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KNOWLEDGE AND PRACTICES OF TRANS-CULTURAL CLIENT CARE AMONGST PRACTICING NURSES OF BUEA, CAMEROON

Achi R. Acha[1], Landis C. Fongang[2], Sylvester Ndeso Atanga[3], Mary, B.S.Atanga[4]

[1]Ministry of Public Health, Cameroon
[2]Catholic School of Health Sciences, Shishong, Cameroon
[3]Faculty Of Health, St Monica International University, Cameroon
[4]Department of Nursing/Midwifery, Faculty of Health Sciences, University of Bamenda.

ABSTRACT: *Trans-cultural client care nursing has been described as the art of providing care to individuals, families, groups and community with a consideration given to the cultural background of the client in order to ensure compliance and improve health. It is a recommended and patronized strategy, due to its insistence on culture competence in care giving, as well as its potential to instigate culture desire in health care personnel. The objective was to investigate professional qualification, academic level, longevity of service, type of in-service training and the way the influence trans-cultural care nursing. It was also aimed at investigating knowledge of the importance, chronological steps, orientation in trans-cultural care, most appropriate person to provide information- trans-cultural communication and culture care preservation. Stratified samples of nurses/midwives working in Health Care Institutions in Fako Division, were administered multiple choice questionnaires, for a period of three weeks. One hundred and sixty five (165) participants filled the questionnaires and SPSS 16.0 was used to analyze the data collected and simple percentages were used to present the results. The results have demonstrated that: Nursing education, qualification and training influence trans-cultural client care among nurses/midwives in Health Care Institutions in Fako Division. It is thus recommend that Health Care Institutions should regularly organize seminars and workshops on the effective use and application of clients' culture during care.*

KEYWORDS: Trans-Cultural Care Nursing, Influencing Factors, Knowledge, Importance

INTRODUCTION

The nursing profession is a caring profession wherein her practitioners empathize as they apply and blend theoretical knowledge with practical skills to ensure that their client continue to remain well and healthy (health promotion) or on the contrary to enable them regain physical, mental and psychological balance (curative and rehabilitative nursing)[1]. This implies that, education, training, qualification and experience could be determinants and/or predictors to the type and quality of care provided by nurses and midwives to clients in health care institutions.

Nurse education at all levels should include culture sensitive care together with multiple theories of communication, family development theories, anthropology, sociology, psychology, anatomy and physiology, biology, ecology, nutrition, pharmacology, religion, history, economics, political science, and linguistics. A cultural group's objective cultural attributes, such as art and music, are important and are included [2].

Training in culture sensitive care model has twelve culture domains which should enable any professionally trained nurse to be able to practice trans-cultural care nursing.

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Leininger [3] introduced the concept of trans-cultural nursing and developed the Culture Care Theory to explain cultural competency. It was the first attempt in the nursing profession to highlight the need for culturally competent nurses. Leininger's theory of Culture Care may be considered the major contribution in support of trans-cultural nursing as both a discipline and vital component of daily nursing practice. Her theory continues to be used as a credible, holistic model that continually contributes new research-based and advanced knowledge to trans-cultural nursing[4, 5].

This theory is important because it describes three practical ways through which clients' culturally diverse and universal complexities can be managed.

In trans-cultural nursing care (culture competent care), nurses depict cultural competence as having the ability to understand cultural differences in order to provide quality care to a diversity of people. Culturally competent nurses are sensitive to issues related to culture, race, ethnicity, gender, and sexual orientation. Furthermore, culturally competent nurses have achieved efficacy in communication skills, cultural assessments, and knowledge acquisition related to health practices of different cultures. Cultural competence involves nurses continuously striving to provide effective care within the cultural confines of their patients [3, 6, 7, 8].

