the most essential components in establishing patient rapport (Purnell & Paulanka, 2008). Arthur Kleinman's eight questions is a modified patient-centered approach to determine cultural influences on patient illnesses through opening communication and can be included during the domain of Communication. The questions are:

1. What do you think caused the problem?
2. Why do you think it happened when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a short course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness? (Purnell & Paulanka, 2008)

Each question strives to give the provider a better understanding of cultural influences on illness and the disease process as perceived by the refugee. Arthur Kleinman's eight questions are easily remembered and applied in everyday practice. Each question may assist in discovering the complex cultural dynamics of Purnell's Model for Cultural Competence (Purnell & Paulanka, 2008).

Next would be deciphering familial roles and organization, such as gender roles, child rearing, and family priorities. The NP inquires about established roles within the culture or family unit. The next domain is workforce issues and establishing if language barriers, time orientation, gender roles, or other factors contribute to a multicultural work environment. Distinguishing Biocultural factors, such as more common diseases and health conditions within the Somali population, would help guide assessment and

history data, providing clues to possible illness causes. Does the patient partake in high-risk behaviors including tobacco, alcohol, and unsafe sex practices? Are there any typical health-seeking behaviors within the culture (Purnell & Paulanka, 2008)?

For the domain of Nutrition, important inquiries include the meaning of food, common preparations, rituals, or dietary practices used for health and illness. NPs explore cultural views on pregnancy and fertility, contraception, prenatal and postpartum periods, and gender roles during pregnancy. If death occurs, what are common terms? Are there specific death rituals? The domain of Spirituality includes all behaviors that give meaning to life. The NP requests information regarding religious association, the use of prayer, meditation, and what gives the Somali patient strength and meaning. The remaining two domains are Health Care Practices and Practitioners. NPs inquire about the beliefs that influence promotion or prevention of health care practices. What are common responses to pain or mental illness? Does the Somali patient utilize traditional medicine? What barriers exist in relation to health care? NPs explore health care provider perceptions within the culture and/or acceptance of health care providers, etc. (Purnell & Paulanka, 2008).

In working with refugee populations, service providers must understand both the culture of the individual's country of origin and the immigration experience. Purnell's model provides an in-depth view of how culture specifically influences each aspect of health care. Purnell displays the importance for health care providers to determine how each factor influences patient understanding of health (Purnell & Paulanka, 2008).

By imploring the principles suggested by Dr. Larry Purnell and modeling cultural sensitivity through education, providers should be able to replicate, build confidence in their provider-patient relationship, and encourage continued growth in educational attainment. Application of theoretical models is necessary to continue to define nursing as a profession. With the proposed framework, NPs can assist refugee women with acclimation to a new health system while explaining available resources.

CHAPTER THREE. METHODOLOGY

Design

The goal of this project is to emphasize culturally competent care in primary care settings by designing and nationally distributing a continuing online education module designed for NPs utilizing PowerPoint with audio (Appendixes F and G). A multidisciplinary approach in collaboration with the Information Technology Department at North Dakota State University assisted in the voiceover and recording portion of the educational module. A contract with the American Association of Nurse Practitioners Continuing Education Center established the inclusion of the viewable program on the continuing education website that provides 1.25 continuing education units (CEUs) to NPs who completed the entire program (Appendixes B, C, and D). Participants were not able to receive CEUs if they did not complete the entire module including the pretest, posttest, and evaluation (Appendixes F, G, H, I, and J). A PowerPoint handout was available for participants to print and take notes during the program (Appendix G). Pretest, posttest, and evaluation surveys were administered to assess the participants knowledge, both prior to and after observing the module, in order to validate the method of online provider learning (Appendixes H, I, and J).

After considerable literature review regarding the best way to increase understanding and knowledge in relation to a specific subject area while accessing a large population or sample, the program was developed. Depending upon the state and certifying body, NPs need to obtain continuing education credits. Members certified through the AANP are required to complete at least 75 continuing education hours every 5 years (AANP, 2013). Continuing education is a way that practitioners can develop a deeper understanding of health care and improve upon personal growth and practice.

Few studies demonstrated a preferred learning style or technique. Of the available studies, emphasis placement on distance education occurred. No single study could answer the question about the best educational technique for increasing knowledge (Andrusyszyn, Cragg, & Humbert, 2001; Mountain Area Health Education Center [MAHEC] Department of Continuing Education, 2004). Andrusyszyn and colleagues (2001) found variation with participant responses related to the best teaching strategies and suggested that a single approach may not be suitable for all participants. Genetics and previous learning experiences contribute to the ability to meet specific outcomes (MAHEC

Department of Continuing Education, 2004). Generally, convenience or ease of access to information rates higher than a specific method or learning style. Research supports the “demand for portable, flexible, quality, interactive courses” and can contribute to lifelong learning (Andrusyszyn et al., 2001; Black, 2003, p. 1). Two studies suggested that, when considering the development of education materials, the design should include a variation of delivery methods to optimize subject delivery (Andrusyszyn et al., 2001; MAHEC Department of Continuing Education, 2004).

The majority of the educational modules displayed on the AANP Continuing Education (CE) Center website are PowerPoint presentations with audio or article review. This author chose to create a PowerPoint presentation and augmented the presentation with audio and a handout (Appendixes F and G). Creating an effective PowerPoint presentation began by developing the educational module script (Appendix F). Thomas Saylor (2005) found that the content of any presentation is the most important part of a presentation; the quality of the research, organization, and transitions need to be directly related to the main purpose and should be established prior to creating the PowerPoint template. After specific content criteria were established, information gathering regarding how to create an effective presentation utilizing PowerPoint occurred. The mention of the “Joy of Six” in varying articles refers to a maximum of six points per slide (Cothran, 2009; Purdue University Online Writing Lab [OWL], 2013; Saylor, 2005). Content should be methodically arranged and create a focus (Purdue OWL, 2013). Use text sparingly; color combinations should be chosen with care and should unify all slides within a presentation. Carefully select visual images, animated text, and transitions as to not distract the audience from the content (Saylor, 2005). The best PowerPoint presentations are slides put together with appropriate transitions (Purdue University OWL, 2013). Following the previously mentioned guidelines, suggestions, and Purnell’s Model for Cultural Competence Framework to guide how, what, and when information was presented, the PowerPoint was created (Appendixes F and G).

Descriptive statistical analysis focuses on common data features within a study with emphasis on describing what the data shows (Terry, 2012; Trochim, 2006). Descriptive studies focus on providing an overall picture of a situation as it would occur naturally in order to advance proposed theories, identify current practice problems, justify current practices, make decisions, or determine what others in similar

situations are doing given the same circumstances (Burns & Grove, 2009). Descriptive studies focus on a

“holistic worldview that believes the following ideals: 1. There is not a single reality, 2. Reality, based on perceptions, is different for each person and changes over time, and 3. What we know has meaning only within a given situation or context” (Burns & Grove, 2009, p. 51).

Researchers combine the pieces of the puzzle to make a whole, creating the meaning and understanding to cultural variations (Burns & Grove, 2009). The ability of a provider to define health in the context of refugee women will depend upon the consideration of pertinent information in regards to current health status and the relationship that exists between the provider and the patient. This practice improvement project gave support to the proposed framework and helped to identify current practice problems in relation to cultural sensitivity with the formation of an educational module.

Setting

The setting for the application of the continuing education module was the American Association of Nurse Practitioners CE Center website. The online environment allowed the participant to choose a time that was convenient for their schedule. Participants completed the educational module in the setting of their choice, and thus the specific setting is unknown to the author.

Population and Sample

The population of focus was NPs who are members of the American Association of Nurse Practitioners and who are seeking additional continuing education units related to cultural competence and awareness of refugee women. The free, online continuing education units for AANP members may have contributed to the total number of participants. It was difficult to predetermine the total number of potential AANP member participants because this educational module was available entirely online per individual convenience. Eight-five participants completed the module (Appendix K).

Data Collection Methods and Procedures

The AANP CE Center collected and summarized all data from the pretest, posttest, and evaluation administered within the educational module. Reported results (Appendix K) to this author occurred via e-mail from the AANP on a monthly basis starting in February of 2013 for the first quarter and quarterly after that time, for duration of two years. Due to time constraints, only the data from the first report (February 2013) was analyzed.

Evidence Based Intervention Plan

Descriptive data analysis allowed evaluation of the participating AANP members' perceptions of their preparedness for providing culturally sensitive care after graduation and the effectiveness of the educational module (Appendixes H and I). The ultimate goal was to provide cultural competence and refugee-specific information. The intervention was the educational module that continues to be displayed on the American Association of Nurse Practitioners CE Center website (Appendixes F and G). This module attempted to add to providers' knowledge of refugee cultures and practices by expanding upon what NPs may have already known or not known.

Instrumentation and Methods of Evaluation

The instrument used in this project was the educational PowerPoint module with audio created by this author (Appendixes F and G). The author recorded the audio portion because it was felt that the author would be able to express passion regarding the subject through words while maintaining the audience's attention. After obtaining a contract with the AANP CE Center, the module was displayed on the American Association of Nurse Practitioners CE Center website (Appendixes C and D). A pretest, posttest, and evaluation were administered to participants of the educational module. The pretest and posttest ascertained if awareness or knowledge improved during the educational module (Appendix H and I). In coordination with the American Association of Nurse Practitioners standard evaluation question set and incorporation of Purnell's Model for Cultural Competence, the questionnaires were expanded upon to evaluate knowledge prior to and after completion of the module. Additionally, evaluation questions were added to clarify understanding of the participants' responses related to graduate education and effectiveness of the educational module (Appendix J).

Timeline for Project Completion

Chapters One, Two and Three were completed and revised with the evolving project focus in November of 2011. In November 2011, the proposal to discuss the project and defend the rationale behind the importance of the dissertation topic's continuation in regards to practice improvement occurred. After the Plan of Study committee made suggestions, the author made the according revisions. In the summer of 2012, the reorganized focus of the practice improvement was represented to the committee through e-mail communication with a detailed project plan. Approval occurred in August of

2012. The educational module was completed in December of 2012 and accepted by the American Association of Nurse Practitioners Continuing Education Center on January 8, 2013. The module went live on the continuing education website on January 10, 2013, and data collection began at that time, with monthly data results sent to the author. In February of 2013, the author received the first set of aggregate data, and completion of chapters Four, Five, and Six followed. The final defense occurred in March of 2013. Final revisions ensued after committee approval. In April of 2013, the revised dissertation was submitted to the Graduate School.

Ethical Issues and Measures to Protect Human Subjects

Institutional Review Board (IRB) approval is required for research projects to ensure that the rights of the subject are not impinged (Burns & Grove 2009). There are three levels of review involved during the IRB process: exempt from review, expedited review, and complete review (NDSU Research, Creative Activities, and Technology Transfer [RCATT], 2011). Consultation with The North Dakota State University Institutional Review regarding the level of review for this practice improvement project occurred prior to the initiation of the educational module. A letter from the NDSU IRB deemed this practice improvement project as not requiring IRB approval, or certification of exempt status, because it did not fit the regulatory definition of “research involving human subjects” (Appendix A).

Data Analysis

Data analysis occurred after receipt of the first monthly report from the American Association of Nurse Practitioners in February of 2013 (Appendix K). The report was examined in collaboration with the Statistics Consultation Service at North Dakota State University. The AANPs first month of statistical aggregate data report was organized to address the purpose of the project. Data organization occurred within the two distinct project purposes: (a) participant perceived graduate preparedness for encountering care with refugee women, and (b) perceived effectiveness of the educational module. Aggregate data received from AANP did not allow for inferential statistical analyses or determination of significant change in NP knowledge. Chapter Four further describes and differentiates the data by the project purposes.

CHAPTER FOUR. RESULTS

Introduction

This chapter describes the demographics, descriptive data, and purpose of the project. One month after the launch of the educational module, the AANP CE Center sent data that included demographics, pretest, posttest, and evaluation.

Demographic Information

Although a larger number of AANP members accessed the program, 85 participants completed the entire module in the first month of program availability on the AANP Continuing Education Center website (Appendix K). All participants were members of the AANP. The AANP member cohorts were not differentiated in the demographic data but may have included practicing NPs, NP students, associate NPs, and retired AANP members. Other demographic data available included the participants' estimated percentage of refugee patients in their practice (Appendix K). The responses are aggregate and calculated as total participant percentages rather than individualized responses per the data-collection methods of the AANP CE Center; therefore, no comparisons or inferences were possible.

Assessment of Learning

Table 2 contains the pre and posttest responses for AANP members related to the educational module. The highlighted row with an asterisk is the correct response for each question. The first column is the total participant pretest score percentage, and the second column is the total participant posttest score percentage. The majority of participants were aware of the rationale behind the importance of NP cultural competence (88.9%), the definition of health disparities (70.2%), the ACA cultural promotions (75.6%), and the definition of FGM (93.1%) based on pretest response percentages. In the pretest, the majority of participants chose the incorrect definition for cultural competence (38.9%) although after completion of the educational module participants identified the correct definition (71.2%).

Table 2

Pretest and Posttest Responses

Question	Response Choices	Percentage	
		Pre	Post
Nurse Practitioner understanding of cultural competence is important:	To meet professional standards of practice.	4.4	2.6
	Because many refugees maintain their cultural and traditional health beliefs	5.6	1.0
	As perceived and actual access barriers to health care may exemplify disparities.	1.1	0.0
	In the emphasis of The Patient Protection and Affordable Care Act.	0.0	0.0
	*All of the above	88.9	96.2
Cultural Competence is defined as:	*A set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations.	38.9	71.2
	Integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups.	14.4	7.7
	The capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.	46.7	21.2
What is a health care disparity?	A difference in health, which is not only unnecessary and avoidable but is considered unfair and unjust.	13.3	6.7
	A condition of being unequal.	3.3	20.2
	Any difference amongst a population that is statistically significant and differs from the reference group by at least 10 percent.	13.3	2.9
	*All of the above	70.0	70.2
The Patient Protection and Affordable Care Act promotes all of the following except:	Development and evaluation of model cultural competence curricula.	6.7	3.9
	Dissemination of cultural competence curricula through online clearinghouse.	7.8	3.9
	*Continuing only with current educational health care modules.	75.6	88.3
	Cultural competency training for primary care providers and home care aides.	7.8	3.9
	Collaborative research on topics including cultural competence.	2.2	0.0
Female Genital Mutilation is:	Defined as all procedures that intentionally alter or injure female genital organs for non-medical reasons.	3.3	6.7
	Linked to cultural factors such as tradition, religion, economics, and ethnic identity.	3.3	1.0
	Practiced widely in 26 African countries.	0.0	1.0
	*All of the above	93.3	91.3

Program Evaluation

After viewing the educational module and completing the posttest, participants completed a 14 question post-program evaluation (Appendix J). The purpose of the evaluation questions was to assess the effectiveness of the chosen educational strategy, PowerPoint with audio, and to assess if the participants felt that their cultural understanding improved after viewing the education. The questions followed a prepared AANP template. Ten of the questions utilized a Likert-type scale ranging from “completely” to “not at all”; two questions required a yes or no response; and two open-ended questions asked the participant to compose a response. The participant’s responses were arranged by descriptive analysis into the project purposes.

Perceived Educational Preparedness

The first question was as follows: Do you feel that your graduate education provided you with the appropriate tools to address cultural competence or sensitivity in the care of your patients? Ninety percent (n=77) of the respondents indicated a “yes” response demonstrating that they were given the appropriate tools to enter practice and address cultural awareness. Ten percent (n=8) indicated a “no” response that their graduate education did not adequately prepare them for culturally sensitive practice.

The second question was as follows: What percent of your practice is of a refugee or immigrant population? Participants options to estimate the percentage of refugees or immigrants in their practice included less than 10%, 11-30%, 31-50%, 51-75% and more than 75%. Approximately half of the respondents (n=63) responded that less than 10% of their patient population is from a refugee or immigrant population. Approximately 20% (n=17) of the respondents stated that their patient population from a refugee or immigrant population was from 11-50%. Less than 6% (n=5) of the respondents reported that more than 50% of their patient population was from a refugee or immigrant population (Figure 2).

The third question was as follows: Have you completed ongoing and continual education related to cultural competence/sensitivity since graduation? Sixty-three percent (n=54) of the participants had completed ongoing cultural sensitivity or competence education since graduation.

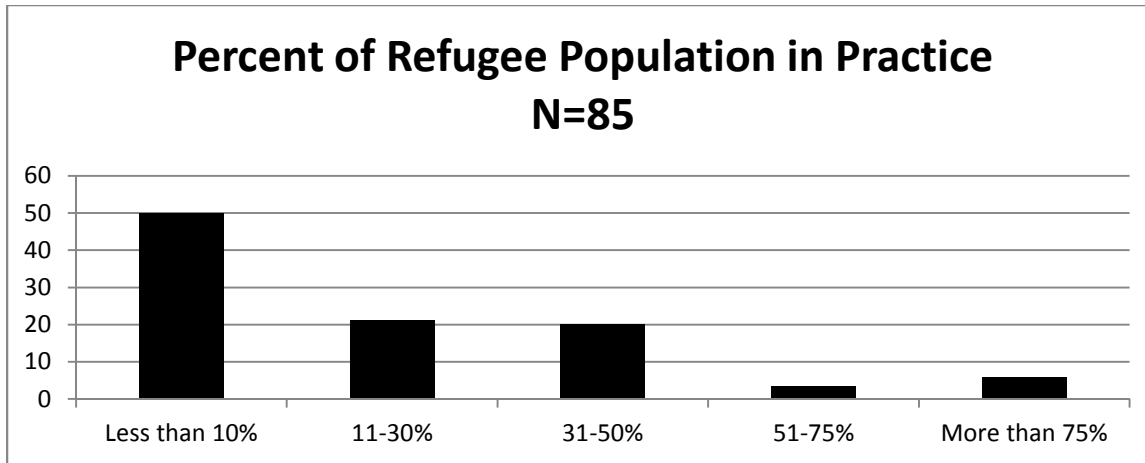


Figure 2. Percent of Refugee Population in Practice.

