

IMMIGRANT WOMEN GIVING BIRTH IN MATERNITY HOSPITAL
Experiences and expectations of immigrant women and perceptions of health
care personnel in Tampere University Hospital

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JUSLÉN SARI: IMMIGRANT WOMEN GIVING BIRTH IN MATERNITY
HOSPITAL Experiences and expectations of immigrant women and perceptions of
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Finland along with most countries in the Northern Hemisphere continues to see increased migration into the country. As the proportion of immigrants in regard to the entire population continues to grow immigrant health and well being become increasingly significant areas of investigation. Maternal health may be considered to be at the forefront of emerging challenges of the field. At this time, relatively few qualitative studies have been conducted from the perspective of immigrant women as to how they perceive and experience care received in the hands of local health care professionals. In general, there has been more of a tendency to uncover aspects of care from perspectives of the caregiver.

The objective of the study is to convey experiences and expectations of immigrant women regarding the care they received while giving birth and being admitted to the Tampere University Hospital (TAYS). Perceptions of midwives working at the Pregnancy and Labour Unit of the hospital involving distinct needs of immigrant women are conveyed. Possible similarities and distinctions in perception of the two counterparts are also examined.

The study was conducted through two phases of thematic interviews in February -March 2012, the first with immigrant women living in the Greater Tampere region, the second among midwives of the hospital. Selection methods utilized at different stages were intentional, snowball or referral and random sampling. A total of 8 women's and 10 midwives' recorded interviews were transcribed to accumulate a total of 166 pages of data of which 117 pages had been translated from Finnish to English. Analysis was conducted via abductive content analysis and viewed from cultural competence context.

Although immigrants interviewed were able to least reasonably communicate in English or Finnish and general views expressed as to experiences and expectations of these women not deviating much from local women, the predispositions were found premature and even misleading. Supportive evidence was irrefutable. Results revealed a genuine need for the individual health care professional to begin developing one's capacity for culturally competent care. The study indicated culturally competent communication and interaction skills to be a major determinant in the manner care is received and perceived. It is a factor reflecting on both patient satisfaction and short as well as long term patient wellbeing.

The researcher views the findings of the study to be inclined to apply to a broader population of immigrant women. Offering care that may be viewed as culturally competent is a long term goal that demands strategic and operational level changes in organizations. Without fundamental changes even the most culturally competent of care givers would be limited in their capacity to offer care that is sensitive to the needs and expectations of women of diverse cultural backgrounds.

Key words: multicultural, cultural competence, culturally competent care, transcultural care, immigrant, maternity, giving birth, labour, health care

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ABBREVIATIONS

PTT-Model	The Papadopoulos, Tilki, Tays Model for Cultural Competence
TAYS	Tampere University Hospital
WHO	World Health Organization

1. INTRODUCTION

Finland's total population on non-Finnish origin, consisting of both non-Finnish citizens as well as those with citizenship, is at an estimated 172.288 in 2010 (Tilastokeskus 2011). The population of immigrants in the country has increased an overall 7.9% from 2009.

The city of Tampere has a population of 213.217. According to latest statistics, a population of 7879 immigrants currently live in the city of Tampere (City of Tampere 2011). They currently compose 3.7 % of the city's inhabitants and a growth in population is imminent in the years to come. A result of growing immigration figures, the proportion of immigrants in Finland, as clients in general health care has grown and continues to do so (Tilastokeskus 2011). Multiculturalism can no longer be seen as a phenomenon of the future.

The Finnish health care system was originally designed to cater to the needs of the majority, meaning the Finnish born-and-bred population. As encounters between health care personnel and the multicultural population are on the rise it can only be assumed that there is an ever heightening challenge to adapt services offered. This is to be done in order to meet the health requirements of an increasingly diverse environment (Devillé, W. Greacen, T. et al. 2011).

Tampere, as the third largest city in the country (City of Tampere 2011), certainly has its share of non-Finnish originating inhabitants. Along with growth is a greater demand for specialized health care services. Maternal and Child Health Clinics may be seen to be at the forefront of such developments in Finnish society. Women requiring these services already form a recognizable proportion of clients in the local Maternal Health Clinics and as patients of the district's hospital, TAYS.

It is to be noted, multicultural health care has been studied to a degree in Finland over the last decades. There are, however, very few studies undertaken regarding how

immigrants and their respective communities experience health care services and particularly, how they are cared for by personnel (Clarke, K. 2003):

It is of great importance to pursue efforts to meet emerging needs and expectations of a multicultural population. The issue is not only one of promoting equality but also a factor enhancing integration into society. Meeting these challenges not only requires the provision of medically acceptable, quality care but also the provision of services that are gender sensitive and culturally appropriate (WHO. 2008). These aspects are also recognized and defined by The Finnish Act on the Integration of Immigrants and the Reception of Asylum Seekers. Efforts are to be continued and resources allocated in order to better serve a segment of the population that is only to increase in the coming years.

The overall aim of the study was to bring forth the experiences and expectations of immigrant women regarding the care they received during their stay at the Tampere University Hospital (TAYS). The study also investigated the perceptions of health care personnel working in Pregnancy and Labor Wards of the hospital. In addition, interviews were conducted for the purpose of uncovering possible similarities in perceptions as well as uncover previously undetected differences as to how administered care is perceived. The possible findings were to be viewed from a cultural competence context regarding care given and received.

A review is presented in the first part of this Thesis in order to provide a perspective into some of the studies conducted in Finland and internationally relating to the issue of culturally competent care. This will be followed by defining some of the key concepts utilized in this work and the specific aims and assumptions of the study. The methods utilized in the study are described prior to the presentation of results.