There are several methods through which culturally competent care can be rendered, with each method or procedure having specific issues to identify and handle. With respect to the scope of this study, selected aspects of great importance to trans-cultural care have been discussed. They include; **Culture care assessment** which is the process of obtaining data that enable the health care provider and the client to formulate mutually acceptable, culturally responsive treatment plan, even though it is a cumbersome task for nurses and other providers to become familiar with the cultural dynamics various ethno-cultural groups[9, 10]. The first step in cultural assessment is to learn about the meaning of the illness of the patient in terms of the patient's unique culture. Rather than taking on the virtually impossible task of learning about multiple cultures, it is more practical and helpful for nurses to use a generic approach in doing a cultural assessment. The basic premise of the cultural assessment is that patients have a right to their cultural beliefs, values, and practices, and that these factors should be understood, respected, and considered when giving culturally competent care

Examples of questions to ask during cultural assessment include[11]:

- What do you think has caused your problem?
- Why do you think it started when it did?
- How severe is your illness? Will it have a long or short course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to get from this treatment?
- What are the chief problems your illness has caused for you?
- What do you fear most about your illness?

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The next step in cultural assessment is to determine how embedded the patient is in his or her traditional culture. Cultural embeddedness refers to how aligned the patient is with the native culture. Examples of questions to evaluate cultural embeddedness include the following[11];

- How recently did the patient immigrate?
- Was the immigration voluntary or involuntary?
- Did the patient live in intermediate countries before coming to the United States?
- What country did the patient immigrate from and how different is that culture from U.S. culture?
- Who does the patient associate with?
- What type of neighbourhood does the patient live in?
- Does the patient follow traditional dietary habits?
- Does the patient wear native dress?
- Does the patient leave his neighbourhood to participate in the larger culture?
- Does the patient use folk medicine or use the practices of a native healer?
- Does the patient come from an urban or rural area in the native country?

Knowing the patient's degree of cultural embeddedness helps the nurse to know where to start negotiating with the patient and his or her family to achieve health care goals. Patients who are highly embedded in the native culture are traditional individuals totally committed to their original cultures. People who are less embedded and more acculturated value open communication and ideas from both cultures. Bicultural individuals can move easily between both cultures. Thus, education, longevity, type of in-service training probably on trans-cultural care and knowledge, and communication all have a role to play in trans-cultural care nursing practice.

Trans-cultural communication

The importance and essence of language can be observed and experienced in different spheres of human endeavours such as, the nurse-patient relationship as well as other interpersonal and communication interactions. In the field of health and/or nursing, the ability to communicate with a patient is a vital necessity and resource as it constitutes the foundation of effective nurse-patient relationship. Language and good communication skills will enable health personnel to obtain accurate and comprehensive patient and family assessment, formulate and implement treatment plan, determine the effectiveness of care as well as evaluate outcome.

However, intercultural communication is not only limited to language (grammar and vocabulary), but also para-linguistics, sociolinguistics and general cultural knowledge, as highlighted below;

- Para-linguistics, sociolinguistics such as accents, tone of voice, volume, pauses, body language, eye contact etc.

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- Having a body of knowledge about the culture in which we live and work such as customs, traditions, etiquette of the health service and the hospital.

There are therefore, several factors or issues worthy of note by the health care personnel during cross-cultural communication and interactions with patients, which will facilitate the process as well as influence outcome. The health personnel (nurses /midwives) must also possess a sound knowledge and comprehension of their own cultural values, attitude, beliefs, and practices as they have acquired from their own families before learning about other cultural ways[5, 12 13].

It requires more than just oral and written communication to be able to effectively carry out trans-cultural communication. Nonverbal cues contribute enormously in conveying messages and given that, these nonverbal gestures vary considerably among different cultures, they ought to be taken seriously and efforts should be made by the health care personnel to understand how nonverbal communication is carried out in different cultures. Understanding these communication cues and their meanings to persons of different cultures is necessary in order for nurses to attain and maintain cultural competency.

Recent qualitative studies have shown that communication problems were the major reasons nurses were not able to provide culturally competent nursing care[14, 15].

Statement of Problem

Health care delivery nowadays is greatly influenced by theories, concepts and principles which constantly change in respond to clients' needs, new research findings and technological know-how. The recipients or consumers of health care services often provide complex and ever changing healthcare demands consequent to socio-cultural and environmental changes. The tasks and responsibilities of health care providers are definitely very challenging and complex. The ideal standard warrants a prompt and dynamic respond through harmonization of new research and technological findings with actual client needs [5].