Perceived Effectiveness of Educational Module

Open-ended response questions were designed for questions four and five. Do you feel you that met your learning objectives during this educational program? Please post suggestions and/or comments about this CE program in the comment box provided. The comments received were generally positive:

- “Great program and very informative”
- “Very good CE. Thank you”
- “The topic content was great, well organized, and included information I will use in practice. The actual IT component – opening up links, etc. did not work smoothly”
- “A little confusing”
- “Very well done”
- “Important information on cultural awareness”
- “good CE”
- “helpful”
- “Very interesting topic”
- “ Very good”
- “It was great”
- “Great”
- “Great information”

- “Great presentation. Very important topic area and should be discussed more in schooling and continuing education courses”
- “Great resource”

In questions six, seven, and eight, participants evaluated whether the educational module met the program objectives by using a Likert-scale. The questions were as follows: “To what degree did this program achieve the following objective:”

- 6) State at least three items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice. Ninety-four percent (n=80) of the participants responded that the module either “completely” or “quite a bit” met the objective (Table 3).
- 7) Define cultural competence, culture, and cultural awareness. Ninety-five (n=81) percent of the participants responded favorably that the objective was met (Table 3).
- 8) Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan. Ninety percent (n=77) of the participants responded that the module clearly met this objective (Table 3).

Table 3

Program Objectives

To what degree did this program achieve the following objective:	Response Choices	Percent
6. State at least 3 items that contributed to Nurse Practitioner cultural understanding and awareness in practice	Completely	55.3
	Quite a bit	38.8
	Somewhat	5.9
	Not at all	0.0
7. Define cultural competence, culture and cultural awareness	Completely	61.2
	Quite a bit	34.1
	Somewhat	4.7
	Not at all	0.0
8. Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan	Completely	57.6
	Quite a bit	31.8
	Somewhat	9.4
	Not at all	0.0

The ninth question was as follows: To what degree did the speaker demonstrate expertise and effectiveness in the topic? Sixty-two percent (n=53) of the participants responded with “completely”; 35% (n=30) of the participants responded with “quite a bit;” 3% (n=2) stated “somewhat;” and no participant chose “not at all.”

The tenth question was as follows: To what degree were the individual objectives and content topics cohesive with one another? Ninety-four percent (n=80) of the respondents stated that the module had either “completely” or “quite a bit” cohesive objectives (Figure 3).

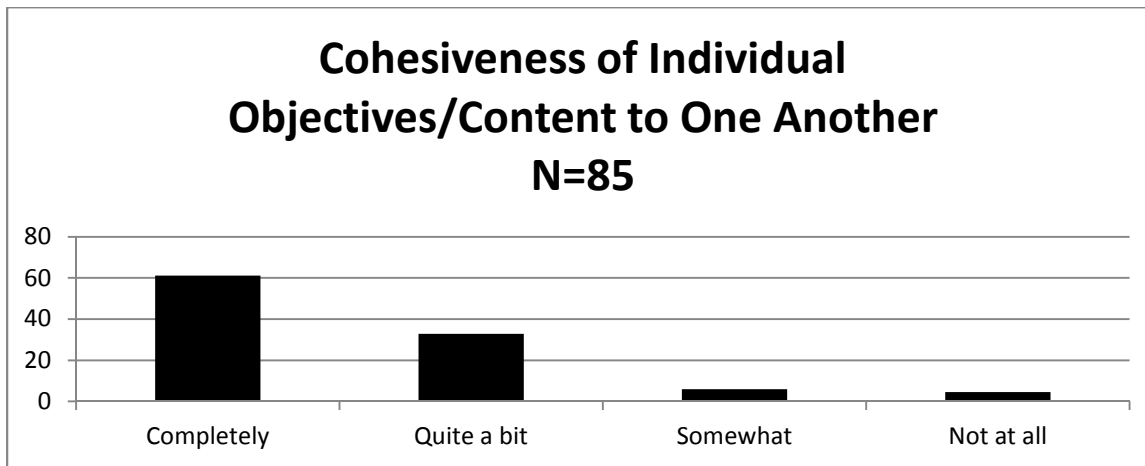


Figure 3. Cohesiveness of Individual Objectives/Content to One Another.

The eleventh question was as follows: To what degree was the content balanced (free of commercial bias)? Question 11 was part of the AANP’s standard evaluation questions and not used to assess effectiveness. Question 11 did not influence this projects objectives or data analysis. Ninety-nine percent (n=84) of the respondents stated that there was little to no commercial bias within the educational module’s content.

The twelfth question was as follows: How appropriate was the format(s) to promoting learning? Ninety-four percent (n=80) of the respondents replied positively that the format did effectively promote learning (Figure 4).

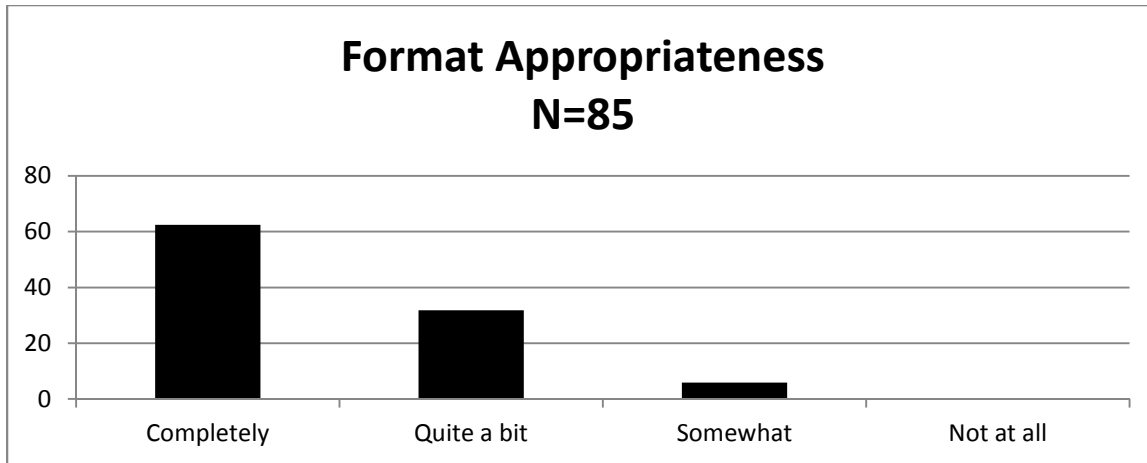


Figure 4. Format Appropriateness.

The thirteenth question was as follows: How likely would you be to recommend this program to your colleagues? Ninety-four percent (n=80) of the respondents said that they would likely recommend this online educational module to their colleagues (Figure 5).

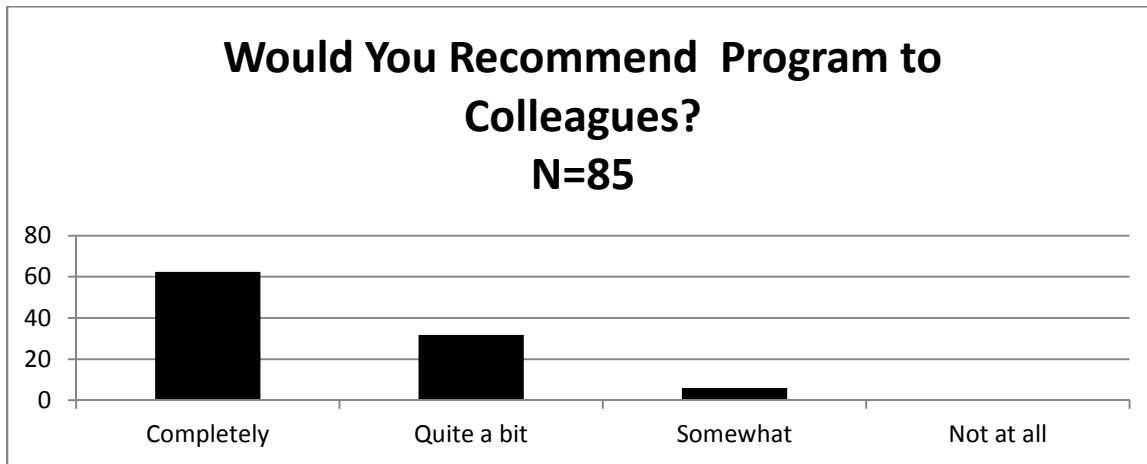


Figure 5. Would You Recommend Program to Colleagues?

The final question was as follows: Was the level of content for NP's: Too basic? Just right? Or Too Advanced? Ninety-four percent (n=80) of the participants responded with that the module content was "just right" (Figure 6).

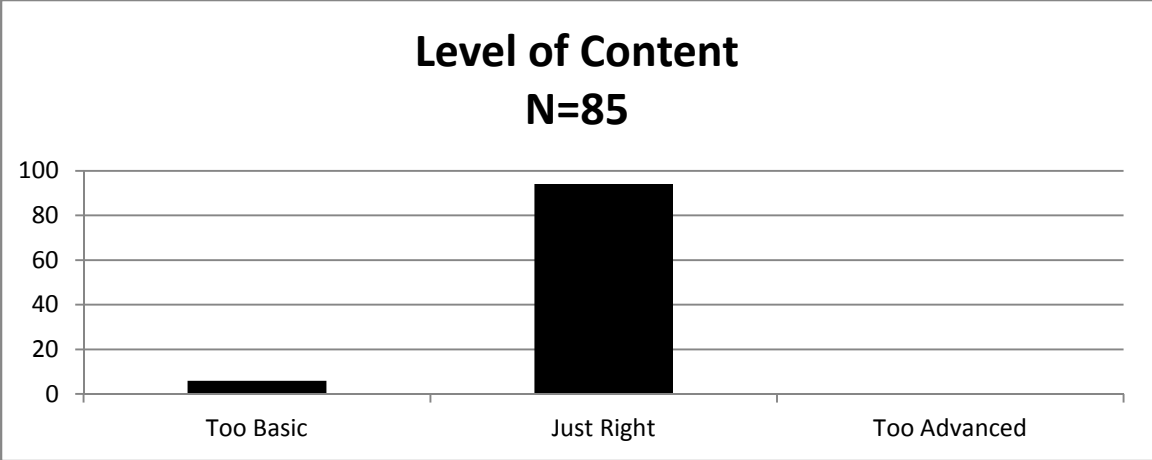


Figure 6. Level of Content for NP.

CHAPTER FIVE. INTERPRETATION OF FINDINGS

Analysis of Project Purposes

In this chapter, the project's findings and limitations will be analyzed. Descriptive statistical analysis provided the most beneficial examination to assess the project purposes because the presented pretest and posttest data were not applicable to inferential analyses due to the lack of access to individual participant responses and the small sample size. The data received from the AANP was aggregate and calculated as a total percentage of participation versus individual participation. Common characteristics in the data were organized in separate or appropriate purposes from the evaluation survey (Terry, 2012). Utilization of the following two project purposes allowed logical organization of the data (a) perceived educational preparation during graduate education, and (b) the perceived effectiveness of the educational method.

Interpretation of Results

The pretest and posttest assessed the educational module's capability for increasing participant knowledge. No individual data were available due to AANP CE Center's data-collection methods, making analysis of pretest and posttest data difficult to assess for statistically significant changes. The data in the pretest and posttest were inadequate to assess the overall effectiveness of the educational module. The data demonstrated an overall increase in correct response from the pretest to the posttest except question five and only a slight increase in question three. Question 3 increased from 70% to 70.2%, which may suggest that the question was poorly designed or the module did not adequately address health disparities. Question 5 evaluated the definition of FGM, correct responses decreased by 2% from the pretest to the posttest. This author is not aware of the rationale behind the decrease in correct participant response.

Discussion of the two project purposes, perceived educational preparedness and perceived effectiveness of the educational module along with analysis and interpretation follows in the proceeding sections.

Perceived Educational Preparedness

The literature review supported the notion that there was a lack of emphasis on cultural awareness education in nursing graduate programs (Benkert et al., 2005). The responses to question

one were contradictory to the literature. Ninety percent of the participants indicated that their graduate education provided adequate education about cultural competence and the integration of cultural competence into practice. Participants may not accurately remember cultural education within their graduate programs, which may account for the overestimation on the evaluation response (Appendix J). The existing literature may not reflect the current state of NPs' personal satisfaction with the culture content offered in their graduate school education or the changes in graduate education standards since the introduction of the Affordable Care Act. Using of a framework such as Purnell's Model for Cultural Competence may improve student understanding of the complex cultural diversity in health care (Purnell, 2005). The overwhelming positive response to adequate graduate preparedness was surprising given that the literature indicated that NP's were not afforded the cultural education needed to be successful in practice (Benkert et al., 2005; Betancourt et al., 2005; Like, 2011).

Participants were asked whether they had completed continuing education related to cultural competence or sensitivity since graduation. The majority of participants (63%) responded that they completed continuing education involving culture post-graduation. Multiple literature sources suggested that cultural education could be continual and lifelong if not fully implemented during graduate education (Benkert et al., 2005; Bentacourt et al., 2005). Implementation of the ACA and the CLAS standards may have compelled health care organizations to mandate annual employee education on cultural competence (Like, 2011; U.S. DHHS OMH 2001a, 2001b, 2007). The ACA and CLAS standards may have influenced responses to this particular question from the practicing NPs due to length of time practicing and government changes within health systems. The continuation of cultural education post-graduation may significantly influence the responses received for this question. NPs are required to obtain a specific number of CEUs to maintain their professional certification; the number of CEUs may differ depending upon their certifying agency. NPs certified through the AANP are required to complete a minimum of 75 hours of continuing education specific to their certification foci every 5 years (AANP, 2013). NPs are able to choose continuing education based on areas of interest within their certification foci, which may additionally influence the responses to completing cultural education post-graduation.

Perceived Effectiveness of Educational Module

Questions four through fourteen focused on the perceived effectiveness of the educational method. In question five, participants made comments or suggestions. The overwhelming majority of comments were positive and in support of the educational method. One comment indicated that the educational module was “a little confusing,” but the author did not elaborate. Unfortunately, it is difficult to assess if the entirety of the module or a single component was “confusing.”

Questions six, seven, eight, and ten addressed achievement of the module’s objectives. These four questions allowed the author to analyze if the educational method was effective in the delivery of cultural information. For each question, the majority of participants responded that the objectives were met “completely” or “quite a bit.” The responses indicated that the author was able to attain the objectives addressed within the educational module. Purnell’s Model for Cultural Competence, guided the development of the educational objectives. Additionally, the participant responses supported Purnell’s theoretical conceptions

Questions nine, eleven, twelve, thirteen, and fourteen assessed the effectiveness of the modules format. The majority of respondents specified that the formatting “completely” or “quite a bit” promoted learning free of commercial bias. The evaluation findings supported literature reports that ease of access and convenience for educational information can positively influence participation (Andrusyszyn et al., 2001; Black, 2003; Robson, 2009). Ease of access for web-based educational modules are associated with colleague referral and discussion (Robson, 2009). Web-based learning can extend beyond the traditional classroom setting, creating environments where colleagues are able to discuss and recommend online learning (Ho, Jarvis-Selinger, Norman, Li, Olatunbosun, Cressman, & Nguyen, 2010). Unfortunately, only a few studies support web-based cultural competence education. Generally, the literature supports the use of PowerPoint presentations with audio for education in other subject areas (Andrusyszyn et al., 2001; MAHEC Department of Continuing Education, 2004).

Overall, the author feels that the practice improvement educational module successfully met the predetermined objectives. A web-based PowerPoint presentation with audio appears to be a successful way to provide continuing education based on the obtained evaluation responses from AANP members. In a similar study by Jean Robson (2009), participants displayed a high level of acceptability for online

learning modules. Participants enjoyed the fact that they could participate in the education at a time they liked with a patient-centered focus and an interesting subject (Robson, 2009). The main objectives of the educational module were met by providing information related to increasing NPs' knowledge of cultural awareness, providing definitions of cultural terms, and explaining common culture-specific health beliefs while utilizing Purnell's Module for Cultural Competence as a guide. In addition, the author has provided a valuable, cost-free, and easily accessible web-based resource for AANP members to further their education related to cultural awareness in refugee women's health care; the module will be accessible until January of 2015. Providing this type of continuing education online will allow for ease of access and increase NPs' knowledge.

Limitations

The original intent of the project was to assess and evaluate the following questions: (a) what barriers to health care access exist that prevent female refugees from seeking care or continuing to seek care?, (b) what educational methods are effective to enhance provider knowledge about cultural beliefs and health care customs of female refugees?, (c) will increased provider education improve health outcomes for refugee women within the primary care setting?, (d) is there a gap between provider knowledge and the application of culturally sensitive health care for a refugee?, and (e) do health care disparities continue to rise despite current efforts to diminish cultural differences for female refugees? Due to various limitations on time and available data, this author was unable to assess the long-term changes in health care outcomes for refugee women, gaps in knowledge, practical application of NPs, and changes in health care disparities. More research should focus on effective cultural educations, application in the clinical setting and improving primary care of refugee women. Of utmost importance is the creation of longitudinal research studying if web-based education contributes to improvement in culturally competent care and the reduction in health care disparities.

This practice improvement project evolved and changed to a new focus over the past two and a half years. Time constraints limited the number of participants and reportable data to a single month (January 2013). This author was pleased with the large number of participants in the first month, 85 AANP members. Participation in the educational module was high even with an alternative cultural educational module available through the AANP CE Center. The results are extensively preliminary

because the module responses were limited to this single month of collection. The lack of long-term data makes it difficult to make broad assumptions and to determine the long-term success of increasing NP knowledge and practical application. Web-based learning does not always translate into changes in practice (Robson, 2009). This author plans to continue to be involved in the data collection and follow-up of the educational module in association with the AANP.

Seven AANP members started the educational module but did not complete the program. The dropout rate may have been due to the length of time (1 hour and 10 minutes not including the pretest, posttest, and evaluation), decreased interest in content, dissatisfaction, difficulty accessing the online module, or not meeting the participant expectations upon initiation of the module. Contribution to dropout rate is often complex and unidentified as is in this practice improvement project (Tyler-Smith, 2006). Generalization of the educational techniques displayed in this project to providers other than NPs is not possible.