The care provided and received researched and conveyed in the Thesis involves the giving of birth. An experience widely considered to impact a woman's life regardless of her origin. There may be an interest on the part of the reader to review findings from literature regarding general experiences and expectations of maternity care and labour.

It is to be noted, the researcher has on the grounds of clarity and cohesion, chosen to confine focus to aspects of care of immigrant women in the cultural competence context.

Content regarding interview groups is presented alongside respective analysis in consecutive order and according to theme in the chapter for Results. Possible similarities and differences in experience and perception are analyzed in the Discussions chapter. The chapter also views the findings in the context of the Papadopoulos, Tilki, Taylor model for Cultural Competence. Conclusions and recommendations are presented in the final part of the Thesis.

Prior to conducting research it was supposed probable, study findings could indicate a reasonable level of cultural competence regarding certain aspects of care administered at the Maternity and Labour Wards at Tampere University Hospital – TAYS.

It was also an assumption, immigrant women would undergo some challenges in being under care of and in interaction with health care personnel at the Maternity and Labour Wards at the Tampere University Hospital – TAYS.

Finally, the researcher supposed findings were likely to indicate a more individualized, culturally adjusted care and support would be called for. It could also point toward possible benefits derived from a more systematic approach to educating staff on multiculturalism and cultural competence.

It is the researcher's view, the study conducted can be seen as relevant in the evaluation, planning and implementation of health care services in the near future. At this point in time, there is a scarcity of research in the field of immigrant health care altogether, in particular from the receiver of care perspective. It is of timely relevance to pursue the development of our health systems in Finland toward an enhanced multicultural and more culturally competent future.

2. LITERATURE REVIEW

2.1 The right to health

The World Health Organization (WHO) mentioned in its Fact Sheet n° 31 "The Right to Health" states "the right to health implies equal and timely access to health care services, the provision of health-related education and information, and the participation of the population in health-related decisions at national and community levels. The right to health also implies equity in access to health care services for equal health needs. Health care services should be physically and financially accessible for all sectors of the population, including vulnerable groups, and should be delivered on the basis of non-discrimination. Facilities, goods, and services are required to respect medical ethics, as well as be gender-sensitive and culturally appropriate. This means they should be culturally and not only medically acceptable. A final prerequisite is that they are scientifically appropriate and of good quality" (WHO 2008).

As evident, "The Right to Health" views availability and accessibility of health care to go beyond that of a legal right to health care with a number of others aspects involved. In this day and age the right to culturally sensitive health care for all immigrants is already widely asserted by experts. It may be noted, that although a broad consensus does exist regarding the major principles of good practice that need to be implemented, some disagreement regarding underlying and more specific issues do exist. These factors require further research (Devillé, W. Greacen, T. et al. 2011).

In Finland, the Act of the Status and Rights of Patients (785/1992) ensures appropriate health care to residents. The Act states that every person who is permanently in Finland is without discrimination entitled to health and medical care personally within the limits of the resources available to health care at the time in question. The Act also states that the patient has a right to good quality health and medical care, and that the individual be treated without violating his/her human dignity and personal convictions are respected. Furthermore, the Act mandates that the patient's native language, individual needs and culture are taken into consideration to the extent possible.

2.2 Definitions related to migration

The term migrant is often used interchangeably with the words immigrant and emigrant. Migration can be defined as to move from one country, place or locality to another (Merriam-Webster. 2011). The Association of Finnish Local and Regional Authorities define an immigrant as a person who moves from one country to another. The term applies to anyone moving, regardless of motive for doing so. (Suomen Kuntaliitto). Another source, Sarvimäki and Kallio (2007) as well as Tiilikainen (2007) reason that the term immigrant is a multi-purpose word addressing all individuals who have moved from one country to another with the intention of permanent residence (Sarvimäki, Kallio 2007 and Tiilikainen 2007).

Immigration can occur on grounds of work, marriage, study, return migration, asylum seeking or family reunification. Sarvimäki and Kallio (2007) also state that tourism and student exchange are not classified as immigration. Statistics Finland adds to the definition by including the context of the person moving to Finland and has or intends to live in the country for over a year without interruption and who has residence permit (Immigration and emigration 2010).

On a more general level, Anis conveys that a migrant in Finland is often also applied to anyone living in Finland, who is born elsewhere and has a different cultural background or has a different appearance than traditional Finns (Anis, M. 2008).

2.3 Definitions related to culturally sensitive health care

In referring to cultural sensitivity in care provided, a number of terms are prevalent. In reviewing publications one comes across terminology such as culturally effective health care, cross-cultural health care and multicultural care. In a review of literature prior to conducting this research, the terms most often referred to, were references to transculturally competent care and culturally competent care.

The reference to transcultural competence has been utilized in Finnish publications fairly regularly. For example, Korkiasaari and Söderling (2007) make the reference in

the context of the country becoming transcultural in a short period of time. Another example is Seminole-Rodriguez (2009), who conveys how transcultural competence is a new emerging qualification requirement for most Finnish nurses.

Culture is defined as “the learned, shared, and transmitted values, beliefs, norms, and ways of life of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerational” (Leininger, M. McFarland, M. 2006). Another definition is “the upbringing and unconscious motives that define actions and thinking” (Narayanasamy, A.White, E. 2004).

Transcultural care is a term often used synonymously with intercultural and multicultural care. All three of these terms are often referred to in discussions related to the reduction of cultural gaps and the creation of cultural synergies (Purnell, L. Paulanka, B. 2003). Taavela (1999) conveys that transculturalism can often be defined by an individual’s nationality tradition, religion and language.