The quality of care given to clients particularly with regards to trans-cultural care nursing in health care institutions on the other hand may vary based on general and professional educational background, working experience and in-service training, knowledge of the importance of trans-cultural client care, culture determinants, culture orientation, communication, person to provide information, and culture preservation. Based on this variations amongst nursing/midwifery education, training and qualification the research on knowledge and practice of trans-cultural client care was conducted.

Research Questions

i. How do nursing/midwifery education, training, qualification, longevity, and in-service training affect trans-cultural client care in health Institutions in Fako Division?

ii. What is the importance of trans-cultural client care among the various cadre of Nurses and Midwives in Health Institutions in Fako Division?

iii. What is the knowledge of nurses and midwives on the chronological steps, culture determinants and orientation in trans-cultural client care in Health Care Institutions in Fako Division?

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iv. What is the role of communication in trans-cultural care among nurses and midwives during trans-cultural client care in Health Institutions in Fako Division?

Assumptions

a. The professional qualification, academic level, longevity, and in-service training of nurses and midwives influences trans-cultural client care in health care institutions in Fako Division.

b. Knowledge of the importance, chronological steps, culture diagnostic determinants, culture orientation and communication influences trans-cultural client care by nurses and midwives in health care institutions in Fako Division.

Objectives

i. To assess how nursing/midwifery education, training, qualification, longevity, and in-service training affect trans-cultural client care in health Institutions in Fako Division.

ii. To identify the importance of trans-cultural client care among the various cadre of Nurses and Midwives in Health Institutions in Fako Division.

iii. To assess the knowledge of nurses and midwives on the chronological steps, culture determinants and orientation in trans-cultural client care in Health Care Institutions in Fako Division

iv. To assess the role of communication in trans-cultural care among nurses and midwives during trans-cultural client care in Health Institutions in Fako Division.

MATERIALS AND METHODS

The research design was a cross-sectional descriptive and analytic study design based on the research questions which reflected the objectives aimed at describing how trans-cultural client care was carried out. Data was collected only at the convenient time without any prior notification or preparation of whatever sort with the participants. Informed consent and every other ethical negotiations related to participants was done on the spot. The study was carried out in Fako Division of the South West Region of Cameroon, which has many health care institutions among which are 2 referral or Regional hospitals (Buea and Limbe Regional Hospitals). All the health institutions found within the area were eligible for the study but were selected on the basis of stratified sampling. The population under investigation was nurses and midwives in the South West Region of Cameroon.

The stratified sampling technique was used for this study. Since there are different categories of nurses and midwives within the study area, the target population was stratified into the different nursing categories for example, senior nurses, higher nursing diploma, state registered, specialized nurses and nurse Aids. Thereafter, proportionate sample of each category were determined. Based on this, Health care Institutions within the study were chosen and the various proportions of the different categories were chosen randomly and administered the research questionnaires. This enabled us to obtain representative samples of each category, which in turn strengthens the validity of inferences and generalizations made. This sample size

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calculation was based on the estimation of the proportion of nurses and midwives found in health institution in Fako Division.

From the number Nurses and midwives in Fako, the minimum sample size needed was calculated using the following formula adopted from Babbie E.[56], Michael and Michael [57], lagers and Justo [58] and Eng[59] as follows:

$$\boldsymbol{n = \frac{(z^2)pq}{d^2}}$$

Where

n_o= minimum sample size required for infinite population

p= pre-study estimate of the proportion of personnel in Health institutions in Fako division (and since there is no pre-studied estimate from previous studies, 50% or 0.5 will be used)

q= 1-p

d= the degree of precision or the accuracy (=5% or 0.05)

z= standard normal variant at confidence level of 95% (normal value is 1.96)

Hence,

Sample size (n_o) = $(1.96)^2(0.5)\ (0.5)/\ (0.05)^2$

= 0.9604/0.0025= **385 persons / participants** expected.

But, assuming that the total population of nurses/midwives, N is about 400.

The minimum sample size required for the finite population, n, was gotten by applying the formula below;

$$\mathbf{n=\frac{n_o}{1+\frac{n_o}{N}}}$$

n= 385/ (1+ 385/400)

=385/1.9625

=**196(approximately 200) nurses/midwives**

Thus the study targeted about 200 nurses/midwifes.