As the data were aggregate, it is unknown if there were positive or negative changes in individual participant responses for the pretest and posttest questions. Participants may have responded correctly for the pretest and incorrectly for the posttest, and vice versa. Without individual participant data, it is unknown if the changes for participant responses directly relate to an increase or decrease in understanding cultural awareness and refugee women's health care. Only general assumptions can be made about the positive changes between the pretest and posttest responses. The pretest and posttest demonstrate an increase in correct responses. Could the positive increase in correct responses be due to the fact the questions were easier than originally anticipated? Alternatively, did the participants have more knowledge in relation to cultural awareness at the beginning of the module? The difficulty in addressing the previous two questions lies in the inability to collect additional data from the participants. Future projects should include data collection that provides evaluative methods of individual participant responses. Additional data could allow for a greater depth of analysis and increase generalizability to a larger population.

The cultural background of the participants were not part of the collected demographic data but may have influenced evaluation responses. Having a personal connection with a specific culture may have biased a participant's responses. Participant ethnocentrism, the view that one's culture is central or

dominant, may contribute to evaluation responses (Welch Borden, 2007). For future research, obtaining more specific demographic data related to participants; cultural background, the number of years practicing, and the area of practice within the United States would be pertinent to further address the variances and influences for specific responses.

The evaluation survey inquired whether participants felt that each educational objective was met (questions six, seven, and eight). The wording of the questions was open-ended and should have been specific and objective, allowing for accurate author interpretation of participant understanding. The open-ended nature of the questions makes it difficult to determine if the educational module met the learning objectives. During future revisions, the wording on evaluation questions six, seven, and eight will be adjusted to provide accurate interpretation of participant responses.

CHAPTER SIX. DISCUSSION AND CONCLUSION

Discussion

The purpose of this project evolved into a twofold focus from the original objectives: to provide culturally sensitive education for NPs and to determine the effectiveness of the educational delivery method. Refugee populations are changing, and NPs need to stay up to date on variations within the health care setting while being proactive in implementing the Affordable Care Act. As refugees seek refuge in the United States and implementation of the ACA occurs, the need for NPs to understand other culture's health beliefs becomes more relevant. The literature supports that there is a cultural transformation happening within the United States, specifically within the health care system (ANA, 2011; Jenks, 2011; Like, 2011; U.S. DHHS, 2011). Providers and health systems need to continue to create culturally relevant and sensitive educational methods to meet the needs of all patients. Chapter Six discusses recommendations for practice and future research, how the project met the Doctor of Nursing Practice Essentials, the overall effectiveness of the practice improvement project, and author personal reflections.

Andrusyszyn and colleagues (2001) supported that ease of access to varying educational strategies weights higher than a specific layout for content. A PowerPoint presentation with audio addresses both visual and audio learners, and is the traditional presentation method used on the AANP CE Center website. The PowerPoint handout addressed tactile learners (Appendix G). Larry Purnell's Model for Cultural Competence guided the formation of the educational module and provided a theoretical framework for NP care of refugee women. The objective of the educational module was to analyze the strategy of a PowerPoint presentation with audio as a possible preference of NPs for web-based continuing education. The evaluation survey results support that a web-based PowerPoint educational module is an appropriate format for the delivery of culturally related material.

Use of this educational module as an educational strategy during graduate education has the potential to contribute to an increase in cultural knowledge. The increase in knowledge may translate into practice and lead to an improvement in practice. Utilizing organizations such as the AANP may be an effective way to reach NPs and to educate them through collaboration with the Continuing Education Center. Unfortunately, this practice improvement project was unable to evaluate the long-term outcome

or potential changes of cultural sensitivity and awareness within an individual NP's practice. The cultural transformation demands more longitudinal research that evaluates whether cultural education has an impact on the delivery of culturally sensitive and competent care.

Certain variables have influenced this project, including the rearrangement of the overall focus in the summer of 2012 to emphasize the education of several refugee cultures and factors that affect NPs' practice related to cultural awareness. It would have been preferred to have a longer period of data collection by completing the educational module at the beginning of the fall semester of 2012 versus the end of 2012, thereby expanding the representativeness of AANP members. In addition, the collection of individual pretest and posttest responses would have been a valuable resource and would have allowed for inferential statistical analysis demonstrating if the module was statistically significant in creating increased NP knowledge after participation in the module.

In future revisions of the educational module, the author will take note of, review the strategies employed during the portion on female genital mutilation, and reassess how to discuss FGM specific information, in addition to any new information related to cultural awareness. The author will update and change information as necessary to keep the module current with cultural trends and education as applicable to NP practice. The following changes will be considered by the author: necessary time related updates, improve fluency of audio, and timing of the slides with spoken information. The author intends to update the content of the module on a regular basis to include newly published, relevant, evidence-based information. Gathering data from refugee women of the discussed cultures to support or deny evidence regarding traditional health beliefs and practices would be interesting. In addition, having a refugee woman from each culture discussing personal transition stories during the educational module may provide a personal note for participants.

Recommendations for Nursing Practice and Future Projects

NPs are in the unique position to meet and assess refugee-related health concerns in health care settings through a focus on integration and an application of cultural awareness. Culture plays an important role in understanding and seeking health care not only for refugee and immigrant patients but also for all patients. Traditional beliefs and practices influence health-related behaviors and need to be incorporated into daily practice. A focus to increase practitioner competency in culturally sensitive care in

conjunction with education modules may contribute to the promotion of health and the prevention of disease within all populations.

Important for practitioners is the need to develop a rapport with their patients in order to provide consistent and culturally competent care. NP awareness of patients' cultural perceptions and beliefs may influence health-related concerns. For NPs and refugees to reach mutually established goals requires the melding of western medicine and rationally health beliefs. The Affordable Care Act will start to cause a health care transformation during its implementation, and Doctor of Nursing Practice (DNP) graduates are distinctively prepared to create positive impacts on health policies related to cultural sensitivity. NPs need to emphasize the ability to recognize and incorporate traditional health beliefs in order to meet the goals of the cultural transformation. NPs must continue to seek continuing education related to culture and to attempt to incorporate lessons taught in the hope of increasing knowledge and potentially translating to a decrease in health care disparities.

Collaboration between refugee women and NPs may assist in the development of culturally aware educational materials that will educate NPs who are responsible for promoting health and well-being. Implications for future NP practice include continued investigation about the validity of online educational modules and the NPs' preference for continuing education obtainment. Developing and utilizing frameworks such as Dr. Larry Purnell's Model for Cultural Competence may assist in the development of future continuing educational modules that are specific for NP's.

Marie Curie once said, "You cannot hope to build a better world without improving the individual" (Chism, 2013, p. 3). It takes the initiation of each Doctor of Nursing Practice (DNP) student to promote the professional development of every individual while supporting colleagues during practice transitions, such as what will occur with ACA implementation. DNP education goals include a "scholarly approach to the discipline and a commitment to the advancement of the profession" (Chism, 2013, p. 5). Specific recommendations for DNP students' education include the continued support for leadership roles and political roles to promote the cultural transformation into practice. DNP prepared graduate students are uniquely trained to influence health care outcomes, to manage care, and to develop and implement health care policy as required by the ACA (Chism, 2013). DNP education takes specific notice of health care policy and advocacy. This practice improvement project considered and applied the ACA and promoted

health care related policy changes. Continuing education during graduate and postgraduate education is essential for the development and advancement of the profession. Utilizing evidence-based education programs, similar to the one provided within this project, geared towards the DNP student will continue to help promote expertise within DNP practice. Even though participants indicated that they received adequate education on cultural sensitivity in their educational programs, it is essential that DNP curriculum evaluate their current culture content and adjust as necessary to meet the changing needs of the patient population. Consideration for using the educational module provided for this project could increase exposure and cultural content within programs and could provide a reliable framework with Purnell's Model for Cultural Competence. The author's intent was not to be a comprehensive review of all refugees health beliefs, rather, to focus on 10 specific refugee groups and to apply Purnell's Model for Cultural Competence framework.

The AACN Essentials of Doctoral Education for Advanced Nursing Practice outlines the curricular elements and competencies that must be present in programs conferring the Doctor of Nursing Practice degree. The eight essentials delineate the foundational competencies for DNP graduates (American Association of Colleges of Nurses [AACN], 2006). This project was able to address all eight essentials in some small part. The essentials are as follows:

- I) The Scientific Underpinnings for Practice. The practice improvement project discussed the unique attributes and cultural beliefs to the top 10 refugee cultures. The information provided within the educational module should be applicable in any practice setting by using the principles from Purnell's Model for Cultural Competence.
- II) Organizational and Systems Leadership for Quality Improvement and Systems Thinking. DNPs should be able to meet the needs of refugee and immigrant populations regardless of the country of origin with the conceptualization of Purnell's Model for Cultural Competence. The module not only provides the ACA changes in practice related to cultural awareness but also provides additional resources for DNPs to stay informed about practice changes to meet the current and future needs of their patients regardless of cultural traditions and health beliefs.

- III) Clinical Scholarship and Analytical Methods for Evidence-Based Practice. Essential three was met through synthesizing the information gathered in the literature review, creating the educational module, contracting with the AANP to offer the module for continuing education, and through disseminating project intent and findings with a poster presentation at the North Dakota Nurse Practitioner Association Pharmacology Conference in October of 2012 and the Sanford Advanced Nursing Symposium in May of 2013, pending abstract approval. The author plans to submit a journal article for consideration to *The Journal of Continuing Education in Nursing (JCEN)*. *JCEN* expressed interest after the author's letter of inquiry in January of 2013.
- IV) Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care. The practice improvement project created the educational module and collaborated with the AANP CE Center to support improvement of care.
- V) Health Care Policy for Advocacy in Health Care. Discussion of the ACA and the recommendations for future practice change that addresses culturally sensitive care demonstrates competency of Essential five. The educational module will likely facilitate the delivery of culturally sensitive health care.
- VI) Interprofessional Collaboration for Improving Patient and Population Health Outcomes. The sixth essential was met by means of establishment of a collaborative team with the AANP CE Center.
- VII) Clinical Prevention and Population Health for Improving the Nation's Health. The practice improvement project included aggregate or shared cultural dimensions of health care. The module may assist in integrating/referring for specific health related services for refugee populations.
- VIII) Advanced Nursing Practice. The final essential addressed the development of cultural competence/awareness regardless of area of practice. AANP members are of varying practices and specialties, likely allowing for a wide range of practices that have access to the educational module.

Time limitations in DNP education prohibit the evaluation of outcomes or practice improvement long-term. Development and evaluation of a long-term NP cultural educational project may reduce refugee-related health care disparities for refugees within NP practices. Creation of a longitudinal project that follows NPs from entry into practice and at varying intervals (5, 10, and 15 years) during practice, which provides culturally related education while simultaneously tracking changes in health related disparities specific to refugee patient populations, may be able to accurately assess if increased knowledge could translate to a decrease in disparities. The ability to assess for long-term changes in health care outcomes, gaps in NP knowledge and practical application of cultural awareness using Purnell's Model for Cultural Competence, and changes in health care disparities would be important areas to address in future research related to NPs.

Conclusion

Refugees continue to seek refuge in the United States. With the ongoing cultural transformation of the United States, it is of vital importance that NPs stay up to date on culturally appropriate and sensitive practice and treatment guidelines. NPs are in a unique position to meet the health care needs of diverse populations, to advocate for improved access to care for refugees, to champion efforts to eliminate health care disparities, and to promote cultural sensitivity in practice. An educational framework to maintain cultural awareness, enhance understanding, and increase communication becomes a forefront issue to assist with the coordination of care in the hopes of diminishing health care related disparities. The government has taken note of the need for change by introducing the Affordable Care Act. The ACA will continue to make changes within the health care system to promote culturally sensitive care. Now is the time for NPs to increase their knowledge and understanding of traditional health beliefs and to incorporate that information into practice.

There is a need for easily accessible, web-based, cost-effective, NP focused educational modules addressing cultural awareness and culturally competent practice. Educational approaches and learning strategies need to incorporate cultural complexities within NP health care settings and continuing education (Harris, Roussel, Walters, & Dearman, 2011). Web-based educational programs utilizing PowerPoint with audio are an effective way to access NPs, to increase NPs' cultural awareness about

refugee women, and to provide education with varying time settings in order to meet all NP schedules. PowerPoint with audio is an appropriate way to increase access for continuing education. More research is needed to validate whether web-based PowerPoint cultural education increases NP knowledge. Specifically, it would be important to know if a change in NP knowledge occurred and if the change in knowledge translated into improved practice. It is difficult to assess within this dissertation if increased NP understanding of cultural awareness will relate to an overall improvement in refugee health care outcomes and a decrease in health care disparities for refugees.

This project has been a revelation about the cultural diversity within the United States and the overall lack of refugee access to health care. NPs or other health care providers need more information about the validity of culturally based guidelines and the use of guidelines in the provision of care to refugees. From the authors perspective, development of the educational module was, at times, difficult because of my personal knowledge deficit about recording equipment, and techniques which, made collaboration with NDSU DCE a necessity. Organizing the studio time and recording time was relatively user-friendly thanks to the NDSU Department of Continuing Education. Recording the audio was certainly more difficult and time consuming than anticipated, requiring twice as much time as originally planned. Several sections needed to be recorded several times for word fluency. A prepared script was extremely important for accuracy and timing in the narration component of the module. Through personal narration of the audio component, the author hoped to display her passion for culturally competent care. The author will continue to promote culturally sensitive and specific health care in future practice both with my patients and with colleagues. The cultural transformation is real and happening in the United States, and NPs need to seek out opportunities to improve the health care of all patients, regardless of cultural background, beliefs, or traditions. A strong sense of self was found during the discovery and development process of this practice improvement project and I realized that creating change in practice is possible with time, effort, and patience.

REFERENCES

- Agency for Health Care Research and Quality. (2003). *National healthcare disparities report*. Retrieved from <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm>
- Agency for Health Care Research and Quality. (2011). *National healthcare disparities report*. Retrieved from <http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf>
- American Association of Colleges of Nurses. (2006). *The Essentials of Doctoral Education for Advanced Nursing Practice*. Retrieved from <http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf>
- American Association of Nurse Practitioners. (2010). *Standards of practice for nurse practitioners*. Retrieved from <http://www.aanp.org/images/documents/publications/StdsofPracticeforNPs.pdf>
- American Association of Nurse Practitioners. (2013). *Continuing education*. Retrieved from <http://www.aanpcert.org/ptistore/control/recert/ce>
- American Nurses Association. (2011). *Health care reform: Key provisions related to nursing*. Retrieved from http://www.rnaction.org/site/DocServer/KeyProvisions_Nursing-PublicLaw.pdf?docID=1241&verID=1
- Andrusyszyn, M., Cragg, C. E., & Humbert, J. (2001). Nurse practitioner preferences for distance education methods related to learning style, course content, and achievement. *NP Preferences for Distance Education*, 40(4), 163-170.
- Arjomand, S. A. (2010). The Iranian revolution in the new era. *Current Trends in Islamist Ideology*, 10. Retrieved from <http://www.currenttrends.org/research/detail/the-iranian-revolution-in-the-new-era>
- Ball, T. (2008). Female genital mutilation. *Art & Science Women's Health*, 23(5), 43-47.
- Barron, S., Okell, J., Yin, S. M., VanBik, K., Swain, A., Larkin, E., Allot, A. J., & Ewers, K. (2007). Refugees from Burma: Their backgrounds and refugee experiences. Cultural Orientation Resource Center. *Culture Profiles*, 21.
- Belanger, C. (2011). *Our World: Cuba 2011*. Toledo, OH: Great Neck Publishing.
- Benkert, R., Tanner, C., Guthrie, B., Oakley, D., & Pohl, J. M. (2005). Cultural competence of nurse practitioner students: A consortium's experience. *Journal of Nursing Education*, 44(5), 225-232.