A number of transcultural researchers convey how culture is an underlying factor in the individual’s experience of health and wellbeing. Culture is also a defining factor in how preventive interventions are experienced and care in general, viewed. The interaction between health care personnel and patient may be viewed from the perspectives of the cultural background of personnel, that of the patient and finally the cultural setting of care provided. (Sainola-Rodriguez, K. 2009).

Transcultural care according to Koskinen (2010) refers to care provided to members from different cultures or to a particular cultural community wherein personnel and patients are from separate cultural and ethnic groups. The care providers take into account a patient’s cultural background and honor arising differences in all aspects of interaction.

The term multicultural competence was initially introduced in a mental health publication by psychologist Paul Pedersen in 1988. Pedersen’s multicultural competence model emphasized three components: awareness, knowledge and skills (Pedersen, P. 2000). One of the original definitions for culture competence defines the

idea as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is utilized as it implies a pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word competence is used because it implies having the capacity to function effectively” (Cross T. et al. 1989).

A later definition sees cultural competence in health care as the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. It is seen as both as a vehicle to increase access to quality care for all patients as well as a means to attract new patients (Langer N. 1999. van Ryn, Burke J. 2000).

In closing, it is beneficial to note there are several recognized models for culturally competent care. They all have minor differences, in terms of concepts utilized as well as purpose. Due to the nature of this study they will not all be presented in this Thesis. It is also good to bear in mind that as the ideas behind cultural competence are further evolving it is likely to include more concepts and a variety of aspects and perspectives in the years to come.

2.4 Cultural competence

The definition for cultural competence by Papadopoulos, Tilki and Taylor defines culture as “the shared way of life of a group of people, which includes beliefs, values, ideas, language, communication, norms and visibly expressed forms such as customs, art, music, clothing and etiquette”. They also state “culture has an influence on the individual's lifestyle, personal identity therein affecting the relationships with other people within as well as outside their culture” (2006).

Papadopoulos (2003) defines cultural competence as”The capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs. Cultural competence is the synthesis of a lot of knowledge and skills which we acquire

during our personal and professional lives and to which we are constantly adding”. Papadopoulos has defined transcultural health as the study of cultural diversities and similarities in health and illness as well as their underlying societal and organisational structures, in order to understand current health care practice and to contribute to its future development in a culturally responsive way”.

Cultural competence is seen to contain three aspects. These involve skills in the areas of cultural awareness, cultural knowledge, and cultural sensitivity all adding up to a fourth aspect, cultural competence. The four aspects, being interconnected bring about a continuum of transculturally efficient care.

2.4.1 Significance of culturally competent care

Cultural diversity is a key factor in a thriving society of this day and age. Maintaining diversity as an asset in society has implications for health care services from policy to service delivery level. Health care services today are evaluated more than ever for their capacity to understand and respond effectively to the cultural needs brought by patients into the encounter between patient and personnel. (Centre for the Advancement of Health. accessed 22.3.2012).

In the provision of culturally competent health care services an appropriate offering would require interpreter staff; translated written materials; sensitive discussions regarding consent of treatment and clear guidelines for preventive measures. It would also require health care personnel who have the understanding and capacity to ask about and negotiate cultural issues; appropriate food choices; and other significant measures. The provision of these kinds of services has the potential to improve patient outcomes. This translates into efficiency in operations and cost-effectiveness in health care delivery (Center for the Advancement of Health. accessed 26.3.2012).

It is well recognized that a number of health care providers feel they do not have adequate knowledge on what to prepare for how and how respond to these emerging circumstances. As targets for culturally competent services are determined in health policy and directed toward the operational level, a unified understanding of what this

entails is essential to assuring quality. (Center for the Advancement of Health. accessed 22.3.2012).

A health care provider asserting cultural competence may yet make it impossible for the receiver of services, the patient or client, to actually understand as to how the claim actually relates to services experienced. Currently, there remains an inability to make accurate and comprehensive evaluations on how services are perceived in the context of cultural competence. A basis of evaluation is required for health care service researchers, policymakers and providers to continue improving the quality of their services from the perspective of the receiver of care. (Center for the Advancement of Health. accessed 24.3.2012).

2.4.2 Barriers to culturally competent care

Dalrymple and Burke (1995) have stated that unless clients are considered as true partners, culturally sensitive care is not being achieved; to do otherwise only means that professionals are using their power in an oppressive way. Equal partnerships involve trust, acceptance and respect alongside encouragement and discussion.

Possible difficulties in communication and understanding may often be the result of the tendency of health care professionals to project their own cultural values and behaviour onto the foreign-born patient. Such projection may contribute significantly to non-compliance on the part of the patient, an inadequate assessment of care required and perhaps even to a failure in provision of adequate care. In order to avoid such developments, it is important for health care practitioners to become aware of the values of their own cultural background from the cultural background and values of the patients for whom they provide care (Capell, J. Dean, E. Veenstra, G. 2008).

Circumstances where an individual or a group considers one's own culture and its values to be superior or even preferable to another ethnic group's culture, is called ethnocentrism (Papadopoulos et al.2006). Ethnocentrism may well surface at a collective level and can be perceived as dominance or even intolerance of one individual to another, from one group to another, and onward to a regional and national level (Ray 2010). It is important to realize ethnocentrism is part of culture. It pertains to

one's own views, values and beliefs do to its familiarity, of being raised in that very environment and the fact that there is no understanding of other cultures (Berry, J. 1992). It is human to be an ethnocentric and often these views are unconscious to the perceiver. One's own culture is viewed as the norm and all other cultures and related views and practices are viewed as foreign and even odd. Ethnocentrism is a mindset that enhances excessive patriotism and hidden racism (Giger, J. Davidhizar, R 2003, Dowd, S. et al. 1998).