Data collected were treated confidentially and anonymously. Cross and double checking for complete and correct filling was done upon collection.

Descriptive statistics was used to describe how the phenomenon under study (trans-cultural client care) presents and vary with some influencing factors among nurses and midwives in health care institutions Fako Division. Inferential statistics was used to determine the relationship that exists between the studied variables.

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The data collected were presented first of all using simple frequency distribution tables, and bar charts for descriptive purposes. Crossed tables were equally done in order analyse and/or investigate the relationship that existed between the dependent and independent variables.

Ethical issues were considered such the study respected ethics, norms and recommended standards for research on humans. These were:

- Authorization from the South West Regional Delegation of Public Health and Ethical clearance board to carry out the study
- Authorization from the directors or administrators of institutions involved in the study.
- Participant consent form assuring their informed consent to participate in the study.
- Verbal consent from participants prior to administration of questionnaire.
- None of the participants were obliged to participate in the study.
- Participants were fully informed of their right to withdraw or retrieve consent any time deemed necessary.
- Ethical clearance from the Institutional Review Board (IRB) of the Faculty of Health Sciences, University of Buea was also obtained.

RESULTS AND DISCUSSION

Table 1: Professional qualification of research participants.

Professional Qualification	Frequency	Percent
Nurse Aid	50	30.3
State Registered Nurse	45	27.3
Mid wife	12	7.3
Senior Nurse	30	18.2
Specialist Nurse	4	2.4
Other[1] (specify)	24	14.5
Total	**165**	**100.0**

Table 1 shows that Nurse Aids constituted the majority of the research participants were 50 (30.3%), followed by State Registered Nurses who were 45 (27.3%); midwives were 12 (7.3%) and senior nurses were 30 (18.2%). Specialized Nurses constituted the lowest number (minority) of research participants; while others not specified were 24 (14.5%). From a general perspective, the greater majority of the participants were nurses who had trained for one year only as nurse aids indicating that there was already going to be a level of unawareness. This is because most of the trans-cultural care is taught when nurses are trained for a longer period.

[1]These are nurses/Midwives whose categories were not mentioned in the questionnaire. They include: Brevete nurses, auxiliary Nurses, Higher National Diplomat (HND) Nurses and State Enrolled Nurses (SEN).

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Longer training means therefore that more concepts and theories about patient care especially culture competent care, must have been taught to at least at the minimum required level

Table 2: Academic level of research participants

Academic level	Frequency	Percent
Ordinary Level	43	26.1
Advance Level	93	56.4
Bachelor's Degree	26	15.8
Master's Degree	3	1.8
Doctorate Degree	0	0
Total	**165**	**100,0**

Table 2 reveals that, more than half of the research participants were Advanced level certificate holders (56%), followed by Ordinary level holders (26.1%). Master's degree holders were the minority of the research participants (1.8%). With an academic qualification like advance level, taking on new or untaught aspects of care is easier. Such providers may require just a few hours of training and trans-cultural client care will be attained.

Table 3: Longevity of service of research participants

Longevity at service	Frequency	Percent
0-5 years	99	60.0
6-11 years	42	25.5
12-17 years	16	9.7
more than 18 years	8	4.8
Total	**165**	**100.0**

Table 3 shows that, a greater proportion of the research participants (60%) were those who have not worked or served for more than 5 years. Those who had worked or served for period between 6 and 11 years were seldom many (25%). Very few had served or worked for more than 18 years (4.8%). Health care practitioners who have been long in practice may pick up aspects of care from experiences. Less than five years may not quite expose someone to the subject matter under discussion and so will consequently affect his/her knowledge (16)

With regards to a factor like in-service training in trans-cultural care and any other in-service training, 75 (45.5%) affirmed, while 90 (54.5%) had not had any form of in-service training. Those who had undergone in-service training on any aspect of clinical techniques may stumble over trans-cultural client care order than those who have never had any such training (17)

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Table 4: Types of in-service training of research participants

Type of training	Frequency	Percent
Clinical techniques	66	94.5
Human relations/ counseling	9	5.5
Total	**75**	**100.0**

It can be observed on table 4 that, out of the small proportion (45.5%) of those who have had at least an in-service training, most of them-66 (94.5%) had the in-service training on aspects related clinical care and techniques which might have included aspects of trans-cultural client care.