- Betancourt, J. R., & Green, A. R. (2010). Linking cultural competence training to improved health outcomes: Perspectives from the field. *Academy of Medicine, 85*(4), 583-585.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence in managed care, government, and academe, cultural competence is emerging as an important strategy to address health care disparities. *From the Field, 24*(2), 499-505.
- Black, L. (2003, Winter). Adult and distance education management: An application of the metaphor "organizations as organisms." *Online Journal of Distance Learning Administration, 6*(4). Retrieved from <http://www.westga.edu/~distance/ojdla/winter64/black64.htm>
- Bodeker, G., Neumann, C., Lall, P., & OO, Z. M. (2005). Field report: Traditional medicine use and healthworker training in a refugee setting at the Thai-Burma border. *Journal of Refugee Studies, 18*(1), 76-99.
- Broome, B. (2006). Culture and diversity issues: Culture 101. *Urologic Nursing, 26*(6), 486-488.
- Burns, N., & Grove, S. K. (2009). *The practice of nursing research* (6th ed.). St. Louis, MO: Saunders Elsevier.
- Byrne, D. (2006). Female genital mutilation. *Midwifery Matters, 109*, 10-12.
- California Endowment. (2002). *A manager's guide to cultural competence education for health care professionals*. Woodland Hills, CA: The California Endowment: A Partner for Healthier Communities.
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P. (2007). Caring for Somali women: Implications for clinician-patient communication. *Patient Education and Counseling, 66*, 337-345.
- Center for Disease Control and Prevention. (2012a). *Background: Bhutanese refugee health profile*. Retrieved from <http://www.cdc.gov/immigrantrefugeehealth/profiles/bhutanese/background/index.html>
- Center for Disease Control and Prevention. (2012b). *Ethnographic guides*. Retrieved from <http://www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/default.htm>
- Chism, L. A. (2013). *The Doctor of Nursing Practice: A guidebook for role development and professional issues* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

- Commonwealth of Australia. (2006, August). *Eritrean community profile*. Retrieved from http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/_pdf/community-profile-eritrea.pdf
- Cooper, D., & Underwood, A. (2010). *Eritrea cultural profile*. Retrieved from <http://ethnomed.org/culture/eritrean/eritrean-cultural-profile/?searchterm=eritrea>
- Cothran, H. M. (2009). Business retention and expansion (BRE) programs: Making your (Power) point. *University of Florida: IFAS Extension*. Retrieved from <https://edis.ifas.ufl.edu/pdffiles/FE/FE71300.pdf>
- Culture Profiles. (2007). *SPIRASI Cultural Profiles*. Retrieved from <http://cultural.profiles.spirasi.ie/>
- Department of Immigration and Citizenship. (2006). *Congolese community profile*. Retrieved from http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/_pdf/community-profile-congo.pdf
- Duncan, A., & Hayden, M. (2008). *Ethiopian cultural profile*. Retrieved from http://ethnomed.org/culture/ethiopian/copy_of_ethiopian-cultural-profile/?searchterm=ethiopia
- Egede, L.E. (2006). Race, Ethnicity, Culture, and Disparities in Health Care. *Journal of General Internal Medicine*, 21(6), 667-669.
- Epstein, D., Graham, P., & Rimsza, M. (2001). Medical complications of female genital mutilation. *Journal of American College Health*, 49(6), 275-280.
- EveryCulture. (2013). *Countries and their cultures*. Retrieved from <http://www.everyculture.com/>
- Georgetown University. (2001). *Rationales for cultural brokering in health care*. Retrieved from http://www.culturalbroker.info/2_role/index.html
- Giger, J., Davidhizar, R. E., Purnell, L. D., Harden, J. T., Phillips, J., & Strickland, O. (2007). American academy of nursing expert panel report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, 18(2), 95-102.
- Grantmakers Concerned with Immigrants and Refugees. (2012). U.S. immigration statistics. Retrieved from <http://www.gcir.org/immigration/facts/statistics>

- Haadal, C. C. (2009). Refugee and asylum-seeker inflows in the United States and other OECD member states. *Congressional Research Service*. Retrieved from www.crs.gov
- Harris, J. L., Roussel, L., Walters, S. E., & Dearman, C. (2011). *Project planning and management: A guide for CNLs, DNP's, and nurse executives*. Sudbury, MA: Jones & Bartlett Learning.
- Health Services Research Information Central. (2012). Health disparities. *U.S. National Library of Medicine: National Institutes of Health*. Retrieved from <http://www.nlm.nih.gov/hsrinfo/disparities.html>
- Hess, R. F., Weinland, J., & Saalinger, N. M. (2010). Knowledge of female genital cutting and experience with women who are circumcised: A survey of nurse-midwives in the United States. *American College of Nurse-Midwives, 55*(1), 46-54.
- Higginbottom, G., Richter, M.S., Mogale, R.S., Ortiz, L., Young, S., & Mollel, O. (2011). Identification of nursing assessment models/tools validated in clinical practice for use with diverse ethno-cultural groups: an integrative review of the literature. *Biomedical Central Nursing, 10*(16).
- Ho, K., Jarvis-Selinger, S., Norman, D.C., Li, L.C., Olatunbosun, T., Cressman, C., & Nguyen, A. (2010). Electronic communities of practice: Guidelines form a project. *Journal of Continuing Education in the Health Professions, 30*(2), 139-143.
- Horowitz, C. R., & Jackson, J. C. (1997). Female "circumcision" African women confront American medicine. *Journal of General Internal Medicine, 12*(8), 491-499. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497147/>
- Immigration and Nationality Act. (2010). *INA: Act 101 – Definitions*. Retrieved from <http://www.uscis.gov/portal/site/uscis/menuitem.f6da51a2342135be7e9d7a10e0dc91a0/?vgnnexto id=fa7e539dc4bed010VgnVCM1000000ecd190aRCRD&vgnnextchannel=fa7e539dc4bed010Vgn VCM1000000ecd190aRCRD&CH=act>
- International Rescue Committee. (2009). *The health of refugees from Iraq*. Retrieved from www.theIRC.org

- Jacobs, C. G. (2012). *National standards for culturally and linguistically appropriate services in health care: Ensuring quality health care for all* [PowerPoint slides]. Retrieved from http://www.diversityconnection.org/diversityconnection/leadership-conferences/2012%20Conf%20Docs/Enhancing_Health_Care_with_CLAS.pdf
- Jenks, A. C. (2011). From "lists of traits" to "open-mindedness": Emerging issues in cultural competence education. *Cultural Medical Psychiatry, 35*, 209-235.
- Jewish Vocational Service. (2006). *Culture guide*. Retrieved from <http://jcdhe.jocogov.org/sites/jcdhe.jocogov.org/files/docs/Cultural%20Guide.pdf>
- The Johns Hopkins University Evidence-Based Practice Center. (2004). Strategies for improving minority healthcare quality. Retrieved <http://archive.ahrq.gov/research/minorhlth.htm>.
- Johnson, R. W. (2009). *Nursing and the National Priorities Partnership: Aligning efforts to transform America's healthcare* [Workshop summary]. Retrieved from http://www.nationalprioritiespartnership.org/uploadedFiles/NPP/NonPartners/Newsletters/NU RSING_NPP_FINAL_JUNE2010.pdf
- Kemp, C. (2006). *Cuban*. Retrieved from https://bearspace.baylor.edu/Charles_Kemp/www/cuban_refugees.htm
- Kontoyannis, M., & Katsetos, C. (2010). Female genital mutilation. *Health Science Journal, 4*(1), 31-36.
- Lewis, C. (2003). *The Iranian culture*. Retrieved from <http://www.cwti.org/RR/Iran.pdf>
- Like, R. C. (2011). Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions, 31*(3), 196-206.
- Little, C. M. (2003). Female genital circumcision: Medical and cultural considerations. *Journal of Cultural Diversity, 10*(1), 30-34.
- Lloyd, P. (2009). *Somali-Bantu refugee women's beliefs about preventative healthcare and experiences in healthcare settings in San Diego: Implications for health care delivery* [PowerPoint slides]. Retrieved from <http://healthcaremissions.org/Lectures2009.html>
- Martin, D. C., & Yankay, J. E. (2012, May). *Refugees and asylees: 2011*. DHS Office of Immigration Statistics, Policy Directorate. Retrieved from http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_rfa_fr_2011.pdf

- Mateen, F. J., Carone, M., Al-Saedy, H., Nyce, S., Ghosn, J., Mutuerandu, T., & Black, R. E. (2012). Medical conditions among Iraqi refugees in Jordan: Data from the United Nations Refugee Assistance Information System. *Bull World Health Organization, 90*, 444-451.
- Matteliano, M. A., & Street, D. (2012). Nurse practitioners' contributions to cultural competence in primary care settings. *Journal of the American Academy of Nurse Practitioners, 24*, 425-435.
- Maxym, M. (2010). *Nepali-speaking Bhutanese (Lhotsampa) cultural profile*. Retrieved from <http://ethnomed.org/culture/nepali-speaking-bhutanese-lhotsampa/nepali-speaking-bhutanese-lhotsampa-cultural-profile>
- Momoh, C. (2004). Attitudes to female genital mutilation. *British Journal of Midwifery, 12*(10), 631-635.
- Mountain Area Health Education Center Department of Continuing Education. (2004). *Teaching styles/learning styles*. Retrieved from https://portal.utpa.edu/portal/page/portal/utpa_main/daa_home/hshs_home/pasp_home/pasp_preceptors/preceptors_files/4B2A02D4002F4E39E044000E7F4F73A4
- Neiman, A., Soh, E., & Sutan, P. (2008). *Karen cultural profile*. Retrieved from <http://ethnomed.org/culture/karen/karen-cultural-profile>
- North Dakota State University Research, Creative Activities, and Technology Transfer. (2011). Institutional Review Board. Retrieved from <http://www.ndsu.nodak.edu/research/irb/index.html>
- Ogunsiji, O., Wilkes, L., & Jackson, D. (2007). Female genital mutilation: Origin, beliefs, prevalence and implications for health care workers caring for immigrant women in Australia. *Contemporary Nursing, 25*, 22-30.
- Parker, V. A. (2010). The importance of culture competence in caring for and working in a diverse America. *Generations, Journal of the American Society on Aging, 34*(4), 97-102.
- Purdue University Online Writing Lab. (2013). *Designing an effective PowerPoint presentation: Quick guide*. Retrieved from <http://owl.english.purdue.edu/owl/resource/686/01/>
- Purnell, L. D. (2005). The Purnell model for cultural competence. *The Journal of Multicultural Nursing & Health, 11*(2), 7-15.
- Purnell, L. D., & Paulanka, B. J. (2008). *Transcultural health care: A culturally competent approach* (3rd ed.). Philadelphia, PA: F.A. Davis Company.

- Queensland Health and Multicultural Society. (2011). *Community profiles for health care providers*. Retrieved from http://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp
- Refugee Council. (2004). *A guide to Congolese culture and social norms*. Retrieved from <http://www.refugeecouncil.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=F370F137-A389-4F4C-90D3-D3F1A37D831F&mode=link>.
- Robert Wood Johnson Foundation. (2009). *Nursing and the National Priorities Partnership: Aligning efforts to transform America's healthcare*. Retrieved from <http://nursingworld.org/DocumentVault/NursingPractice/NCNQ/NNPP-Summary.pdf>
- Robson, J. (2009). Web-based learning strategies in combination with published guidelines to change practice of primary care professionals. *The British Journal of General Practice*, 59(599), 104-109.
- Saylor, T. (2005). *Creating an effective PowerPoint presentation* [PowerPoint slides]. Retrieved from http://people.csp.edu/saylor/effective_powerpoint.htm
- Stafford, L. (2010, February). The rich history, current state, and possible future of natural and traditional medicine in CUBA. *HerbalGram*, 85.
- Stratis Health. (2012). *Iraqis in Minnesota: Increasing the cultural competence of health care providers serving diverse populations*. Retrieved from http://www.culturecareconnection.org/documents/InformationSheet_Iraqi.pdf
- StudentsFIRST. (2012). *Democratic Republic of Congo*. Retrieved from <http://studentsfirstproject.org/childadolescent-mental-health/at-risk-populations/refugees/democratic-republic-of-congokinshasa/>
- Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing*, 15(2), 93-102.
- Taylor, R. (2005). Addressing barriers to cultural competence. *Journal for Nurses in Staff Development*, 21(4), 135-142.
- Terry, A. J. (2012). *Clinical research for the Doctor of Nursing Practice*. Sudbury, MA: Jones & Bartlett Learning.
- Texas Department of State Health Services. (2009). *Texas guide to school health programs*. Retrieved from <http://www.dshs.state.tx.us/schoolhealth/pgtoc.shtm>

- Thierfelder, C., Tanner, M., & Kessler Bodiang, C. M. (2005). Female genital mutilation in the context of migration: Experience of African women with the Swiss health care system. *European Journal of Public Health, 15*(1), 86-90.
- Trochim, M. K. (2006). *Descriptive statistics: Center for social research methods*. Retrieved from <http://www.socialresearchmethods.net/kb/statdesc.php>
- Tyler-Smith, K. (2006). Early attrition among first time eLearners: A review of factors that contribute to drop-out, withdrawal and non-completion rates of adult learners undertaking eLearning programmes. *Journal of Online Learning and Teaching, 2*(2). Retrieved from <http://jolt.merlot.org/vol2no2/tyler-smith.htm>
- United Nations Human Rights. (1948). *Universal Declaration of Human Rights: What are human rights?* Retrieved from <http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx>
- United Nations Refugee Agency. (1951). *Convention and Protocol Relating to the Status of Refugees*. Retrieved from <http://www.unhcr.org/3b66c2aa10.html>
- U.S. Census Bureau. (2011). *Statistical abstract of the United States: 2011*. Retrieved from <http://www.census.gov/compendia/statab/2011/tables/11s0050.pdf>
- U.S. Department of Health and Human Services. (2010). *Background on potential health problems for Somali Bantu*. Retrieved from http://www.globalhealth.gov/refugee/refugees_health_bantu.html
- U.S. Department of Health and Human Services. (2011). *Health disparities and the Affordable Care Act*. Retrieved from <http://www.healthcare.gov/law/infocus/disparities/index.html>
- U.S. Department of Health and Human Services Office of Minority Health. (2001a). *National standards on culturally and linguistically appropriate services in health care: Executive report*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf>
- U.S. Department of Health and Human Services Office of Minority Health. (2001b). *National standards on culturally and linguistically appropriate services in health care: Final report*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

- U.S. Department of Health and Human Services Office of Minority Health. (2007). *National standards on culturally and linguistically appropriate services (CLAS)*. Retrieved from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
- Vasey, K., & Manderson, L. (2012). Regionalizing immigration, health and inequality: Iraqi refugees in Australia. *Administrative Sciences, 2*, 47-62.
- Welch Borden, A. (2007). The impact of service-learning on ethnocentrism in an intercultural communication course. *The Journal of Experiential Education, 30*(2), 171-183.
- Williams, D. P., Acosta, W., & McPherson, H. A. (2002). Female genital mutilation in the United States: Implications for women's health. *American Journal of Health Studies, 15*(1), 47-52.
- World Health Organization. (2010a). *Democratic Republic of the Congo: Factsheets of health statistics 2010*. Retrieved from <http://www.afro.who.int/en/democratic-republic-of-congo/country-health-profile.html>
- World Health Organization. (2010b). *Female genital mutilation fact sheet*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs241/en/>
- World Health Organization. (2010c). *Global strategy to stop health-care providers from female genital mutilation*. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.9_eng.pdf

APPENDIX A. INSTITUTIONAL REVIEW BOARD LETTER

NDSU

NORTH DAKOTA STATE UNIVERSITY

701.231.8995

Fax 701.231.8098

Federalwide Assurance #FWA00002439

Institutional Review Board

Office of the Vice President for Research, Creative Activities and Technology Transfer

NDSU Dept. 4000

1735 NDSU Research Park Drive

Research 1, P.O. Box 6050

Fargo, ND 58108-6050

December 10, 2012

Tina Lundeen and Andrea J. Middlestead
Dept of Nursing
Sudro Hall

Re: Your submission to the IRB: "Cultural Awareness and Provider Based Care for Refugee Women"

Research Team: Tina Lundeen and Andrea Middlestead

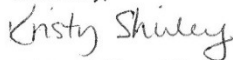
Thank you for your inquiry regarding your project. At this time, the IRB office has determined that the above-referenced protocol does not require Institutional Review Board approval or certification of exempt status because it does not fit the regulatory definition of 'research involving human subjects'.

Dept. of Health & Human Services regulations governing human subjects research (45CFR46, *Protection of Human Subjects*), defines 'research' as "... a systematic investigation, research development, testing and evaluation, designed to contribute to generalizable knowledge." These regulations also define a 'human subject' as "... a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information."

It was determined that your project does not require IRB approval (or certification of exempt status) because individual identifiable records are not being obtained for the research. The board makes this determination conditional on your assertions that the information provided by the American Association for Nurse Practitioners (AANP) will provide only aggregate data on the total number of participants, total number of correct/incorrect responses and will not provide any individual, private or identifiable information.

We appreciate your intention to abide by NDSU IRB policies and procedures, and thank you for your patience as the board has reviewed your study. Best wishes for a successful project!

Sincerely,



Kristy Shirley, CIP; Research Compliance Administrator

NDSU is an EO/AA university.

APPENDIX B. CORRESPONDENCE WITH THE AANP

Hello Andrea

We are glad to review your program to add to our AANP CE Center. We have CE through NP doctoral students and they are very well received. I have attached our Education Policies to give you a reference for what we need. When you get ready to send to us I will need the following information:

- Title of program
- Program in its electronic format(s) to post
 - We encourage a set of handouts to go with any video as many participants like these for notes and review.
 - If the file(s) are large, I can provide you with an FTP site to upload.
- Program length - time for viewing of video
- Objectives for the CE
- Your Bio (see attached) with contact information
- Your Disclosure (see attached)
- Post-test questions - to provide completion of the activity

We provide the CE Center venue, evaluation and certificate. If you have specific questions you would like asked as part of the program evaluation, please send those with the above information. When we accept the program and post in the Center you will receive standard evaluation reports with user comments. We review programs monthly for the first quarter and then quarterly until it's completion. As a general rule programs are approved for 2 years.

Please let me know if you have any questions and thank you,

Stormy

Stormy Causey

AANP CE Coordinator
2600 Via Fortuna, Ste 100
Austin, TX 78746
512-442-4262 x 5244

scausey@aanp.org
Fax: 512-442-6469

AANP Online CE Center

"May happiness come on secret winds and surround you forever in the ways of beauty."

APPENDIX C. EDUCATIONAL MODULE LETTER OF ACCEPTANCE

AMERICAN ASSOCIATION OF NURSE PRACTITIONERS Incorporated 1985

Administration: PO Box 12846 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: admin@aanp.org · Web Site:
www.aanp.org

Office of Health Policy: PO Box 40130 · Washington, DC 20016 · 202-966-6414 · Fax: 202-966-2856 · E-mail: dcoffice@aanp.org
Journal (JAANP): PO Box 12965 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: journal@aanp.org

January 8, 2013

Andrea Nelson
3712 Taylor St. S.
Fargo, ND 58104

Dear M Nelson,

The continuing education activity *Cultural Awareness and Provider Based Care for Refugee Women* is accepted for the AANP CE Center and approved for continuing education by the American Association of Nurse Practitioners. The appropriate wording for this is:

“This program is approved for 1.25 contact hours of continuing education by the American Association of Nurse Practitioners. Program ID 1212452”

In addition, the following statement will accompany this AANP-approved activity: “This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standards.”

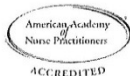
ID number 1212452 has been assigned to this application. Please refer to this number with all communication pertaining to this application. This program has been approved for 2 years (through January 31, 2015), provided no changes are made. Program and evaluation reports will be maintained in the AANP CE Center and sent monthly for the first 3 months the program is active and they quarterly until it expires.

Thank you,



Stormy Causey
CE Coordinator

APPENDIX D. AANP COPYRIGHT TRANSFER AGREEMENT



COPYRIGHT TRANSFER AGREEMENT

Date: Click here to enter a date. **Contributor name:** Andrea J. Middelstead

Contributor address: Click here to enter text. 3712 Taylor St. S., Fargo, ND 58104

Manuscript title (the "Contribution"): *Cultural Awareness and Provider Based Care for Refugee Women* for publication in the *AANP CE Center* published by the American Association of Nurse Practitioners (AANP) Education Department as an online, peer reviewed publication for the purpose of continuing education.

A. COPYRIGHT

1. In exchange for the AANP's efforts in reviewing, editing, and publishing the Contribution, the Contributor assigns to AANP, during the full term of copyright and any extensions or renewals, all copyright in and to the Contribution, and all rights therein, including but not limited to the right to publish, republish, transmit, sell, distribute and otherwise use the Contribution in whole or in part in electronic and print formats of the *AANP CE Center*. Continuing education materials are typically kept active for a minimum of two years and may be extended if contents remain appropriate.