The key to resolving such circumstances is in the acknowledgment of the existence of such beliefs of one ethnic group being superior to others. This is the initial step to ethnocentrism being dissolved. (Ray 2010). It is seen to be of relevance that health care personnel in their interactions with immigrants, become aware of their own cultural backgrounds, recognize its impact on their assumptions, attitudes and beliefs and how it is reflected in their day-to-day work Purnell, L. Paulanka, B. 2003).

2.5 Studies conducted in Finland

2.5.1 Studies conducted on immigrant health care

According to Finnish researchers who have reviewed international studies the health of non-Western immigrants is especially vulnerable. Ethnic minorities in all age groups have been found to have poorer health than the majority population. The utilization of health care services may often be scarce and may even be of poorer quality than the treatment of the majority population. Although the difficulties immigrants have in receiving required social, health and even services of employment is well recognized, attempts to find solutions to the challenges have not been numerous (Gissler – Malin – Matveinen 2006. Peltola 2005).

There is very little data on how immigrants use health services, and comprehensive scientific study on immigrant health is still lacking in Finland. Statistics on immigrant background have not been compiled in health care user registries. Municipalities are at most able to differentiate immigrant clients from the majority population at customer number level. As a result, existing data on immigrant health is not readily available and

the needs and use of health services of specific immigrant groups is unknown. (Malin – Gissler 2006. Rauta 2005. Sarvimäki – Kangasharju 2006).

The statistical practices of the social and health services would require modification to enable gathering of data on how immigrants use social and health services. Social and health care statistics on the ethnicity of the client should be filed under uniformed criteria. Uusijärvi (2003) suggests that it is the challenge of the near future to assemble comparable statistics in which the immigrant background of a client is defined and registered in a consistent manner.

As for hospitals in Finland, further investigation may be necessary to find out to what extent data on immigrants may be available. At TAYS, for example, the numbers of immigrants receiving care at the Maternity and Labor wards are not available, nor are any figures regarding the different language groups or countries of origin. (Kalvas A. 28.10.2011).

In regard to qualitative research conducted in Finland on immigrants and their utilization of health care services in general, the perspective assumed has been that of the health care professional. It may be noted, qualitative research from the perspective of an immigrant, the actual receiver of care, is rare indeed. One such study is a Master's Thesis on immigrants from Kosovo and Russia along with Finnish expatriates and their reasons for seeking health care back in their countries of origin (Gashi, F. 2009). The study was conducted as part of the Masters of Health Sciences, International Health Programme of the University of Tampere.

There are undeniably significant measures in the field of sexual and reproductive health research that have been given priority in Finland in recent years. An example is the Social and Health Ministry's 5-year plan from 2007 till 2011 which also underlines the development of services for special target groups such as immigrants (STM 2007). The Family Federation, Väestöliitto, a social and health sector organization focusing on family wellbeing in Finland has also raised awareness regarding the needs of

immigrants in their 2-phase program for sexual and reproductive health launched in 2006 (Väestöliitto. 2009).

Another project implemented and an indication of steps being taken regarding the immigrant population of Finland is a research project pilot initiated in 2010 and followed thereafter by a larger study was undertaken by the National Institute for Health and Welfare – THL in Finland. The study, named “Maamu”, aims among a number of themes, to uncover factors affecting the health and wellbeing of immigrants and focuses on three ethnic groups of immigrants in the country. Findings of the study are to be released in 2012 (THL, accessed 9.10.2011).

2.5.2 Studies conducted involving cultural competence in health care

As earlier conveyed the scarcity of health care research on immigrants makes it quite clear that there are also very few studies conducted in Finland that focus on how immigrants and their respective communities perceive the care provided by Finnish health care personnel and the health care system as a whole (Clarke 2003). The situation in terms of studying perceptions of care in this manner has not changed significantly from 2003. A dissertation by Sainola-Rodriguez published in 2009 does however convey findings about the skills needed in multicultural encounters between health care personnel and their migrant patients. The skills in this study are evaluated utilizing transnational competence framework and do involve interviewing immigrants in 2002 as well as primary health care personnel 2005-2006 in the field of psychiatry.

More studies have been conducted evaluating cultural competence solely from the experience and perception of health care personnel. One such study, a Master’s Thesis by Tuokko (2007), aims to convey cultural competence as experienced by health care students having experience of working with immigrants.

It is evident, taking into account the challenges referred to earlier in obtaining extensive and reliable quantitative data, that extensive research of the qualitative kind, involving inhabitants of non-Finnish origin may not be easily conducted to the extent that would currently be required. In reviewing theme related studies of qualitative nature, the

majority of the studies, both quantitative and qualitative were from the perspective of health care personnel. Most of these studies conducted at the Polytechnic, meaning Applied Sciences level are not elaborated upon further by the researcher.

2.6 Findings in international studies

The benefits of culturally competent health care provision have already been recognized internationally. Van Ryn and Burke (2000) state that although few studies actually do make the direct link between cultural competence and the elimination of racial/ethnic disparities in health care, professionals and officials alike perceive matters and are convinced. Health care professionals, advisors and officials in government, managed care, academia, and community health care already have already derived a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities (van Ryn, Burke J. 2000).