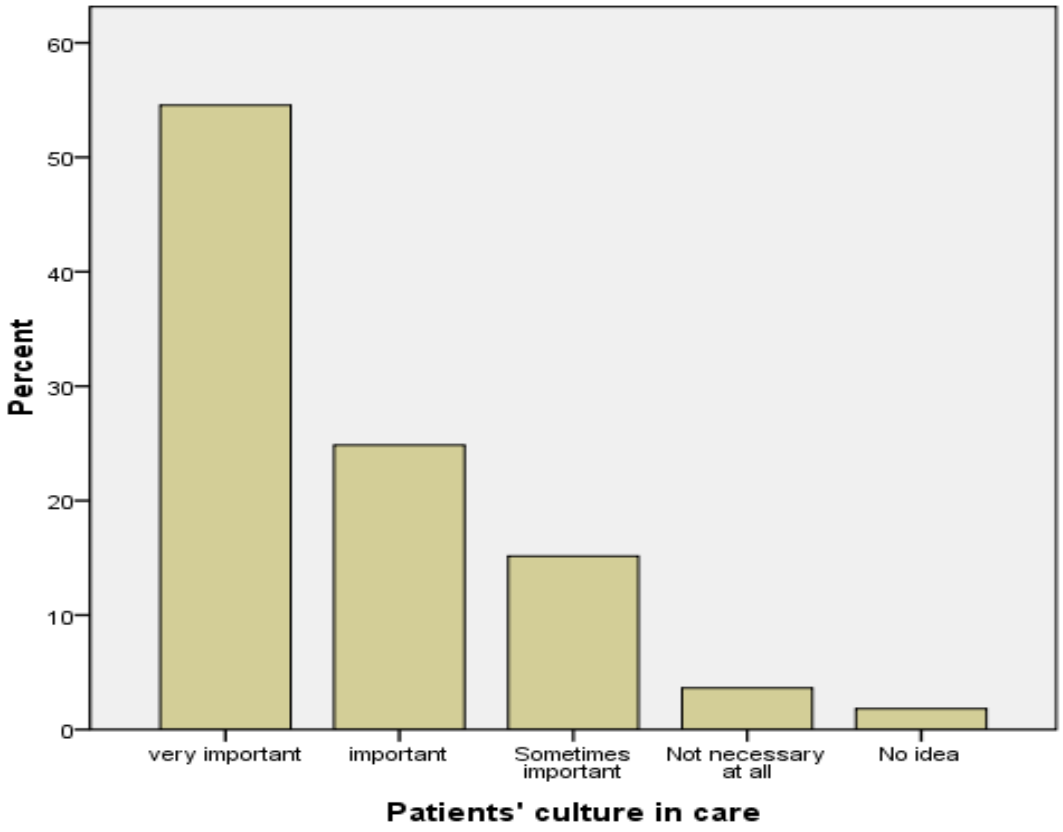

Figure 1: Bar chart of Participants' opinion on the importance of trans-cultural client care.

Figure 1 is a Bar chart that highlights the fact that, the majority of respondents (55.2%) were of the opinion that, culture is a very important aspect to be considered when caring for patients, while some others were of the opinion that it is not important to consider culture when caring for patients. However, very few participants were virtually ignorant of the relevance of culture in patient care. Where a health care provider feels that culture is important, he/she will take

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precautions when carrying out certain functions. Will have respect for the clients culture in such discharge of his/her duties that the client ends up very happy with the care and is stress free. A stress free client is one that can recover faster or just as expected.