2. Reproduction, posting, transmission or other distribution or use of the final Contribution in whole or in part in any medium by the Contributor as permitted by this Agreement requires a citation to the *AANP CE Center* and an appropriate credit to AANP, suitable in form and content as follows: (Title of Article, Contributor, AANP Title and Volume, Copyright © [year], Publisher). Links to the final article on the AANP website are encouraged where appropriate.

B. RETAINED RIGHTS

Notwithstanding the above, the Contributor or, if applicable, the Contributor's Employer, retains all proprietary rights other than copyright, such as patent rights, in any process, procedure or article of manufacture described in the Contribution.

C. PERMITTED USES BY CONTRIBUTOR

AANP licenses back to the Contributor the following rights: (1) excerpt the Work in other publications in lengths not to exceed one half of the total material; (2) reprint the Work upon prior written request to and approval by AANP; (3) make copies of the Work for use in classroom teaching or for internal distribution within the Author's place of employment; (4) reuse all or part of the Work in a book written by the Authors after the Work is published in the Compendium; and (5) present the Work orally at any function.

D. CONTRIBUTOR'S REPRESENTATIONS

The Contributors warrant that: (1) they are the rightful owners of all right, title, and interest in the Contribution and have the authority to transfer all right, title, and interest to AANP; (2) they possess the right to enter into this agreement and to submit the article for publication; (3) the article is an original work that has not been published elsewhere; and (4) the article is only submitted to the *AANP CE Center*.

All Contributors must sign below.

Contributor's signature:

Date: 1/8/2013

Type or print name and title: Andrea J. Nelson, DNP/FNP-Student, RN

Co-contributor's signature:

Date: 1/8/2013

Type or print name and title: Dr. Tina M Lundeen, DNP FNP-BC

APPENDIX E. PERMISSION TO REPRINT PURNELL'S MODEL FOR CULTURAL COMPETENCE

Larry Purnell [LPurnell@UDel.Edu]

Actions

To: Andrea Nelson

Dissertation II

Wednesday, December 05, 2012 1:18 PM

You replied on 12/7/2012 1:44 PM.

Absolutely no problem. You have permission to use the Model.

Larry Purnell PhD, RN, FAAN

Professor Emeritus, University of Delaware

Adjunct Professor, Florida International University

Consulting Faculty, Excelsior College

410-438-3826

----- Original message -----

Date: Wed, 5 Dec 2012 21:10:32 +0000

From: Andrea Nelson <Andrea.J.Nelson@my.ndsu.edu>

Subject: The Purnell Model for Cultural Competence

To: "lpurnell@udel.edu" <lpurnell@UDel.Edu>

Andrea Nelson

Sent Items

Wednesday, December 05, 2012 1:10 PM

Dr. Purnell,

I am a Doctor of Nursing Practice student at North Dakota State University. I am currently working on my dissertation entitled "Cultural Awareness and Provider Based Care for Refugee Women" and have been using your model as a guide to my educational module which, after review, will be displayed on the American Association of Nurse Practitioners Continuing Education Center. It allows Nurse Practitioners to view the educational program and obtain continuing education credit for maintenance of licensure and accreditation. I would like to obtain permission to discuss/use your model during my educational module if you would so allow.

Let me know your thoughts and if you would like any additional information.

Thank you for your time.

Andrea J. Middlestead, RN, BAN
Doctor of Nursing Practice Student
North Dakota State University
Andrea.J.Nelson@my.ndsu.edu
(701) 200-0288

APPENDIX F. EDUCATIONAL MODULE SCRIPT

- Slide 1: Welcome to Cultural Awareness and Provider Based Care for Refugee Women.
My name is Andrea Middlestead and I am a Doctor of Nursing Practice student at North Dakota State University. I am currently working on my Dissertation in conjunction with Dr. Tina Lundeen who is an Assistant Professor at North Dakota State University and the Chair and Principle Investigator of my Dissertation Committee.
- Slide 2: This educational module will take you approximately 1 hour to complete.
There are a few pretest questions to be completed prior to starting this educational module. Following completion, there is a short posttest and evaluation.
- Slide 3: This continuing education module is part of a Doctor of Nursing Practice Clinical Dissertation Project.
- Slide 4: This program will be submitted to the American Academy of Nurse Practitioners. This program was planned in accordance with AANP Continuing Education Standards and Policies and AANP Commercial Support Standards.
- Slide 5: In 1966, Martin Luther King Junior stated “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”
- Slide 6: Pretest
- Slide 7: Pretest
- Slide 8: The Learning objectives are to:
- State 3 items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice
 - Define cultural competence, culture, and cultural awareness
 - Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan.
- Slide 9: Why is it important that we focus on Cultural Awareness?
- (SPACE BAR) Despite being geographically displaced and exposed to a new health system, many refugees maintain their cultural and traditional health beliefs. Immigrant populations that are displaced in foreign countries experience changes in health and health practices contributing to health care disparities that may be difficult to address. Despite being geographically displaced and exposed to a new health system, many refugees maintain their cultural and traditional health beliefs that may contribute to disparities. Perceived and actual access barriers may result in adverse health consequences. Refugees are particularly vulnerable to multiple health risks. Health needs can be determined by “pre-migration circumstances and experiences, factors precipitating flight, differences in selection criteria, and the resettlement process including an often extended period of detention” (Vasey & Manderson, 2012, p. 49).
- (SPACE BAR) Traditional beliefs need to be incorporated in to the U.S. health system and employed by providers to diminish refugee health disparities. Article 25 of the Universal Declaration of Human Rights states that “health care is an essential right for everyone regardless of their social, cultural, and economic status” (United Nations Human Rights, 1948).

(SPACE BAR) Professional standards in education and practice require culturally competent care.

(SPACE BAR) Literature review demonstrates a need for improvement of cultural awareness within Nurse Practitioner education that stresses a deep understanding for clinical practice and coincides with a multicultural learning experience (Benkert, 2005). Unfortunately no studies were found which incorporated a multicultural learning experience that coincides with the educational process of nurse practitioner students.

(SPACE BAR) In addition to the Affordable Care Act, the CLAS or culturally and (SPACE BAR) Linguistically Appropriate Services has implemented 14 standards and which will be discussed in more detail later.

Slide 10: Professional standards in education and practice require culturally competent care. Providing culturally competent care requires that health care providers respond to individuals in a way that is sensitive to and respectful of culturally rooted ideas and behaviors in order to assess, diagnosis, treat, implement a plan, complete follow-up and evaluation of all patients (AANP, 2010; Benkert, Tanner, Guthrie, Oakley, & Pohl, 2005, p. 225).

The Nursing and National Priorities Partnerships' strategies include a goal to increase patient and family engagement that comprise honoring individuals including their differing cultural backgrounds, languages and social customs (Robert Wood Johnson Foundation, 2009). This should be a goal for all Providers.

Slide 11: Why should we incorporate cultural awareness during graduate education?

Continuing medical education (CME) plays an important leadership role as a call to action is implemented to disseminate cultural understanding (Like, 2011). The Liaison Committee on medical Educations (LCME's) and the Association of American Medical Colleges (AAMC) require all medical schools to have an integrated cultural competence component into the curriculum (Betancourt et al., 2005).

The Association of American Medical Colleges has mandatory diversity accreditation requirements (Betancourt et al., 2005).

There is a need for improvement of cultural awareness within nurse practitioner education that stresses a deep understanding for clinical practice and coincides with a multicultural learning experience. "Nurse practitioner programs may be too short in length to ensure competence; developing a provider group who seeks a lifelong discovery of cultural uniqueness and community justice may be a more realistic and an appropriate goal for Nurse Practitioner educators" (Benkert et al., 2005, p. 232).

In order to eliminate health care disparities, continuing education needs to be developed, implemented and evaluated with a focus on evidence-based, cultural competence and awareness, health promotion and prevention, diagnosis and treatment for patients from varying backgrounds throughout the life span (Like, 2011). In addition, the formation of educational programs should instill self-reflection, critical thinking and humility. The key word is ongoing or lifelong education.

Slide 12: (SPACE BAR) What is a disparity?

(SPACE BAR) It is a "Difference in access to or availability of facilities and services" (HSRIC, para. 1, 2012). Or a condition of being unequal (AHRQ, 2003). Health disparities disproportionately affect minority, ethnic and lower socioeconomic status individuals. We need to be aware of the barriers that exist that may prevent refugee populations from seeking care or continuing care after encountering the health system in the United States.

(SPACE BAR) Why are health care related disparities increasing?

(SPACE BAR) Often a combination of (SPACE BAR) impeding access, (SPACE BAR) insurance coverage, (SPACE BAR) poverty, (SPACE BAR) little to no social and cultural support and (SPACE BAR) difficulties understanding the health system. Refugee status, affordability, ability to speak English, beliefs, transportation, knowledge gap, and insurance all contribute to disparities in health care.

Numerous facilities lack the adequate resources and funding that allow refugees to properly communicate and discuss their health concerns. Lack of resources include: structural access, geographic barriers and access, time, variation in care, lack of female providers, fear of mistreatment, lack of translators, decreased level of comfort, and a perception of a lack of empathetic care (Carroll et al., 2007; Hess et al., 2010; Thierfelder et al., 2005).

Many refugees and immigrants fall between the cracks when dealing with health care in the United States as most are not familiar with the way that the system works. Depending upon the background of the refugee or immigrant group, they may prefer to have traditional medicine including shamans and medicine men rather than a primary care provider. As a provider, knowing what options are available to the population that one is working with is essential to providing continued and consistent care. Continuing to provide thorough education on prevention and care will continue to be essential lifelong and being aware of the cultures traditional treatments will augment traditional western medicine.

(SPACE BAR) The provider has a direct relationship on health outcomes of refugee and minority populations.

Health care in the United States should be a bridge that connects what a refugee woman is familiar with in regards to health care to how health care functions in the country of refuge. An effort to increase nurse practitioner education and cultural sensitivity about refugee cultures may contribute to the promotion of health and prevention of disease by creating an open forum within the newly settled community. It is often found to be difficult for providers to determine the cause, the diagnosis and the treatment as cultural beliefs influence refugee responses and interpretations of health and illness. Not all refugees exercise the same traditional health beliefs nor have they been acculturated to the same level; many have varying opinions when responding to questionnaires and interviews on personal and cultural practices. There is significant variation within each ethnic group meaning that diversity exists within diversity (Jenks, 2011; Parker, 2010). And culture is not static (Jenks, 2012) but we as health care providers need to identify how we can continue to create open communication despite the previously listed barriers.

Previous research demonstrates that comfort level of providers with cultural assessments is strongly linked with previous multicultural learning or life experiences; therefore experience is incorporated into practice.

Cultural identity is central and important for every individual but may influence them differently. "Defending that identity becomes especially important when the group has faced colonialism (as in Africa), when immigrants are faced with a stronger majority culture, and when change does not favor those holding social power" (Horowitz & Jackson, 1997). A woman's "lived experience" together with educational background, family heritage, cultural background, socioeconomic factors, work experiences, origins and individual characteristics influences how she will make decisions in regards to her and her families health.

Slide 13: The National Health Disparities Report lists 7 areas of improvement for all populations due to the following reasons:

1. Inequality in quality exists in health care as minorities and the financially poor may receive lower quality care

2. Inequalities pay both a personal and societal cost
3. There are differences in access to care that may contribute to overall quality
4. Preventative care opportunities are frequently missed
5. There is limited knowledge of why disparities exist and more research in this area is needed in order to develop plans and policies that may affect disparities
6. Improvement is needed and is possible if everyone plays a part in advocacy for patients, holds coworkers accountable and participates in ongoing education

Slide 14: The Patient Protection and Affordable Care Act will become a central component over the next 4 years in meeting provider cultural awareness and eliminating health care related disparities.

The goal of the Health Care Reform Bill in relation to minorities is to increase access, increase quality of care, and to decrease disparities (U.S. Department of Health, 2011). The Patient Protection and Affordable Care Act lists several provisions directly related to cultural competence and health care disparities, specifically addressing language services, community outreach and cultural competence training. Provisions place emphasis on the “development and evaluation of model cultural competence curricula, dissemination of cultural competence curricula through online clearinghouse, cultural competency training for primary care providers and home care aides, and collaborative research on topics including cultural competence” (Like, 2011, p. 197).

The Affordable Care Act mentions cultural competence 19 separate times in the document. According to Section 5208, the reform bill will authorize “grants for Nurse Managed Health Centers that provide comprehensive primary care or wellness services without regard to income or insurance status for patients” (American Nursing, 2011). As grants continue to become available, the ability of Advanced Practice Nurses (APRN) to provide care to all patients’ regardless cultural background or financial status increases. A provision of the bill includes \$200 million towards educating more Advanced Practice Nurses who will work in primary care and provide preventative care and management of chronic conditions, such as those associated with female circumcisions (American Nursing Association, 2011).

(SPACE BAR) The cultural competence movement has made provider education a priority going forth.

Slide 15: The Culturally and Linguistically Appropriate Services is a department within the Office of Minority Health. It addresses culturally competent care, language access services, and organizational support for services related to cultural competence.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. The CLAS has identified fourteen standards which are activities recommended by the Office of Minority Health for adoption as mandates by Federal, State, and national accrediting agencies that address inequities in current provisions of health care which will likely make services more responsive to consumer needs after conducting both a technical and policy literature review.

Current mandates include 4 standards which state that:

One. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. Two. Health care organizations must provide to patients or consumers information in the preferred language both by verbal offers and written notices informing them of their right to receive language assistance services. Three. Health care organizations must assure that competent language assistance is provided to limited English proficient patients or consumers by interpreters and

bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer). And Four. Health care organizations must make available and easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

The remaining 10 standards are guidelines and recommendations suggested by the Office of Minority Health for adoption by health care organizations. Newly revised and updated standards by CLAS should be coming out in 2012.

The Culturally and Linguistically Appropriate Services states that health care organizations should verify that all staff members at all levels and in all disciplines participate in ongoing continuing education that is based on educational learning principles, include pre and posttest evaluations and is conducted by appropriately trained individuals. Staff education and training may be the single most important area to assure cultural and linguistic competence.

What does this mean for practice? We need to keep our eyes open for continual changes regarding cultural competence at a national, organizational and individual level and remain up to date in our practice.

What is available for health care providers? Organizations like the Culturally and Linguistically Appropriate Services (CLAS), The Joint Commission, The National Committee for Quality Assurance and several others are encouraging and in some instances requiring development of clinical and organizational cultural competence training and implementation. We can monitor these sites to stay up to date. At the end of the presentation I provided a slide with websites that are useful for providing culturally competent care.

Slide 16: According to the 1951 United Nations Refugee Convention, a refugee is defined as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country." Asylum seekers have submitted a claim for refugee status and are waiting for this claim to be accepted or rejected. Refugees and Asylees comprise the majority of displaced persons resettled to the United States.

On the other hand, an Immigrant is an alien admitted to the United States as a lawful permanent resident. Permanent residents are also commonly referred to as immigrants; however, the Immigration and Nationality Act (INA) broadly defines an immigrant as any alien in the United States, except one legally admitted under specific nonimmigrant categories (INA, 2010).

Travel and technology have dramatically changed the idea of relocation for most of the world's citizens. These luxuries are not a choice but rather a necessity for those that live in countries where their landscapes have become playgrounds for war lords and corruption, leaving paths of devastation, persecution, death and destruction behind. Seeking refuge has become the only available option. With an ever-increasing change in diversity in the United States, cultural disparities in refugee health care continue to rise.

The United States is among the highest recipient of refugees in the world and allows up to 80,000 refugees into the country annually. In 2011, more than 56,000 refugees were admitted into the United States. Many refugees have been living in refugee camps for up to 10 years or more. In the US, ethnic minorities are projected to comprise 40% of the US population by 2035.

The state in which the refugee resides is "obligated to provide law abiding admitted refugees with many of the same rights and privileges that citizens enjoy, such as access to courts, the right to pursue gainful employment, public education, medical access, artistic expression, and the like"

Due to the large number of refugees in the United States, the focus of this presentation is on the 2011 refugee census.

Slide 17: This is the 2011 statistics on the top 10 refugee cultures arriving in the United States as reported by the Office of Immigration. It includes: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, The Democratic Republic of Congo, Ethiopia, and Afghanistan. Each of these cultures will be discussed in this program and include common and traditional health beliefs and practices in addition to women's specific health care after we develop an understanding of cultural awareness.

Slide 18: What is cultural competence?

Let's start with some basic definitions that will guide cultural understanding.

To fully understand cultural competence we need a rudimentary understanding of what both culture and competence are separately.

'Culture' refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups (California Endowment, 2002).

Where as

'Competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices and needs presented by patients and their communities" (California Endowment, 2002).

Cultural competence is defined as a set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations (California Endowment, 2002). It is the term used to describe how health care providers consider and understand how social and cultural factors influence an individual's health and attitude towards illness and disability. It is the process of obtaining cultural understanding and is not meant to be a onetime event but rather a continual evolution of learned behaviors and application of understanding. It can change the "one size fits all" health care system to meet the needs of a progressively diversified population (Betancourt et al., 2005).

"Cultural competence requires health care providers to make a shift from authority figure to learner in cross-cultural interactions" (Taylor, 2005, p. 137).

Clinical cultural competence is the ability of a health care provider to "communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds" (Betancourt & Green, 2010, p. 583).

Slide 19: Culture is an interplay of several variables including geography, race, religion, biology, sociology, language, religion and spirituality (Jacobs, 2012).

The Culturally and Linguistically Appropriate Services has expanded the definition of culture to include:

The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how information is received, how rights and protections are exercised, how health information is processed, how symptoms and problems are expressed, who should provide treatment for the problem and what the treatment should entail. Cultural issues are central in the delivery of health care due to the beliefs about nature, the human body and the disease process. With this understanding, providers can meet the unique needs and respond appropriately to cultures that may be different from the prevailing culture.

Culture is largely unconscious but has a powerful effect on health and illness (Purnell & Paulanka, 2008).