In regard to barriers to culturally competent care Philips K et al. (2000) takes an example from the U.S. health care system, where the issue has been at the forefront for decades, and state that the existing barriers among patients, providers, and the health care system in general may be a factor that decidedly affects quality and contributes to racial/ethnic disparities a number of issues. They perceive the effects on quality of care to include the lack of diversity in health care's leadership and workforce and state that systems of care to be poorly designed to meet the needs of diverse patient populations. It is also seen as a question of poor communication between providers and patients of different racial, ethnic, or cultural backgrounds (Phillips K. A. et al.2000).

One distinct finding in research reviewed is how beliefs of the immigrant patient may guide the making of choices regarding one's health and wellbeing. The health care professionals on the other hand may regard these views as in opposition to scientific medical knowledge. This may result in a number of challenges in caring for the patient and the choice of asserting one's authority or not in the circumstances can be a difficult choice to make Culley, L. Dyson, S. 2010). In order to provide culturally competent

care the nurse needs to be aware of these health related beliefs as they may have significant impact in the outcome of administered care (Dogan, H. et al. (2009). It should also be recognized that illnesses are expressed in a culturally orientated way, meaning the symptoms of a given condition may be experienced differently according to the patients' cultural background (Dogan, H. et al. (2009).

One research article of significance to mention, involves an attempt to set universally applicable standards of practice for the provision of culturally competent nursing care. The article lists 12 standards to begin with. They are social justice, critical reflection, culturally competent nursing knowledge, cross cultural practice integrated into healthcare systems and organizations, patient advocacy and empowerment, multicultural workforce, education and training, cross cultural communication, cross cultural leadership, policy development and evidence-based practice and research. The underlying factor for the standards is social justice, meaning the understanding, that every individual and group is entitled to fair and equal rights. There is also the mention that nurses require further education (Douglas, M. et al.2009: 257-269). Star and Wallace (2009) indicate that an estimated 60 % of nurses would be interested in receiving multicultural training and feel that it should be provided by their employer.

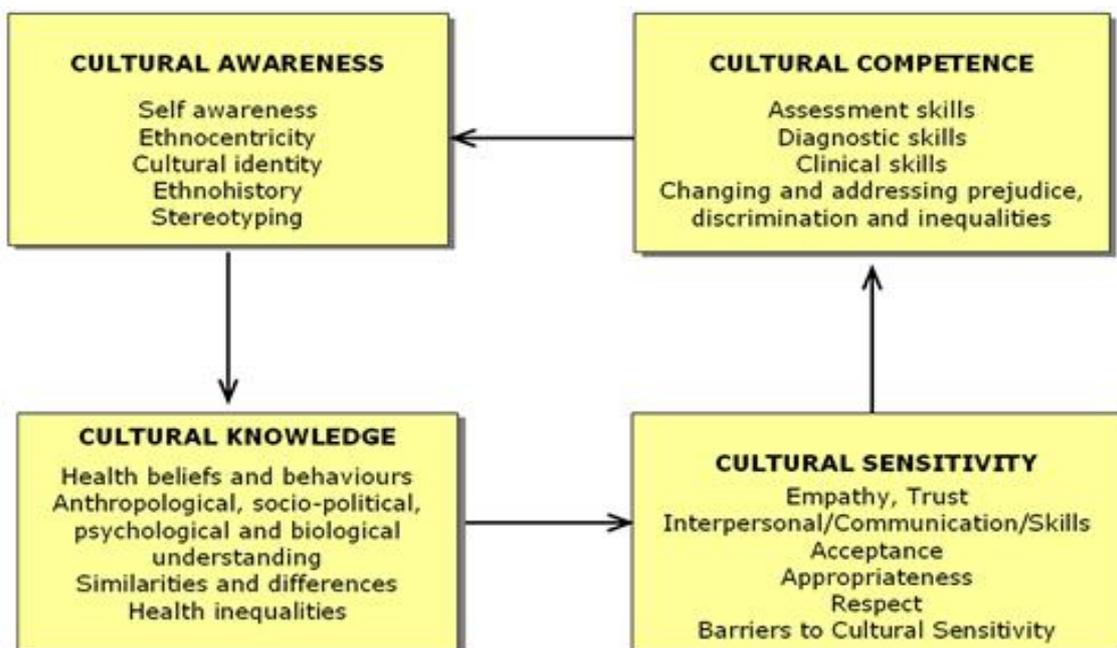
To conclude, there are consistencies in the challenges recognized in culturally competent care. In the first instance there is a lack of overall cultural knowledge resulting in prejudices and harmful attitudes towards migrant patients. Communication difficulties exist due to inadequate language and interpretation skills. There are also challenges due to the lack of universally applicable standards of practice for culturally competent nursing. Finally, health care personnel's' perceptions and convictions about immigrants in general as well as immigrants as patients does reflect into the care and interaction with these patients.

2.7 Papadopoulos, Tilki and Taylor Model for Cultural competence

The model for developing cultural competence was first derived by Papadopoulos, Tilki and Taylor already in 1998. It was initially introduced under the transcultural care theme (Papadopoulos, I. et al.1998).

The PPT model consists of four different levels: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos et al. 2006). The model is depicted in the following table.

Table. 1



Papadopoulos, Tilki and Taylor model for Cultural competence (Papadopoulos, I. 2006).

Papadopoulos, Tilki and Taylor’s model offers a comprehensive approach and conveys a gradual process for developing cultural competence that may be evaluated. (Papadopoulos, I. 2006).