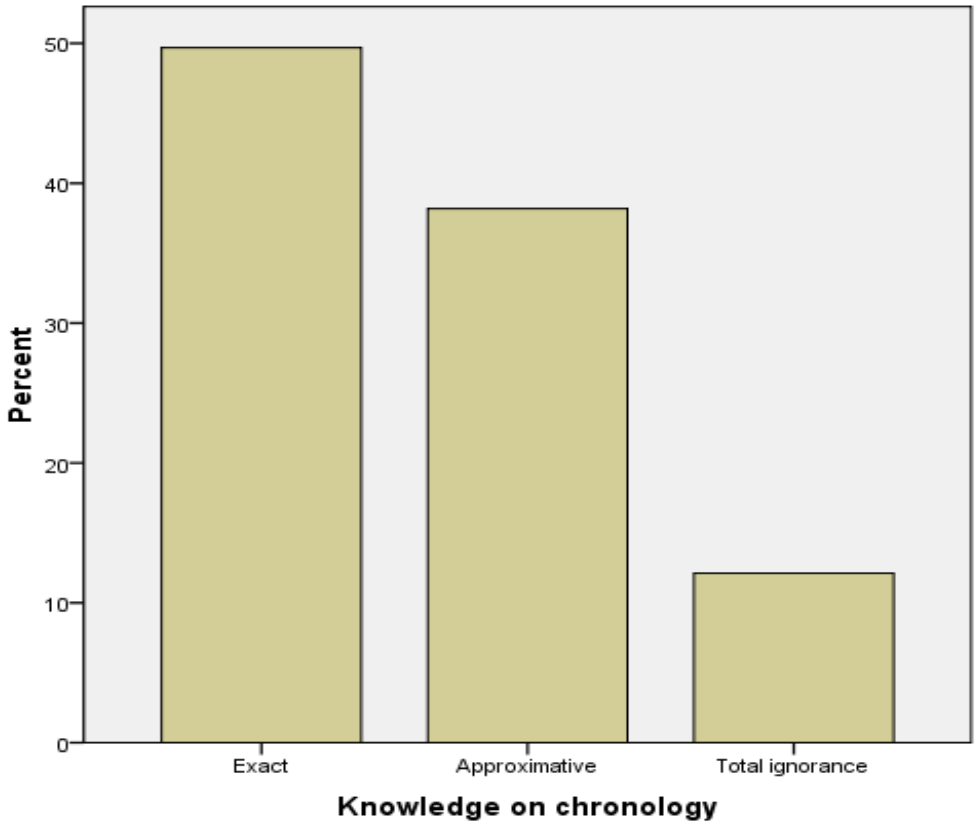

Figure 2: Bar chart of Participants' knowledge on the chronological steps involved in trans-cultural client care

It can be asserted by observation of figure 2 that, not more than half of the research participants have an exact knowledge on the chronological steps involved in trans-cultural patient care. Nevertheless, some of the participants (12.1%) do not have any idea on chronological steps involved in trans-cultural client care. The chronological steps require that the client if first at ease and is willing to state what his/her culture demands. Then the health care provider used the knowledge to provide care that suits that culture or care in a manner that does not infringe too much into some cultural barriers. When this is not known, there will be infringement into cultural areas that the client may term as taboo. When this happens, the client simply surrenders his/herself to health care provider but is under stress seeing his/her culture being neglected. The stress may delay the recovery process.

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Table 5: Participants' knowledge on client's culture diagnostic determinants during trans-cultural client care

Diagnostic determinant	Frequency	Percent
Tribe	118	71.5
Clan	8	4.8
Ethnicity	26	15.8
Race	4	2.4
No idea	9	5.5
Total	**165**	**100.0**

Even though table 5 shows that most (71.5%) of the participants know the diagnostic determinant of clients' culture, some few (5.5%) do not have any idea about this aspect. One hundred and eighteen (71.5%) thought that client's cultural aspects to be considered during nursing is tribe only; 26 (15.8%) thought it was ethnicity, clan and race were considered by 8 (4.8%) and 4 (2.4%) respectively. These aspects are very limiting as trans-cultural client care includes respects for client's belief patterns and gradual approach to culture adjustment and not culture change.