Slide 20: What is cultural awareness? Cultural awareness is the ability to understand one's own culture and perspective in addition to stereotypes and misconceptions with other or less known cultures (California Endowment, 2002).

It is an important step in improving culturally competent care and reducing health care related disparities.

Slide 21: In order to meet the multicultural health care needs of patients, practitioners should have a theory to follow to assist in learning. Cultural awareness is an ongoing process that incorporates numerous aspects at different times and places in an attempt to view the entire picture of a patient. Doctor Larry Purnell's Model for Cultural Competence is based on 19 assumptions that were derived from numerous theories and research. Purnell's Model is complex, much like cultural diversity and health care. The model's purpose is to provide a framework to learn concepts and characteristics, define individual circumstances, link culture relationships and characteristics, view individuals within unique ethnocultural environments and give a framework for reflection of human traits (Purnell and Paulanka, 2008). The diagram is represented by a circle with an outlying rim representing a global society, the second rim representing community, a third rim representing family, and an inner rim representing the person, each integral parts that affect a patient. The 12 pie-shaped wedges depict cultural domains and how they relate to one another. The domains are Overview and Heritage, Communication, Family roles and organization, Workforce, Biocultural ecology, High-risk behaviors, Nutrition, Pregnancy and childbearing practices, Death rituals, Spirituality, Health care practices and Health care practitioner concepts. The saw tooth line at the bottom of the diagram represents health care providers and organizations. The diagram is not a depiction of a single culture and should translate to all cultures and variations within a culture.

The framework can assist all disciplines in health care to provide holistic; culturally competent therapeutic interventions; health promotion and wellness, illness, disease, and injury prevention; health maintenance and restoration; and health teaching across all settings through inductive and deductive reasoning in each cultural domain (Purnell & Paulanka, 2008). Once cultural domain information is analyzed through a series of information gathering questions, health care providers can adopt, modify or reject health care interventions and treatments in a manner that continues to respect cultural differences (Purnell & Paulanka, 2008). An example of this would be if a provider was seeing a patient from Somalia for the first time. The provider would take into consideration how the refugee status and political situation in Somalia impacted the patients' migration by asking what the motivation was to come to the United States. The provider could explore aspects such as economic or political reasons and gather a deeper understanding of the transition period to take into account how this could influence current care perceptions. This would give the provider a general overview of the patients' journey. Next would be communication style such as dominant language, communication difficulties since transition, common expressions of thoughts, willingness to share personal information, amount of personal space needed, and so on. Communication is the most complex domain in Purnell's Model for Cultural competence but is one of the most essential in establishing patient rapport and will be discussed further on the next slide. Third would be deciphering familial roles and organization, such as gender roles, child rearing, and family priorities. How are these established within the culture or family unit? The next domain is workforce issues and establishing if language barriers, time orientation, gender roles or other factors contribute to a multicultural work environment. Distinguishing Biocultural factors such as more common diseases and health conditions within the Somali population would help guide assessment and history data and provide clues to possible illness causes. Does the patient part-take in high risk behaviors including tobacco, alcohol, and unsafe sex practices? Are there any typical health seeking behaviors within the culture? For the domain of Nutrition, important inquiries include the meaning of food, common preparations, rituals or dietary practices used for health and illness. Explore cultural views on pregnancy and fertility, contraception,

prenatal and postpartum periods and gender roles during pregnancy. If death occurs, what are common terms and why are they used? Are there specific death rituals? The domain of Spirituality includes all behaviors that give meaning to life. Request information regarding religious association, the use of prayer, meditation and what gives the Somali patient strength and meaning. The remaining two domains are health care practices and practitioners. Ask about beliefs that influence promotion or prevention of health care practices? What are common responses to pain or mental illness? Does the Somali patient utilize traditional medicine? What do they view as barriers to health care? Explore health care provider perceptions within the culture and/or acceptance of health care providers... and so on (Purnell & Paulanka, 2008).

In working with refugee populations, service providers must understand both the culture of the individual's country of origin and the immigration experience. Purnell's Model provides an in-depth view of how culture specifically influences each aspect of health care and displays the importance for health care providers to determine how those factors impact patient outcomes. The domain of communication is multifaceted and will be discussed in further detail in the following 3 slides.

Slide 22: How do we as Nurse Practitioners Promote Cultural Awareness within our practice?

I think that it is important to discuss Arthur Kleinman's eight questions as it is a modified patient-centered approach to determine cultural influences on patient illnesses. As shown here they include: What do you think caused the problem? Why do you think it happened when it did? What do you think your sickness does to you? How does it work? How severe is your sickness? Will it have a short course? What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment? What are the chief problems your sickness has caused for you? What do you fear most about your sickness? Each question strives to give a provider a better understanding of cultural influences on illness and the disease process as perceived by the refugee.

These eight simple questions can be easily remembered and applied into everyday practice. They may assist in the discovery of the complex cultural dynamics of Purnell's Model for Cultural Competence.

Slide 23: Let's put Purnell's Model into practice.

To continue with Purnell's Model for Cultural Competence, I would like to expand upon the domain of communication by providing guidelines for communicating with non-English speaking patients. Use trained interpreters who are able to decode wording and provide meaning to a message. Attempt to use dialect-specific interpreters that are trained in the field of health care to increase understanding by all parties. Avoid medical terms as much as possible and use lay or common terms that are culturally specific when known. Stay away from using family members or children for translation. When using an interpreter, allow the patient and interpreter time alone in order to accommodate for level of comfort. Use the same gendered interpreters and one that is older than the patient whenever possible. If the interpreter is present in the room rather than through a phone, maintain eye contact with both the patient and the interpreter to elicit nonverbal feedback and read nonverbal cues. It is okay to speak slowly and allow time for translation but avoid exaggerating words during pronunciation. Try to ask one question at a time. If you know words in the patients' language, use them. Use your resources such as nonverbal communication, charts, and pictures. During a physical assessment, maintain eye contact with the patient, not the interpreter. Always be cautious as interpreters may relay their own meanings or ideas regarding the patient's response. More often than not, patients can understand more information than they can express by reading your body language. Finally, summarize your understanding with the patient and interpreter at the end of the visit.

As we improve cultural awareness and rapport with refugee patients, we may hope to begin to practice cultural brokering. Cultural brokers need to have developed the trust and respect of the community, have knowledge regarding beliefs, customs and traditions and have experience with navigating health care and support systems within the community (Georgetown, 2001). No formal education or certification is required to act in this role but the community typically appoints a person to fulfill this liaison role. Cultural brokering consists of compromising, negotiating, developing conflict resolution and mutual understanding, in addition to creating a plan that works towards mutually decided upon goals. We use the concepts of brokering in our daily practice whether or not we are aware of it. Here is it important to adjust the concepts to be culturally sensitive towards the refugee patient.

Slide 24: What can we do as primary care providers? (SPACE BAR) We can increase our own understanding in language, customs, values, and beliefs about illnesses. (SPACE BAR) We can adapt our approaches to include cultural awareness as discussed previously. (SPACE BAR) We can continue to increase understanding in cultural norms and practices through ongoing education. (SPACE BAR) We can anticipate contextual situations and dynamic backgrounds (such as financing and insurance coverage) that influence access to care for refugee populations. And we (SPACE BAR) recognize our own cultural practices and beliefs and how they affect the care that we provide for our patients.

Research has demonstrated the need for a holistic approach, a partnership in practice that focuses on cultural competence, an increase in personal connections with patients and cultural brokering which are unique to the Nurse Practitioner profession (Matteliano & Street, 2012). We need to obtain the privilege of cultural brokering and partner with patients in order to reach mutually developed goals. Literature demonstrated that Nurse Practitioners identified additional ways to develop cultural brokering including going beyond the call of duty, developing altruistic motivation, probing for root causes, and advocating for patients while incorporating a culturally sensitive approach (Matteliano & Street, 2012).

When professionals did not match the cultural characteristics that distinguished them from their patients, insights from personal and professional socialization aided in developing trustful and sustained relationships with their patients over time (Matteliano & Street, 2012).

Slide 25: Now we will discuss each of the top 10 Refugee cultures that entered the United States in 2011 separately.

Slide 26: Burma

Burma, also called Myanmar, is largely comprised of two ethnic groups: the Karen and the Chin. Burma has been oppressed by a military regime since 1962 and it is amongst the poorest countries in the world. Both health care and school systems have collapsed leading to numerous Burmese seeking refuge.

Slide 27: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Children choose who they would like to marry but a mediator may be used for matchmaking. (SPACE BAR) Men and women do not touch in public settings. Men tend to carry all authority. Women take care of daily chores with the assistance of female children and unmarried sisters.

(SPACE BAR) Parents are considered sacred within the community. It is not uncommon to have married children continue to live with their parents.

(SPACE BAR) It is disrespectful to sit above or at the level of an elder so in an exam room it may be easier to have the patient sit on the exam table while the provider is seated on a chair. Pointing fingers is highly disrespectful, be cautious of this during your exam. Direct eye contact may be considered impolite. The head is sacred and should never be touched; ask permission

prior to placing your hands on a Burmese head. Burmese are more conscious of the person they are with than of time and take life as it comes rather than planning ahead so it is not uncommon for Burmese to be late to a scheduled appointment.

(SPACE BAR) Seventy to 90% of Myanmar are Buddhist who view health as harmony between fire, air, water, and earth. (SPACE BAR) Illnesses are viewed as an imbalance of these 4 factors or due to black magic or spells. Traditional medicine includes medicine from India, a dietary system based on the planets, massage and herbal medicines.

Health care providers are seen as having a high social status and patients are unlikely to ask questions or express dissatisfaction with prescribed treatments. Providers should use open-ended questions when inquiring further detail or explanation from Burmese patients. Burmese patients tend to be polite and modest but sometimes to the extreme by answering questions the way they think you would want the question answered, be cautious of this.

Slide 28: Health care specific to Burmese women include the following:

(SPACE BAR) Amount of menstrual flow is equated to health status, the heavier the flow the healthier the woman is.

(SPACE BAR) Women are highly admired during pregnancy, unless it is outside of marriage. Prenatal and Neonatal care is well-recognized.

(SPACE BAR) Women in Thai Refugee camps have had to undergo forced sterilization after delivery and prefer home delivery due to fear of this. Most women view hospital deliveries as shameful due to the lack of modesty and presence of male staff and prefer home births. Women who have given birth in United Nations hospitals prior to coming to the United States do not mention choosing home births over hospital births. (SPACE BAR) After delivery, the mother and newborn are placed in seclusion for up to 1 month. (SPACE BAR) Children are typically breast fed up to 3 years of age.

(SPACE BAR) The option of birth control has increased in interest but is difficult to discuss as it is considered an uncomfortable subject. When used, Burmese women prefer natural methods such as lactational amenorrhea.

Slide 29: Bhutan

Human rights violations, torture, imprisonment, and detention without trial since the early 1990's has led to a humanitarian crisis. Numerous Bhutanese have been denied citizenship and placed in Nepalese refugee camps after being forced out of the country. Less than 65% of Bhutanese have access to health care. The leading causes of death include dysentery, diarrhea, respiratory illnesses, malaria and parasitic infections.

Slide 30: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Practices vary based on region, religion and economic status. Most Bhutanese are either Hindu or Buddhist in religious practices.

(SPACE BAR) Homes consist of family members from several generations. Polygamy is not common but is practiced in Bhutan and marriages are typically arranged. Women tend to have less influence on decision making and have less access to information and resources than their male counterparts. (SPACE BAR) Gender roles are clearly defined with women largely taking care of household chores.

(SPACE BAR) Illness is seen as an imbalance of passion or the presence of an evil spirit within a person. (SPACE BAR) Often the use of several remedies and the advice of traditional healers

are sought prior to utilizing western medicine. Traditional healers attempt to restore balance through incantations, reading rice and prescribing a special diet. Animal sacrifice occurs during festivities and marriages. Spices such as Basil, Garlic, turmeric, ginger, and cardamom are used to treat common illnesses.

(SPACE BAR) The idea of preventative medicine is not a common practice. Most Bhutanese will need to know that a provider understands and does not condemn traditional health practices prior to sharing what has been done prior to seeking Western medicine. Western medicine is not usually considered as an option until an illness is severe.

(SPACE BAR) Common health concerns include malnutrition, depression and reproductive or women's health care.

Slide 31: Women's health concerns include the following:

(SPACE BAR) Prenatal care is often not obtained due to inadequate access, though for women living in refugee camps, prenatal care is required.

(SPACE BAR) Childbirth is preferred in a hospital with western technology if accessible otherwise home birth with or without a midwife is common practice (maxim, 2010). Infant mortality is high at 118 deaths per 1,000 live births.

(SPACE BAR) After delivery, the mother's focus is on the newborn and bedrest. No household activities are performed during this 11 day period. After the 11th day, a naming ritual is performed and the mother returns to work. It has been common practice for the mother to leave the infant at home alone while she went to work. (SPACE BAR) Infants are breastfed for the first six months and then cow's milk and solid food, such as rice, is introduced.

(SPACE BAR) Contraception is common and widely accepted.

Slide 32: Iraq

Since the early 1980's, Iraq has been in turmoil. Oppression, political and economic sanctions have led to a humanitarian crisis with the displacement of more than 4.2 million people. Only ten to 15% of Iraqis have had access to adequate health care. A high number of physician kidnappings and homicides have led to the remaining providers fleeing for protection of their own lives.

Slide 33: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Iraq is comprised of several ethnic and religious communities. Islam is the religion practiced by more than 97% of Iraqis and the majority of citizens classify themselves as Iraqi Arabs. Ramadan typically starts in July and lasts for 30 days; all Muslims are expected to fast except for pregnant and lactating women (Jewish, 2006). Muslims may refuse to take medications during Ramadan. Iraqi Arabs will be the focus of the following 2 slides.

(SPACE BAR) Family is the center of this patriarchal life. The father makes all decisions. Family life is very private and women often have little to no interaction with others outside of their family unit. Protection of women is a central component in the Islamic faith. Women from upper class families have access to education and can maintain a career outside of the home. Marriages are often still arranged but do not have to be. Men may have up to 4 wives but must support each wife equally. Polygamy is a common practice but is being outlawed in some areas of Iraq.

(SPACE BAR) Iraqis may refuse health care by someone of the opposite sex as they tend to be modest.

(SPACE BAR) Conservative Iraqi Muslims may avoid preventative health care due to the belief that God has predetermined an individual's lifespan. Medical decisions are typically discussed with family members prior to making a final plan.

(SPACE BAR) Traditional health remedies include cures and treatments for common conditions.

Slide 34: (SPACE BAR) Birth control is not practiced in Iraq as it is viewed as an interference with the Islam law.

(SPACE BAR) During pregnancy, the woman of the house is relieved of typical household duties as they are taken care of by other female household members. (SPACE BAR) Sonograms during pregnancy may be refused due to the belief that determining the sex of the child pre-birth is against God's will. (SPACE BAR) Minimal prenatal care is provided and midwives typically help women deliver at home. Boys are circumcised within the first few days of birth and girl's ears are pierced at one week.

(SPACE BAR) Breastfeeding is very common for up to one year.

Slide 35: Somalia

In the 18th century, Italians colonized and enslaved Somalia. In the 1930's emancipation was obtained but in the 1990's, a civil war began and has continued. Somalis are the largest population that have been granted asylum in U.S. history.

Slide 36: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Faith has a highly significant influence on day to day activities and most Somali practice Islam. Family is central in Somali beliefs and practices.

(SPACE BAR) Marriages can be arranged or based on personal choice. Polygamy again is a common practice as long as the husband is able to support each wife. (SPACE BAR) There is a strict separation of the sexes. Men are the head of the household. Women care for the children, complete household chores, and manage the finances. More and more, women are working outside of the home but this becomes difficult in a foreign country due to lack of family support. (SPACE BAR) Women are required to cover their bodies when in public.

(SPACE BAR) Health care is treated as a legacy, one that incorporates traditional prayer, religious ceremonies, spirits, herbal medicines, various foods and home remedies.

(SPACE BAR) Illness is caused from The Evil Eye or bad spirits. Mental illness is thought to be brought on to an individual by one's bad behaviors directed towards God or evil spirits.

(SPACE BAR) Traditional healers are consulted for any and all health concerns. When seeking western medical care, Somali expect to receive a medication for every illness. Somali prefer a health care provider that is of the same sex.

(SPACE BAR) Preventative medicine is an unfamiliar concept and adherence to it typically low as most Somali are not familiar with the idea of preventative care.

Slide 37: (SPACE BAR) Most Somali women have little or no experience with preventative health care prior to their arrival in the United States.

(SPACE BAR) It is important to discuss female circumcisions as it impacts women's health care. The World Health Organization defines all "procedures that intentionally alter or injure female genital organs for non-medical reasons" as female genital mutilation (FGM) and thus the act and/or procedure will be referred to with this term throughout this educational module (WHO,

2010a). FGM has been linked to cultural factors such as tradition, religion, economics and ethnic identity. FGM is believed to have been developed as a means to control fertility and depending upon the source is or is not directly linked to religious beliefs and practices. The World Health Organization additionally states that FGM is performed to reduce libido, prevent illicit premarital sexual intercourse, and maintain cultural ideals of femininity and social pressures to conform to one's cultural society's beliefs and practices. In Somalia, FGM is related to both gender identity and virginity. FGM is widely practiced today in numerous cultures including Algeria, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Cote d'Ivoire, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Libya, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Republic of the Congo, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Tanzania, Togo, Uganda, Zaire and Zimbabwe.

Some Somali women may be hesitant to state their medical concerns to a provider who does not understand their culture and is not of the same gender; negative reactions from providers about FGM will only deter the relationship building process.

(SPACE BAR) Prenatal care is not a common practice as most Somali women do not view it as necessary if the pregnancy is going according to plan. (SPACE BAR) Pregnancy enhances a Somali woman's status and begins at an early age, as early as 14 in some cases. The more children that a Somali woman bears, the higher her status becomes. (SPACE BAR) Deliveries traditionally take place at home with a midwife. (SPACE BAR) After delivery, the mother and child remain indoors for 40 days to prevent the Evil Eye from seeing the infant and mother leading to poor health. (SPACE BAR) Children are often breast fed up to 2 years of age.

(SPACE BAR) Contraception is only viewed as acceptable if the woman has a serious health risk related to pregnancy.