2.7.1 Cultural awareness

The model consists of four stages. The first stage in the model is cultural awareness which begins with an examination of our personal value base and beliefs. The

acknowledgement of one's own cultural identity is of significance in this phase and enables one to be aware of others' cultural backgrounds. The nature of the construction of one's cultural identity and its influence on people's health beliefs and practices are viewed as the necessary and initial steps of learning (Papadopoulos I, 200

2.7.2 Cultural knowledge

Cultural knowledge, the second stage, can be gained in a number of ways. Meaningful contact with people from different ethnic groups can enhance knowledge around their health beliefs and behaviours. The observation of lifestyle choices of individuals and groups by the health care professional can prove highly enlightening. This enables an understanding to emerge around the problems these ethnic groups encounter. The recognition of cultural barriers on this stage of competence forms the key to cultural sensitivity, which in its turn creates the basis for mutual trust in a nurse-patient relationship, and creates an improved ability in preventing and controlling conflicts. Sociological study may be utilized in the learning about power. Issues regarding professional power and control are addressed and existing links between personal position and structural inequalities are recognized. Anthropological knowledge enables the understanding of the traditions and self care practices of different cultural groups thus enabling the consideration of similarities and differences (Papadopoulos, I 2006).

2.7.3 Cultural sensitivity

An important element in achieving cultural sensitivity, which is the third stage depicted in the model, is how health care professionals view those in their care. Characteristics related to sensitivity such as a capacity for empathy, good interpersonal and communication skills, a capacity to trust, respect and accept the patient's knowledge and views regarding care proposed as well as received. This requires the nurse to view the patient as an equal partner. As referred to earlier by Dalrymple & Burke (1995), partnership is an essential element of cultural sensitivity and is of true significance in avoiding oppressive practice. When true partnerships exist, meaning no power relationships are involved, genuine choices can be offered.

Papadopoulos continues in conveying how a health care professional must develop transcultural communicative competence. This is seen as a combination of developing specific knowledge and insights into a specific culture as well as having the skill to use this knowledge to guide ones understanding of the patient (Papadopoulos, I. 2003).

The importance of cross-cultural interpersonal communication cannot be underestimated. Ting-Toomey already in 1991 warned of most interpersonal communication theory originating from individualistic, Western culture. This would inevitably mean that approaches in such theories would reflect a Western-based ideology. It should be underlined, therefore, that although any concept proposed under the cultural sensitivity theme should be part of health care professional training, there is indeed no guarantee that what is being taught comes from a genuinely transcultural perspective.

The demand for practitioners to develop a generic ability to recognize communication and interaction challenges across cultural borders is a significant one. The challenge is however greater, as discussed here, than one would initially perceive. It is clear, however, that a most common barrier to cultural sensitivity would be an ignorance of culturally appropriate communication and interaction (Papadopoulos, I. 2006).

2.7.4 Cultural competence

The fourth stage, cultural competence requires the coming together and application of previously gained awareness, knowledge and sensitivity. More focus is given to practical skills at this stage. Skills such as assessment of needs, clinical diagnosis and other caring skills are underlined. A health care professional's skills evolve throughout ones working life as they are put into practice and modified according to insights accumulated (Gerrish, K. Papadopoulos I. 1999). Competence in terms of how cultural identity mediates health or arriving at a deeper understanding of how structures of society and organizations either promote or hinder culturally competent care are all of assistance in the acquiring culture-specific competencies, meaning, competencies that are specific to certain cultural groups. It should be noted that it is impossible for any health worker to know all about the numerous cultural groups of one's area. It is

possible, however, to gather the relevant culture-specific information needed to care for a particular patient. (Papadopoulos, I. Lees, S. 2002).

Another significant component of the cultural competence stage of development is the ability to recognize and challenge racism and other forms of discrimination and oppressive practice. The model combines both the multiculturalist and anti-racist perspectives. Such an approach enables the enhanced and continuous development of a broader understanding of inequalities and human rights. This in turn, promotes the development of skills needed to bring about change at the patient-care level (Papadopoulos I.2006).

2.7.5 Utilization of the PPT Model

It is well recognized that cultural competence as an area of study may be viewed as rather abstract in character. Research findings in such a field are not always easily uncovered through direct questioning. Findings of this nature are also not easily and quantifiably measured. Segmentation into smaller aspects within a theme is of key significance (Alkula, T. Pöntinen, S.Ylostalo, P. 1994).

The PPT model for developing cultural competence offers a means to view the different qualities and attributes as segments. It is of importance to recognize the model does not require rigid inspection from one stage to the next in chronological order. This is especially significant in terms of evaluating findings. Once flexibility in movement between different aspects is maintained, the model does have the propensity to prove highly applicable to the purpose and objectives of the study.

3. OBJECTIVES OF THE STUDY

The objectives of the study are the following:

To bring forth the experiences and expectations of immigrant women regarding the care they received during their stay while giving birth and being admitted to the Tampere University Hospital (TAYS).

To uncover perceptions of Health Care personnel working in Pregnancy and Labour Wards, regarding the distinct needs of immigrant women giving birth at the hospital.

To detect and examine possible similarities in perceptions and to shed light on previously undetected differences between the previously mentioned groups, as to how administered care is in actuality perceived by the receiver.

4. SUBJECTS AND METHODS

The following deliberates on the subjects and various aspects involved in data collection and analysis of the study conducted. There were a number of stages and significant factors to consider in order in ensuring requirements of the parties involved were adhered to. It is for these purposes the researcher has taken necessary precautions to convey aspects of collection and analysis methods in a thorough manner.

4.1 Subjects of study

The interviews for the study were conducted in two phases. Phase I interviews were conducted from mid February to the beginning of March 2012 and Phase II interviews during the 2nd week of March 2012.