Table 6: Participants' knowledge on aspects that provide leading orientation about clients' culture in trans-cultural care

Diagnostic orientation	Frequency	Percent
Exact	21	12.7
Approximate	134	81.2
Total ignorance	10	6.1
Total	**165**	**100.0**

With respect to knowledge on aspects that can provide a leading or good orientation about clients' culture, table 6 reveals that absolute majority (81%) of the respondents possessed just an approximate knowledge on this aspect (respect, morals, positions to assume when greeting elders among others) while some very few but not negligible proportion (6.1%) are totally ignorant on this aspect. A leading orientation in client care to ensure that trans-cultural care is achieved is by following the chronological steps of knowing a bit of the client's culture first and using the positive aspects of the culture most often but not neglecting the negative aspects completely. The negative aspects are approached gradually with some appreciation and not harseness.

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Table 7: Participants' knowledge on who is most appropriate to provide information about a clients' culture during trans-cultural client care

Cultural informant	Frequency	Percent
Exact	77	46.7
Approximate	80	48.5
Total ignorance	8	4.8
Total	165	100.0

Table 7 indicates that, almost half (46.7%) of the participant know exactly who is most appropriate or preferable to provide or give information about a client's culture during trans-cultural client care. These persons are often the significant others in the client's life. It is equally worth noting that a little proportion (4.1%) of the participants did not possess any idea about this aspect. The lack of knowledge indicates that no clients' culture is considered in care. Hence, the provider acts as a boss, gives instructions for the client to just follow. This of course may cause stress in the client and the care outcomes are delayed.

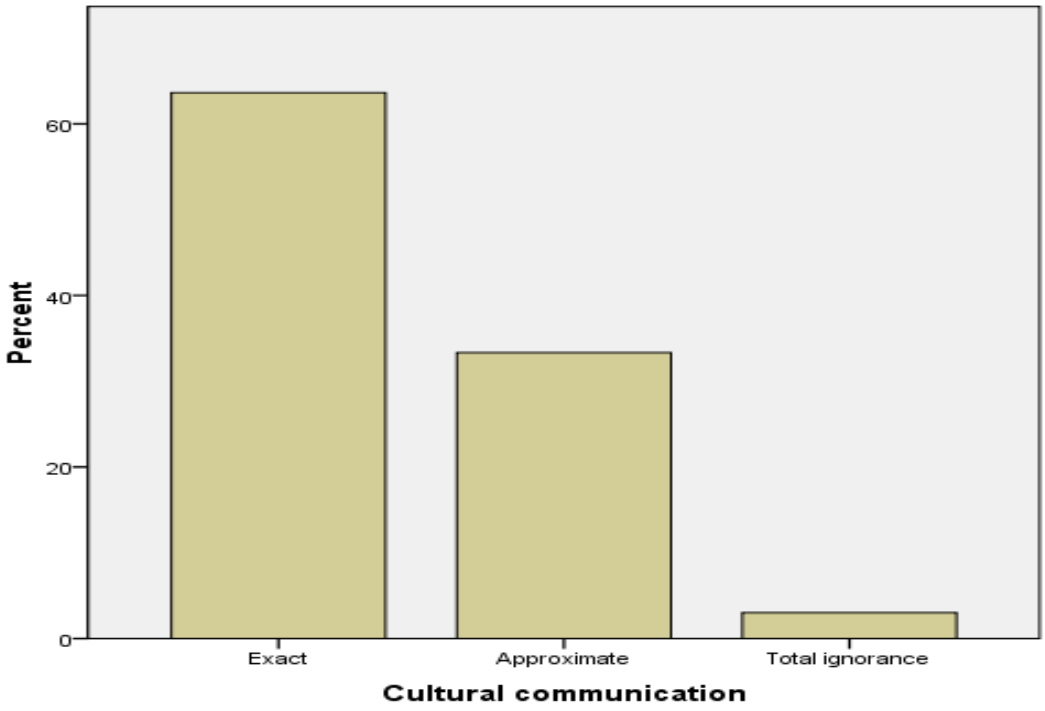

Figure 3: Bar chart of participants' responses relative to aspects that enhances trans-cultural communication with clients during trans-cultural client care

Figure 3 is a bar chart that provides information that enable us to conclude that more than half (63.6%) of the research participants possess an exact knowledge on how to enhance or foster trans-cultural communication during trans-cultural client care (like when to communicate, what to begin communication with, how to initiate, among others), with a few of them (5.0%) totally ignorant. Trans-cultural communication is good in enhancing care in that when there is an exchange of cultural views between the provider and receiver of health care, the receiver

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becomes more comfortable as he/she understands that other people also have cultures which can be modified to enhance health and wellbeing.