Slide 38: Cuba

Fidel Castro gained control of the Cuban government in 1959 and Cubans have fled since that time period.

Slide 39: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Cuban culture is difficult to define due to the extreme variations of class, ethnicity and rural or urban upbringing.

(SPACE BAR) Most Cubans come from a large extended family but due to immigration, the nuclear family is considered the basic support system. Men are usually dominant though Cuban women can be outspoken in both private and public settings.

(SPACE BAR) Direct eye contact is common in all interactions.

(SPACE BAR) Health care is provided to every individual in Cuba free of cost but due to a shortage of medications, unfortunate diet and other confounding factors, most chronic diseases have been left untreated. Upon arriving in the United States, most Cubans have a difficult adjustment due to the change in required payments for health care and the change in provider/patient relationship. Providers are highly regarded in Cuba and typically direct all health care measures and treatments whereas in the United States, providers and patients partner together to improve health.

Health is viewed as a sense of well-being, freedom from discomfort, and a robust appearance. The mind, body and spirit are entwined. (SPACE BAR) Obesity is seen as an indication of good health.

(SPACE BAR) Spirituality and faith are typically merged as a potential cause of illness and is utilized as an overriding treatment.

(SPACE BAR) If a terminal diagnosis is expected, traditionally family is informed prior to the patient.

Slide 40: (SPACE BAR) Pregnant women are expected to remain in doors to avoid exertion and evade contact of others that have deformities or other health related illnesses. They are protected from any negative conversation that has the potential to increase undue stress. In the past due to strong religious beliefs regarding contraception and premarital sex, women had abortions as a means of birth control.

(SPACE BAR) Traditionally, the husband is not present at childbirth but the woman's mother is involved in the labor and delivery process. (SPACE BAR) After childbirth, women and children are to remain in the home for 41 days due to the belief of susceptibility to supernatural illnesses. The woman's mother and other female members of the family are expected to care for the woman and her child during this time frame.

(SPACE BAR) Most Cuban mothers' breastfeed the infant and believe in the practice of circumcision.

Slide 41: Eritrea and Ethiopia will be discussed as a single culture due to their long history of ruling by a single government and similar health beliefs and practices.

The government was overthrown in the 1970's by an oppressive regime which has maintained control since that time. In 1962, Ethiopia annexed Eritrea but the countries remain economically underdeveloped and ruled by a few large landlords that face annual flooding and fighting with neighboring Somalia. Most seek refuge due to political reasons. There is generally little access to medical care and private health care can be very expensive.

Slide 42: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Eritreans and Ethiopians live in extended patriarchal families. Men make most if not all decisions and are considered the providers of the family unit. (SPACE BAR) Marriages are usually arranged by the bride's and groom's families. Women take care of household tasks and are considered to be subordinate to their husbands.

(SPACE BAR) Most Cubans tend to be soft spoken but with direct communication and if translation is needed, preference for someone from their ethnic group is preferred.

(SPACE BAR) Health is seen as an equilibrium between body, the outside world and the supernatural world. A lack of balance or angering God can lead to illness.

(SPACE BAR) Treatments include: herbal medicines, prayer and spiritual healing. Medications are highly regarded with injections seen as providing greater therapeutic effect than oral medications and most Eritreans and Ethiopians are dissatisfied if no medication is given when seen by a provider.

(SPACE BAR) Providers are expected to know and educate patients on what is best for the patient at each visit. A poor prognosis or terminal illness is preferred to be relayed to a male family member first as this traumatic news needs to be told with care to protect the patient's mental health.

Slide 43: (SPACE BAR) Female circumcision is a common practice in both Eritrea and Ethiopia.

(SPACE BAR) Sexual health and education traditionally has not been discussed but is becoming a common practice within school settings.

(SPACE BAR) Knowledge and use of family planning is very limited in Ethiopia and is considered a taboo subject to discuss openly but most see the benefit of having a smaller family size. Contraception is not typically available in Ethiopia. Whereas Eritrean women are familiar with and practice birth control. It is widely promoted by the Eritrean government in addition to sex education, sexually transmitted diseases and circumcisions. Breastfeeding often serves as a form of natural birth control for both Ethiopian and Eritrean women.

(SPACE BAR) Pregnancy is not openly discussed until the woman is noticeably showing and (SPACE BAR) prenatal care does not occur until that time. Pregnancy is believed to create an increased risk of susceptibility for disease to both the mother and the fetus. (SPACE BAR) Most Eritrea and Ethiopian women reject the infant prior to delivery to prepare for the pain and discomfort caused by delivery. Women prefer to have female providers deliver their children and traditionally deliver at home with a midwife. (SPACE BAR) Post-delivery, mother and child remain in the home for two to six weeks and often up to six months to accommodate for breast feeding.

(SPACE BAR) Breast feeding is common for up to 2 years of age with a push to introduce solid foods at four months of age.

Slide 44: Iran

In 1979, what is now referred to as 'The Revolution' began where a series of public protests ensued to overthrow the Pahlavi dynasty. Iranian rulers liquidated agricultural and industrial assets placing the profit into their own pockets with violent enforcement to silence any protest movements. Life expectancy is seventy years of age and health care in Iran is considered generally very good.

Slide 45: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Iranian children are considered a blessing and a top priority life task for Iranians. Often the relationship between a parent and child is stronger than the relationship between parents. Older children assist the mother in raising younger siblings.

(SPACE BAR) Men and women do not communicate in public settings despite women playing a large role in Iranian society. Men and women dress modestly to avoid sexual desires. Men traditionally are sensitive, artistic and aware of aesthetic appearances whereas women are emotionally distant and detached. Crying in public is viewed as normal by either sex and affection in public between the same sex is common. Affection between members of the opposite sex is never shown except for between family members. Women may be permitted to work if their husband gives approval.

(SPACE BAR) Marriages are arranged by the woman of the house whereas the father is the disciplinarian. Men may have up to 4 wives.

(SPACE BAR) Most Iranians practice the Muslim religion with approximately 90% being Shiite Muslim and 8% being Sunni Muslim. There are distinctions in the variations and strictness of practice.

(SPACE BAR) Cleanliness of the body and soul is highly valued.

(SPACE BAR) Iranians prefer to work with health care providers of their same gender. Treatment of an illness is not considered complete unless a medication has been prescribed. During Ramadan, medications may only be taken at night. A folk health belief views a need to balance

blood, phlegm, yellow and black bile. This balance is created through the ingestion of hot and cold foods. Very little information exists related to Iranian health, traditional health belief and practices and women's health care. More research is needed in this area.

Slide 46: (SPACE BAR) Iranian women often state that they feel pressured to be beautiful and many wear a large amount of makeup or undergo plastic surgery to meet this societal standard.

(SPACE BAR) Infant mortality remains high at 29 per 1000 births.

(SPACE BAR) Breastfeeding is expected by all new mothers in order to prevent children from being remorseless in the future.

(SPACE BAR) Contraception is allowed if a medical reason exists. Abortions are not permitted and tubal ligations are considered to be undesirable.

Slide 47: Democratic Republic of Congo

Formerly called Zaire, the Democratic Republic of Congo has 62 million people from 200 varying ethnic groups. In 1998, a violent civil war erupted that ended in 2003, just one in a very violent history. It continues to be in turmoil due to continued control by rebel forces forcing approximately 3.6 million Congolese to abandon their home. The United Nations has called the Democratic Republic of Congo one of the world's largest humanitarian disasters.

Malaria remains the highest cause of death and life expectancy is only 49 years of age.

Sexual violence and rape have been used as a weapon of war by both rebels and soldiers. Rape, deliberate infection with HIV/AIDS, abduction and sexual slavery has been widely reported.

Most hospital facilities are considered inadequate for care, with numerous hospitals being closed due to lack of funding or wartime conditions. The health care system is considered to be the poorest in the world.

Slide 48: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Marriages traditionally are arranged but is becoming less common (Department of Immigration, 2006). Children are seen as a sign of prosperity and family size can be quite large. Families tend to live with extended family members. Polygamy is illegal but commonly practiced.

(SPACE BAR) Men are the providers and women complete domestic housework. Women's legal rights are quite limited not allowing a married woman to open a bank account, obtain a passport or rent or sell property without her husband's permission.

(SPACE BAR) Women are regarded differently based on area of residence. Freedom and social norms are typically restricted. Domestic violence is common in this patriarchal society and women tend to view it as an "extension of male authority."

(SPACE BAR) A good appetite and being well fed signifies health. Appearance and living conditions dictates Congolese social health status.

(SPACE BAR) Medications can be found in local pharmacies and markets without prescriptions. Often a Congolese will self-diagnosis and seek self-deemed 'appropriate' treatment including antibiotics for illnesses.

(SPACE BAR) Illnesses that are not immediately symptomatic do not create a cause for concern and rarely is medical attention sought in these circumstances. Only after an unusual or prolonged course of symptoms is medical attention pursued. Congolese are used to paying for

services prior to an appointment or procedure. The cause of illness is expected to be identified and treated with intravenous or intramuscular medication at the time of service. If a cause cannot be found, (SPACE BAR) a spiritual healer is consulted who confirms a supernatural cause and herbs, plants and prayer are used to cure the ailing patient. Physical and mental illness are thought to be caused by natural causes, a curse or punishment from God. There is considerable resistance to accepting help with mental illness as it is viewed as a curse. There is a strong belief that talking about a disease will cause a person to develop the disease, thus discussions regarding health promotion and prevention are often avoided.

(SPACE BAR) Sexual relations are considered a taboo topic and a strong unwillingness to discuss sexual health exists. Sexual intercourse prior to marriage is considered a sin, but depending upon the tribe it may be viewed as acceptable for men to participate in sexual relations prior to marriage.

No preference has been demonstrated as to the sex of the provider.

Slide 49: (SPACE BAR) FGM is a common practice by Congolese.

(SPACE BAR) Teenage pregnancy is extremely common and maternal death rates continue to be high due to a lack of prenatal care. Death during childbirth is thought to be approximately three times higher in Congo than other areas of Africa.

(SPACE BAR) Women choose to deliver in available hospitals. Cesarean sections are viewed as a failure of the woman and avoided at all costs. Infant mortality rate is 94.5/1,000 live births. Males are circumcised within three weeks of delivery and only five percent of females are circumcised after delivery.

(SPACE BAR) The mother is expected to rest for up to 3 months after delivery and the family provides support in that time frame.

(SPACE BAR) Contraception, though available, is not typically used due to the belief that children are a gift from God and utilizing contraception is a selfish act. When employed, natural methods are utilized. The fertility rate is estimated to be around 6.5 children per woman.

Slide 50: Afghanistan

Afghanistan is a tribal based society. In the 20th century, Afghanistan established its' independence but was not able to become politically stable as the Taliban had control of the country and enforced strict Islamic practice until 2001. The United States declared war on terrorists and began to attack Afghanistan terrorist groups. There was high civilian loss and numerous Afghans were forced to seek refuge as the country attempted to recreate political stability. Life expectancy is only 46 years of age.

Slide 51: Common Cultural Beliefs and Practices include the following:

(SPACE BAR) Tribal affiliations are used for societal organization. (SPACE BAR) Afghanistan is a patriarchal society. Most live in extended family units often due to polygamy as men are allowed to have more than one wife as long as they are able to support each wife and family. Men may have up to 4 wives, though most Afghani men cannot support more than 1 wife. Marriages are arranged but each family has variations on how much input the potential candidate may have.

(SPACE BAR) Women have less freedom than their male counterparts. Women tend to care for the children and are overseen by the grandmothers for domestic chores.

Generally, Afghani women have adapted to the United States and are able to work and contribute to the familial income. Men often suffer from a loss of leadership due to wives working and children becoming a crutch for translation in a country of foreign language. Family life is considered private and most Afghani will not share concerns with health care providers.

(SPACE BAR) Most Afghans practice the Islamic faith.

(SPACE BAR) Due to limited access to public health care and Taliban enforcement preventing female health care providers to practice, traditional health practices are employed for almost all illnesses. There is a balance between hot and cold that needs to be maintained as an unbalance can lead to illness. Health is viewed to require regular exercise, fresh food and a balanced diet, keeping the body warm and getting enough rest. Home remedies include herbs and roots. Most Afghans do not trust the United States health care system stating that it relies too much on technology.

(SPACE BAR) Following Islamic law can prevent most common illnesses as it stresses cleanliness and personal hygiene.

(SPACE BAR) Unnatural illnesses are seen as due to evil spirits and can only be treated by a curing ritual.

(SPACE BAR) Health care decisions are made with the involvement of all family members with particular emphasis towards the elders.

Slide 52: (SPACE BAR) During Ramadan, pregnant and lactating women do not participate in fasting.

(SPACE BAR) Less than 14% of women receive prenatal care due to a lack of access.

(SPACE BAR) One in 6 women die during childbirth. In 2005, maternal mortality in four Afghan provinces ranked 130 times higher than the United States, with a reported 50 to 70 mothers dying every day from complications at birth.

(SPACE BAR) Most Afghani women are not comfortable having a male provider but are receptive to health education. Contraception methods include the rhythm method and coitus interruptus as long as both the husband and the wife are agreeable to the same method. Alternative forms of birth control are acceptable if there is a medical reason to not become pregnant.

Slide 53: Recommendations for practice include:

Inquire about the cultures from our patient population in order to address their needs from a holistic and culturally aware perspective.

Recognize our own ethnocentricity, making sure that it does not influence patient assessment and treatment.

Inquire about traditional health care practices and beliefs that are employed by our patients and attempt to incorporate them into the treatment plan by using Purnell's Model for Cultural Competence and Arthur Kleinman's eight questions.

Protect modesty and cultural beliefs of each individual as able.

Provide culturally appropriate assessments that are individualized for each culture and patient.

Create a culture of understanding within organizations, hold others accountable, and help in the promotion of culturally sensitive care.

Slide 54: In conclusion:

We need to continually increase cultural awareness of all populations to provide quality patient care that incorporates traditional and biomedical approaches with the hopes to diminish health care related disparities.

I Hope that the information discussed today will assist in opening communication lines with all refugee patients by providing background information and guidelines to support a culturally sensitive approach to patient care.

Slide 55: Here I have provided some beneficial websites for practice that address culturally competent care. They are also included in your PowerPoint printout.

Center for Disease Control and Prevention:

<http://www.cdc.gov/immigrantrefugeehealth/about-refugees.html>

Ethnomed:

<http://ethnomed.org/>

Office of Minority Health:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

The World Health Organization:

<http://www.who.int/en/>

The United Nations Refugee Agency:

<http://www.unhcr.org/pages/49c3646c2.html>

Cultural Orientation Resource Center:

<http://www.culturalorientation.net/>

Slide 56: If you have any questions please feel free to contact me. Thank you for your time.

Slide 57: Credits and Acknowledgements

Slide 58: References

APPENDIX G. EDUCATIONAL MODULE POWERPOINT HANDOUT


12/12/2012

Cultural Awareness and
Provider Based Care for
Refugee Women

Andrea J. Middlestead, RN, BAN
North Dakota State University
Doctor of Nursing Practice Student

Details

- ✦ This educational module will take you approximately 1 hour to complete.
- ✦ There are a few pretest questions to be completed prior to starting this educational module. Following completion, there is a short posttest and evaluation.



Disclosures

This continuing education module is part of a Doctor of Nursing Practice Clinical Disquisition Project

Accreditation Statement

✦ This program will be submitted to the American Academy of Nurse Practitioners. This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standard

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane”

- Martin Luther King Jr.
1966

Learning Objectives

1. State at least 3 items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice
2. Define cultural competence, culture, and cultural awareness
3. Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan

Cultural Awareness

- ✦ Cultural and traditional health beliefs
- ✦ U.S. health care system
- ✦ Professional standards
- ✦ Nurse Practitioner education
- ✦ Patient Protection and Affordable Care Act (ACA)
- ✦ Culturally and Linguistically Appropriate Service Standards (CLAS)


Professional Standards of Care

1. Culturally competent care
2. The Nursing and National Priorities Partnerships

Nurse Practitioner Education

PAR AVION

- Cultural awareness
- Duration of graduate education
- Continuing education



Cultural Health Disparities


- + What is the definition of Disparity?
 - + A condition of being unequal
- + What contributes to a healthcare disparity?
 - + Poor access
 - + Inadequate insurance coverage
 - + Poverty
 - + Lack of social/cultural support
 - + Limited understanding the healthcare system
 - + Provider ineffectiveness

Improvement Needed

- + The National Health Disparities Report:
 - + *7 areas of improvement for all populations:*
 - + Inequality in quality exists
 - + Personal and societal costs
 - + Quality affected by differences in access
 - + Missed preventative care opportunities
 - + Gaps in knowledge
 - + Improvements are possible!
 - + Additional research is needed


Patient Protection and Affordable Care Act

- + **Emphasis on:**
 - + Development and evaluation of model cultural competence curricula
 - + Dissemination of cultural competence curricula through online clearinghouse
 - + Cultural competency training for primary care providers and home care aides
 - + Collaborative research on topics including cultural competence
- + *The cultural competence movement has made provider education a priority*



Culturally and Linguistically Appropriate Services (CLAS)

- ✦ Support for cultural competence education....
- ✦ What does this mean for nurse practitioner practice?



United States Refugee and Immigrant History




Table 3. Refugee Arrivals by Country of Nationality: 2011

Country of Nationality	Number	Percentage
Total	56,384	100
Burma	16,972	30.1
Bhutan	14,999	26.6
Iraq	9,388	16.7
Somalia	3,161	5.6
Cuba	2,920	5.2
Eritrea	2,032	3.6
Iran	2,032	3.6
Democratic Republic of Congo	977	1.7
Ethiopia	560	1.0
Afghanistan	428	0.8
All other countries including unknown	2,915	5.2

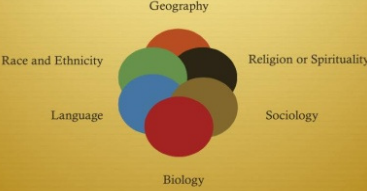
Martin, D.C. & Yankay, J.E. (2012, May). Refugees and Asylees: 2011. DHS Office of Immigration Statistics. Annual Flow Report.