Study participants in the first interview phase were immigrant women having given birth at Tampere University Hospital TAYS during Autumn 2011-Spring 2012. As defined earlier, an immigrant in this study is considered as a person who moves from one country to another and regardless of the reason or purpose for moving (Kuntaliitto). Study participants in the second phase of interviews were Tampere University Hospital midwives employed in the Maternal and Labour Wards.

The interviews were carried out in the homes of the immigrant women interviewed initially in the Hervanta area and at later stages in the Greater Tampere area. Interviews with midwives were conducted at the Maternity and Labour Wards of Tampere University Hospital - TAYS.

4.2. Inclusion criteria

Inclusion criteria for phase I interview candidates

- woman 16-48 –years of age
- country of origin other than Finland, having immigrated to the country from another country
- resident of Finland
- had given birth at the Tampere University Hospital during the designated time frame
- had the capacity to communicate with enough fluency in English or Finnish

Inclusion criteria for phase II interviews

- midwife at Maternity and Labour Wards
- predetermined dates for interviews, random selection during each selected date
- Interviewee duties for the day were not overtly disrupted. This was determined in collaboration with the Head Nurses of the unit

4.3 Recruitment

Eligible participants in the study for the initial phase with immigrant women were recruited by the public health nurses at Hervanta Maternity Clinic. The initial purpose was for the public health nurses to obtain informed consent from those participating in the study and the interviewer contacting the participant to set up an appropriate time to conduct the interview. In actuality, the researcher received the name and phone number from the public health nurse from the Maternity Clinic and then went on to introduce the study in detail to the potential interviewee in order to obtain informed consent. Upon receiving of written consent the interviews were able to be conducted. Recruiting immigrant women presented some challenges which will be discussed in further detail in Chapter 6.7.

Form of recruitment previously conveyed took place via intentional sampling where samples were selected by the criteria indicated earlier. The approach afforded the researcher more control and a greater probability for uncovering credible and applicable data for intended analysis. In addition to intentional sampling, unforeseen developments required the utilization of a purposeful sampling method, snowball sampling' also known as referral sampling.

The non-probability sampling method approaches those already interviewed to refer potential candidates, who in turn are approached for purpose of recruitment. Snowball sampling is utilized with the assumption of significant themes and experiences arise during the course of the interviews until a form of saturation is indicated. This refers to a point where in the course of interviews, new information to be uncovered becomes more scarce and certain themes and experiences arise in repetition from one interview to the next (Leard dissertation. Accessed 12.10.2011).

Eligible participants for the second phase of the study involving midwives were recruited randomly on designated dates from those working in the Maternity and Labour Unit at TAYS. Recruitment of personnel was assisted by the Head Nurses of the Maternity and Labour Unit and coordinated by an appointed Head Nurse. This was done to ensure daily work duties were not overtly interrupted and enough participants were acquired.

The interviews in both phases I and II were to be conducted to the point where a saturation point in data gathered is reached. A data saturation point is reached when the researcher is no longer receiving information that is considered new and information gathered begins to be repetitive (Hirsijärvi, S. et al 2005). In receiving study authorization from the Ethical committee of the Tampere University Hospital a maximum of 20 interviews per group was granted. The saturation point for Phase I interviews with immigrant women was reached after 8 interviews. In Phase II a saturation point was evident at 10 interviews with midwives.

4.4 Methods for protecting against partiality

The eligibility of participants was evaluated before the interviews by the recruiting public health nurses and the researcher in phase I. The Head Nurses at TAYS were of assistance in the recruitment of interviewees in phase II.

Intentional sampling was utilized with the addition of snowball sampling in the phase I interviews and random sampling in the phase II interviews. The intention was to locate significant themes and experiences during the course of the interviews. A saturation point was clearly achieved with distinct themes becoming evident during the course of interviews for Phases I and II.

Protecting against partiality in the interview had been made possible in the first instance, by conducting the selection for eligibility through the Hervanta Maternity Clinic Public Health Nurses. This was done to ensure date of delivery was in according to determined specifications, the immigrant was capable of communicating fluently enough in Finnish or English and that she had preliminarily consented to take part.

The researcher in contacting those who had given preliminary consent as well as those contacts received through referral had the opportunity to review criteria being met accordingly. The interviews of the first phase were conducted in the homes of women to ensure privacy and sensitivity to the issue at hand.

Interviews with midwives were conducted randomly and on predetermined dates. The Head Nurses' involvement with a recognized coordinator among them was highly beneficial acquiring the required amount of interviews. Prior to interviews, a recognized and possible limitation as to the diversity of backgrounds and work experience among midwives interviewed was recognized. This was due to requirements of interviews being conducted amidst ordinary work duties for the day. As interviews were conducted it became evident that midwives with a reasonably broad range of backgrounds and work experience had been interviewed.

It may be indicated, probability of partiality was further reduced by the researcher of the study not being affiliated with any of the instances involved. There was no monetary compensation for research conducted.

4.5 Methods for data collection

Data was collected using thematic interviews. The interview structure started off with structured questions in order to establish relevant background information about the participant. This was followed by an interview outline utilized by the interviewer to gather data during the interviews.

The choice to use the thematic approach for gathering of data was not straightforward from the very beginning of planning the research. The research plan was reviewed by the TAYS Ethical committee and the interview outline regarded as one suitable for a structured interview instead of the initially intended approach. Once authorization for the study had been received, the researcher, having reservations regarding the applicability of the interview approach, had it tested prior to initiating interviews.