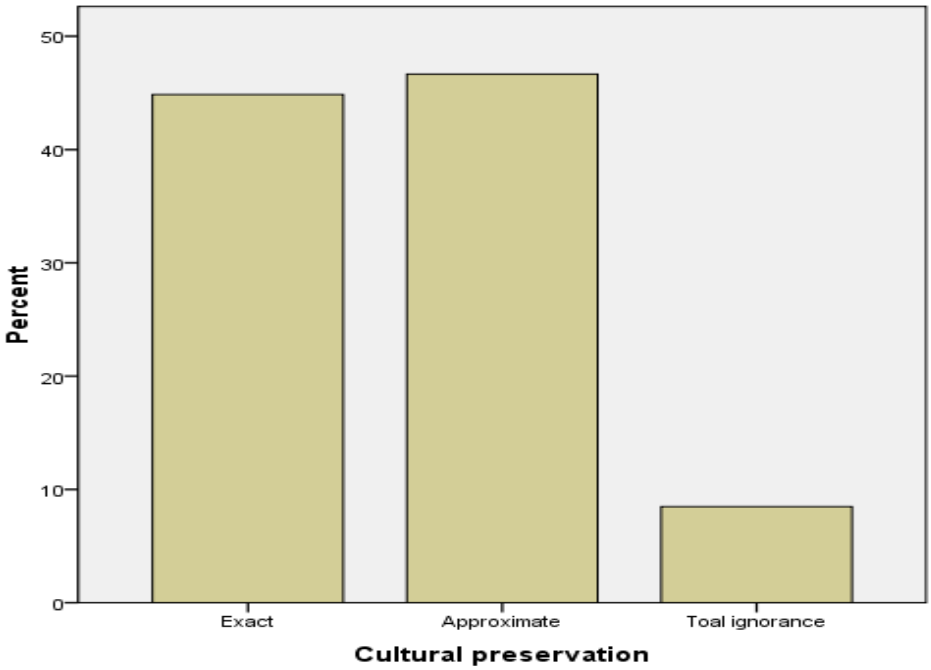

Figure 4: Bar chart participants' knowledge and attitude relative to culture care preservation during trans-cultural client care

As far as knowledge and attitude on culture care preservation was concerned, figure 4 is a bar chart that delineates the fact that sum up to culture care preservation. Not up to half (44.8%) of the research participants possess exact knowledge and attitude on culture preservation like maintaining language, storytelling, past activities and events, among others), while some, (8.5%) were totally ignorant. When a client is supported by a health care provider to preserve good aspects of his/her culture, the clients gains confidence in the provider and take health advice with more ease and implement for better health.

CONCLUSION

Majority of the study participants were nurse aids and so much could not have been obtained on the subject matter

However advance level certificates were used on entry and so they will be knowledgeable on trans-cultural client care with little orientation

Most of the participants had not worked for up to five years and so their experiences may be limiting the application of trans-cultural client care

A majority of these participants had not had any form of in-service training which could have exposed them to the subject under investigation better. Good enough, the in-service training was more in clinical techniques than counseling and other nursing administration activities.

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Majority of the participants knew the importance of trans-cultural client care and had a good knowledge of the chronological steps in such care.

Unfortunately, majority of the participants thought that culture was more of tribe than beliefs and other aspects and had clues to what was considered as culture orientation in trans-cultural client care.

Most of the participants were aware of who should provide trans-cultural client care including the nurse and that trans-cultural communication was a necessity for such care to be provided.

RECOMMENDATIONS

It has been uncovered from this study that:

-No matter the length of training, trans-cultural care must be taught for better implementation since it can enhance recovery

-Trans-cultural aspects of care should be clearly outlined and placed at the disposal of health care providers in all facilities since it is an important aspect of care that improves on health outcomes

-Seminars, workshops and in-service training linked to trans-cultural client care should be organized by health facilities because respect for ones culture encourages better health seeking behaviours.

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