Cultural Competence

“Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations”
(California Endowment, 2002)

Culture



Geography

Race and Ethnicity

Religion or Spirituality

Language


Sociology

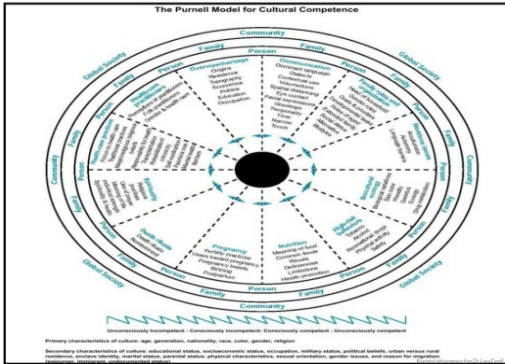
Biology

Jacobs, C. G. (2012). National Standards for Culturally and Linguistically Appropriate Services in Health Care: Ensuring Quality Health Care for All.

Cultural Awareness

“Ability to understand one's own culture and perspective in addition to stereotypes and misconceptions with other or less known cultures” (California Endowment, 2002)





How do we Promote Cultural Awareness?

◆ The Kleinman Questions:

1. What do you think caused the problem?
2. Why do you think it happened when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a short course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

Putting Cultural Awareness into Practice

<p>◆ Tips for Communication</p> <ul style="list-style-type: none"> + Interpreters + Time + Gender + Eye Contact + Speech + Summary 	<p>◆ Cultural Brokering</p> <ul style="list-style-type: none"> + Compromise + Negotiate + Find conflict resolution + Develop mutual understanding + Create a plan
--	--

Putting Cultural Awareness into Practice

- + Recognize language, customs, values, and beliefs about illness
- + Adapt approach
- + Advance understanding of cultural norms & practices
- + Anticipate background dynamics
- + Acknowledge personal cultural practices and beliefs



Refugee Cultures




Burma

- Also called Myanmar
 - 2 ethnic groups: Karen & Chin
- Oppressed since 1962
- Little financial funding
- Collapsed health and school systems

Cultural Beliefs and Practices


- + Practices
 - + Marriages
 - + Gender roles
 - + Parents
 - + Signs of disrespect
- + Health Beliefs
 - + Faith
 - + Health



Women's Health Care

- > Menstruation
- > Prenatal/Neonatal
- > Delivery
- > Postpartum
- > Breast feeding
- > Contraception





Bhutan

- > Human rights violations, torture, imprisonment, and detention without trial since the early 1990's
 - > Most Bhutanese have been denied citizenship
 - > Less than 65% of Bhutanese have access to health care
- > Leading causes of death include dysentery, diarrhea, respiratory illnesses, malaria and parasitic infections


Cultural Beliefs and Practices

- ✦ Practices
 - ✦ Faith
 - ✦ Marriage
 - ✦ Gender roles
- ✦ Health Beliefs
 - ✦ Illness
 - ✦ Home remedies
 - ✦ Preventative medicine
 - ✦ Common health concerns



Women's Health Care

- Prenatal Care
- Delivery
- Postpartum
- Breast feeding
- Contraception






Iraq

- Turmoil since 1980's
- Humanitarian crisis
- 4.2 million people displaced
- Scarce access to health care
- Few health care providers

Cultural Beliefs and Practices


- Practices
 - Religion
 - Marriage
- Health Beliefs
 - Modesty
 - Preventative Health Care
 - Illness Remedies



Women's Health Care

- Birth control
- Pregnancy
- Prenatal Care
- Delivery
- Breast feeding





Somalia


- Clan based society
- 18th century, colonized and enslaved
- 1950's emancipation
- 1990's, civil war
- Asylum in U.S. history

Cultural Beliefs and Practices


- † Practices
 - † Faith
 - † Marriage
 - † Men and women
 - † Public
- † Health Beliefs
 - † Health
 - † Illness
 - † Traditional Healers
 - † Preventative Health Care

Women's Health Care

PAR AVION



- Preventative Health
- Female Genital Mutilation
- Prenatal Care
- Pregnancy
- Delivery
- Postpartum
- Breast feeding
- Contraception



Cuba

- Fidel Castro gained control of the Cuban government in 1959
- Cubans have fled since that time period

Cultural Beliefs and Practices


- † Practices
 - † Culture
 - † Family
 - † Communication
- † Health Beliefs
 - † Health
 - † Obesity
 - † Faith
 - † Health decisions

Women's Health Care

PAR AVION

- Pregnancy
- Delivery
- Postpartum
- Breast feeding





Eritrea and Ethiopia


- Government was overthrown in the 1970's by an oppressive regime which has maintained control since that time
 - In 1962 Ethiopia annexed Eritrea
- Countries remain economically underdeveloped and ruled by a few large landlords that face annual flooding and fighting with neighboring Somalia
 - Most citizens seek refuge due to political reasons
- There is little access to medical care and private health care can be very expensive

Cultural Beliefs and Practices

- + Practices
 - + Patriarchal
 - + Marriage
 - + Communication and translation
- + Health Beliefs
 - + Health
 - + Treatments
 - + Providers

Women's Health Care

PAR AVION



- > Female Genital Mutilation
- > Sexual education and health
- > Contraception
- > Pregnancy
- > Prenatal Care
- > Delivery
- > Postpartum
- > Breast feeding



Iran

- > 1979 series of public protests
- > Rulers liquidated assets, pocketing profits
- > Violent enforcement to silence protests
- > Life expectancy 70 years old
- > Health generally very good

Cultural Beliefs and Practices

- ✦ Practices
 - ✦ Children
 - ✦ Gender Roles
 - ✦ Marriage
 - ✦ Faith
- ✦ Health Beliefs
 - ✦ Cleanliness
 - ✦ Health

Women's Health Care

PAR AVION



- Appearance
- Delivery
- Breastfeeding
- Contraception



Democratic Republic of Congo

- Formerly called Zaire
 - 62 million people
- 200 varying ethnic groups
- Control by rebel forces
- 3.6 million abandoning homes
- Humanitarian disasters

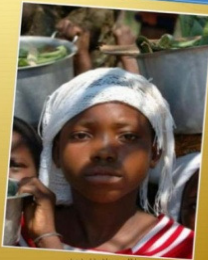
Cultural Beliefs and Practices

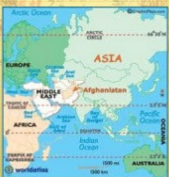
- † Practices
 - † Marriage
 - † Gender Roles
 - † Domestic violence
- † Health Beliefs
 - † Appearance
 - † Diagnosis and treatment
 - † Medical Care
 - † Spiritual Healers
 - † Sexual health

Women's Health Care

PAR AVION

- Female Genital Mutilation
- Pregnancy
- Delivery
- Postpartum
- Contraception





Afghanistan

- 20th century, Afghanistan established independence but was not able to become politically stable
- Taliban had control of the country and enforced strict Islamic practice until 2001
- The United States declared war on terrorists and began to attack Afghanistan terrorist groups
- High civilian loss and numerous Afghans were forced to seek refuge as the country attempted to recreate political stability
 - Life expectancy is only 46 years of age

Cultural Beliefs and Practices

- † Practices
 - † Tribal affiliations
 - † Patriarchal
 - † Marriage
 - † Faith
- † Health Beliefs
 - † Health
 - † Islamic law
 - † Evil Spirits
 - † Health Care Decisions

Women's Health Care

PAR AVION

- Pregnancy
- Prenatal Care
- Delivery
- Contraception




Recommendations for Practice

1. Inquire about the cultures from patient population
2. Recognize ethnocentricity
3. Inquire about traditional health care practices and beliefs
4. Protect modesty and cultural beliefs
5. Perform culturally appropriate assessment
6. Create a culture of understanding within an organization

PAR AVION

Conclusion

- Cultural Awareness
- Holistic Approach



Suggested Websites

- + Center for Disease Control and Prevention:
* <http://www.cdc.gov/immigrantrefugeehealth/about-refugees.html>
- + Ethnomed:
* <http://ethnomed.org/>
- + Office of Minority Health:
* <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
- + The World Health Organization:
* <http://www.who.int/en/>
- + The United Nations Refugee Agency:
* <http://www.unhcr.org/pages/49c364e2.html>
- + Cultural Orientation Resource Center:
* <http://www.culturalorientation.net/>

Questions?

Credits and Acknowledgments

- + Dr. Tina Lundeen, DNP, FNP-BC, DNP Faculty, Advisor, North Dakota State University
- + Stephen Beckerman, Media Technologies Consultant, North Dakota State University
- + American Association of Nurse Practitioners Continuing Education Center

References

- + Please see attached Reference guide

APPENDIX H. EDUCATIONAL MODULE PRETEST

Pretest Review

This copy of questions are provided in order to assess preprogram understanding of the content in the following educational module. Credit may only be received by completing the following in the AANP CE Center:

1. Listen to the educational module.
2. Complete the online posttest with a success rate of 70% or better.
3. Complete and submit the program evaluation.

Pretest Questions:

1. Nurse Practitioner understanding of cultural competence is important:
 - a. to meet professional standards of practice.
 - b. because many refugees maintain their cultural and traditional health beliefs
 - c. as perceived and actual access barriers to health care may exemplify disparities.
 - d. in the emphasis of The Patient Protection and Affordable Care Act.
 - e. All of the above
2. Cultural Competence is defined as:
 - a. A set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations.
 - b. Integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups.
 - c. The capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices and needs presented by patients and their communities.
3. What is a health care disparity?
 - a. A difference in health which is not only unnecessary and avoidable but is considered unfair and unjust.
 - b. A condition of being unequal.
 - c. Any difference amongst a population that is statistically significant and differs from the reference group by at least 10 percent.
 - d. All of the above
4. The Patient Protection and Affordable Care Act promotes all of the following except:
 - a. development and evaluation of model cultural competence curricula.
 - b. dissemination of cultural competence curricula through online clearinghouse.
 - c. continuing only with current educational health care modules.
 - d. cultural competency training for primary care providers and home care aides.
 - e. collaborative research on topics including cultural competence.

5. Female Genital Mutilation is:
- a. defined as all procedures that intentionally alter or injure female genital organs for non-medical reasons.
 - b. linked to cultural factors such as tradition, religion, economics and ethnic identity.
 - c. practiced widely in 26 African countries.
 - d. All of the above

APPENDIX I. EDUCATIONAL MODULE POSTTEST

Posttest Review

This copy of these questions are provided in order to assess preprogram understanding of the content in the following educational module. Credit may ONLY be received by completing the following in the AANP CE Center:

1. Listen to the educational module.
2. Complete the online posttest with a success rate of 70% or better.
3. Complete and submit the program evaluation.

Posttest Questions:

1. Nurse Practitioner understanding of cultural competence is important:
 - a. to meet professional standards of practice.
 - b. because many refugees maintain their cultural and traditional health beliefs
 - c. as perceived and actual access barriers to health care may exemplify disparities.
 - d. in the emphasis of The Patient Protection and Affordable Care Act.
 - e. All of the above
2. Cultural Competence is defined as:
 - a. A set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations.
 - b. Integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups.
 - c. The capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices and needs presented by patients and their communities.
3. What is a health care disparity?
 - a. A difference in health which is not only unnecessary and avoidable but is considered unfair and unjust.
 - b. A condition of being unequal.
 - c. Any difference amongst a population that is statistically significant and differs from the reference group by at least 10 percent.
 - d. All of the above
4. The Patient Protection and Affordable Care Act promotes all of the following except:
 - a. development and evaluation of model cultural competence curricula.
 - b. dissemination of cultural competence curricula through online clearinghouse.
 - c. continuing only with current educational health care modules.
 - d. cultural competency training for primary care providers and home care aides.
 - e. collaborative research on topics including cultural competence.

5. Female Genital Mutilation is:
- a. defined as all procedures that intentionally alter or injure female genital organs for non-medical reasons.
 - b. linked to cultural factors such as tradition, religion, economics and ethnic identity.
 - c. practiced widely in 26 African countries.
 - d. All of the above

APPENDIX J. EVALUATION QUESTIONS OF EDUCATIONAL MODULE

1. Do you feel that your graduate education provided you with the appropriate tools to address cultural competence/sensitivity in the care of your patients?
 - a. Yes
 - b. No

2. What percent of your practice is of a refugee or immigrant population?
 - a. Less than 10%
 - b. 11-30%
 - c. 31-50%
 - d. 51-75%
 - e. More than 75%

3. Have you completed ongoing and continual education related to cultural competence/sensitivity since graduation?
 - a. Yes
 - b. No

4. Do you feel that you that met your learning objectives during this educational program? Are there any additional comments you would like to make in regards to this educational module.

5. Please post suggestions and/or comments about this CE program in the comment box provided. You may also suggest topics for future CE activities. Click Next to complete the evaluation and receive your CE certificate.

6. To what degree did this program achieve the following objective:
State at least 3 items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice.
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

7. To what degree did this program achieve the following objective:
Define cultural competence, culture, and cultural awareness
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

8. To what degree did this program achieve the following objective:
Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

9. To what degree did the author demonstrate expertise and effectiveness in the topic?
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

10. To what degree were the individual objectives/content topics cohesive with one another?
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

11. To what degree was the content balanced (free of commercial bias)?
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

12. How appropriate was the format(s) to promoting learning?
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

13. How likely would you be to recommend this program to your colleagues?
 - a. Completely
 - b. Quite a bit
 - c. Somewhat
 - d. Not at all

14. Was the level of content for NP's:
 - a. Too basic?
 - b. Just right?
 - c. Too advanced?

APPENDIX K. EDUCATIONAL MODULE RESULTS



Cultural Awareness and Provider Based Care for Refugee Women

Program ID: 1212452

Report Date: January 31, 2013

Program Dates: January 10, 2013 through January 31, 2015

Credit: 1.25 contact hour(s)

Program Sponsor: American Association of Nurse Practitioners

Objectives:

- State at least 3 items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice
- Define cultural competence, culture and cultural awareness
- Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan

Faculty:

- Andrea Nelson, RN, BAN, DNPs
- Dr. Tina M. Lundeen, DNP, RN, FNP-BC

Total	# Started Program	# Certs Issued
January 2013	92	85
February 2013		
March 2013		
April 2013		
May-July 2013		

Evaluation Responses

	Yes		No		
Do you feel that your graduate education provided you with the appropriate tools to address cultural competence/sensitivity in the care of your patients?	90.6%		9.4%		
	Less than 10%	11-30%	31-50%	51-75%	More than 75%
What percent of your practice is of a refugee or immigrant population?	49.4%	21.2%	20.0%	3.5%	5.9%
	Yes		No		
Have you completed ongoing and continual education related to cultural competence/sensitivity since graduation?	63.5%		36.5%		
To what extent will this program allow you to:	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
*State at least 3 items that contribute to increased Nurse Practitioner cultural understanding and awareness in practice.	55.3%	38.8%	5.9%	0.0%	
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
* Define cultural competence, culture and cultural awareness.	61.2%	34.1%	4.7%	0.0%	
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
* Recognize common and traditional health beliefs, practices, and female specific health needs of the following refugee populations: Burma, Bhutan, Iraq, Somalia, Cuba, Eritrea, Iran, Republic of Congo, Ethiopia, and Afghanistan.	57.6%	31.8%	9.4%	1.2%	
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
To what degree did the faculty demonstrate expertise and effectiveness in the topic?	62.4%	35.3%	2.4%	0.0%	
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
To what degree were the individual objectives/content topics cohesive with one another?	61.2%	32.9%	5.9%	0.0%	
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all	
To what degree was the content balanced (free of commercial bias)?	72.9%	25.9%	1.2%	0.0%	

	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all
How appropriate was the format(s) to promoting learning?	62.4%	31.8%	5.9%	0.0%
	4 - Completely	3 - Quite a bit	2 - Somewhat	1 - Not at all
How likely would you be to recommend this program to your colleagues?	62.4%	31.8%	5.9%	0.0%
	Too basic?	Just right?	Too advanced?	
Was the level of content for NPs:	5.9%	94.1%	0.0%	

Evaluation Comments:

- Great program and very informative
- Very good CE. Thank you!
- The topic content was great, well organized and included information I will use in practice. The actual IT component - opening up links, etc. did not work smoothly.
- A little confusing.
- Very well done.
- Important information on cultural awareness
- good CE
- helpful
- Very interesting topic
- Very good!!
- it was great
- great
- Great information
- Great presentation. Very important topic area and should be discussed more in schooling and continuing education courses.
- ADHD in children
- Acute Care
- Great resource



American Association of
NURSE PRACTITIONERS™

**Question/Answer Breakdown
Pre-Test/Post-Test Summary**

1. Nurse Practitioner understanding of cultural competence is important:

To meet professional standards of practice.	4.4%	2.9%
Because many refugees maintain their cultural and traditional health beliefs	5.6%	1.0%
As perceived and actual access barriers to health care may exemplify disparities.	1.1%	0%
In the emphasis of The Patient Protection and Affordable Care Act.	0%	0%
* All of the above	88.9%	96.2%

2. Cultural Competence is defined as:

* A set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations.	38.9%	71.2%
Integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups.	14.4%	7.7%
The capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices and needs presented by patients and their communities.	46.7%	21.2%

3. What is a health care disparity?

A difference in health which is not only unnecessary and avoidable but is considered unfair and unjust.	13.3%	6.7%
A condition of being unequal.	3.3%	20.2%
Any difference amongst a population that is statistically significant and differs from the reference group by at least 10 percent.	13.3%	2.9%
* All of the above	70%	70.2%

4. The Patient Protection and Affordable Care Act promotes all of the following except:

Development and evaluation of model cultural competence curricula.	6.7%	3.9%
Dissemination of cultural competence curricula through online clearinghouse.	7.8%	3.9%
* Continuing only with current educational health care modules.	75.6%	88.3%
Cultural competency training for primary care providers and home care aides.	7.8%	3.9%
Collaborative research on topics including cultural competence.	2.2%	0%

5. Female Genital Mutilation is:

Defined as all procedures that intentionally alter or injure female genital organs for non-medical reasons.	3.3%	6.7%
Linked to cultural factors such as tradition, religion, economics and ethnic identity.	3.3%	1%
Practiced widely in 26 African countries.	0%	1%
* All of the above	93.3%	91.3%