A form of pilot testing was conducted to resolve the matter. Two Finnish women having recently given birth were preliminarily interviewed and the results confirmed reservations to be accurate. The originally intended outline form was found preferable for the purpose of uncovering relevant findings. The thematic approach was therefore resumed and outlined questions per themes assumed prompting status.

A thematic interview design uses a semi-structured interview protocol where key themes are approached in a more flexible manner. Although there may be a set of structured questions to establish the required background of the interviewee, it is followed by focused, conversational and more two-way approach fitting the semi-structured category. The idea is for the interviewer to recognize the issues that need to be covered, yet allowing the interviewee the options to take different paths and explore different sentiments and experiences. In its approach the interviewer and interviewee are more equal partners (Offredy, M, Vickers, P .2010).

Unlike the structured interview approach where detailed questions are formulated in advance and a specific order for the questions is followed, the majority of questions are created during the interview, allowing both the interviewer and the interviewee the flexibility to probe deeper into issues and uncover genuinely new findings (Green, J, Thorogood, N. 2009).

The interviews were recorded during the interview sessions. Notes taken were seen necessary to assist in possible challenges arising in the transcription process. Possible challenges in transcribing interviews are related to only being able to transcribe what is being heard and any non-verbal communication otherwise being excluded from the data gathered (Bucholtz, M. 2006).

Interviews with immigrant women in their individual homes lasted from 1 ½ - 3 ½ hours respectively. A total of 8 immigrant women were interviewed, half of them conducted in English, the remaining in Finnish.

In first phase interviews, upon reaching agreement on an appropriate time to conduct interviews in the home of the participant, all precautions possible were taken to ensure the confidentiality of each interview. Experiences and perceptions conveyed were from the culture of origin context. Culturally sensitive behavior on the part of the interviewer was imperative in approaching the highly personal and delicate subject of pregnancy and delivery.

The longer interviews were extended often due the required sensitivity to the issue, the necessity to clarify what was being conveyed or due to unavoidable interruptions during the session. The outcome for phase I interviews was 81 pages of transcribed data. The data was then analyzed and findings utilized in the formation of a structure for phase II thematic interviews

A thematic interview design was utilized for phase II midwife interviews with initial structured questions to establish the required background of the interviewee.

Themes within interviews remained unchanged. As previously indicated, interviews were conducted amidst ordinary working shifts at the wards. The interviews therefore had a more distinct time limit. Most of the interviews did not exceed one hour. Interviews conducted among hospital staff did not delve into individual patient files and maintained a general level. Personal views were conveyed yet in the professional context.

A total of 10 midwives distributed evenly between the different wards of the Maternity and Labour Unit were interviewed. All interviews conducted were in the Finnish language. The outcome for phase II interviews was a total of 85 pages of transcribed data. Upon transcribing all interviews, a total of 166 pages of transcribed data, of which 117 pages had been translated from Finnish to English, became available for analysis.

4.6 Methods for data analysis

In choosing the analysis method content analysis and discourse analysis were both reviewed. Content analysis aims to gather scattered information from data in an abbreviated and condensed form. The purpose of the analysis is to define a clear and simplified view of the area of study and related phenomenon. (Tuomi, J. Sarajärvi, A. 2002). Discourse analysis refers to texts oriented toward broader ideological explorations. It aims to reveal how languages make their impact. The approach aims to reveal more than just the superficial meaning and uncover less obvious social aspects (Green, J, Thorogood, N. 2009). Another definition by for discourse analysis would be “the study of linguistic relations and structures in discourse” (Merriam-Webster Dictionary. (2011).

Discourse analysis is often viewed as a more demanding approach to analysis as it pays particular attention to structures of any kind that may be set into a variety of meanings. For example, it takes into consideration non-verbal expressions of a wide variety and requires for them to be recognized. There is detailed attention to structure, form, organization and patterns. Interruptions, hesitations, pauses all require identification (van Dijk, T. accessed 14.3.2012).

A typical discourse analysis is an explicit, systematic account of structures, strategies or processes of talk in terms of theoretical notions developed in a segment of the topic. (Antaki, C. Billig, M et al. 2002) The challenge of utilizing the approach may be problematic as it is a true challenge to go beyond repeating, paraphrasing, summarizing or commenting upon an expression or phase in the interview texts of this study. While discourse analysis was the initial aim of the researcher significant consideration had to be given to the matter of having to transcribe a total of 18 interviews and in addition translate the majority of them from Finnish to the English language.

Under the circumstances, a thematic content analysis approach was chosen where the content of the data would be categorized to the recurrent and common themes. As Markoff, Shapiro and Weitman already in 1974 conveyed, “content analysis needs to be incorporated into a broader approach than discourse analysis so that it may be seen to perform a clear role within such an approach rather than one which appears to be in competition with it”. Although there may be limitations present in the analysis of the data of the research, the approach referred to previously will also be the aim of the researcher.

Forms of content analysis are, inductive, deductive and theory-driven, also referred to as abductive analysis. All of these forms involve preparation, organizing and reporting. Yet, there are no systematic rules for analyzing data. The unifying factor for all is the classification of many words in the text into much smaller categories. The preparation begins with the data needing to be transformed into written text before analysis. Transcribed material enables the selection of the unit of analysis. This can be a word, or a theme under which transcribed data may be categorized. Deciding on what to analyze in what detail and sampling considerations are important factors before selecting the most appropriate unit of analysis (Polit, D. Beck, C. 2003).

Preparation of data involves organizing, simplifying and reducing it according to determined purpose. This may be seen to open up more diverse analysis opportunities and enables the researcher to become more aware of the opportunities of analysis present. The units of analysis also enable the connection to applied theory.

The next phase would be to group the units of analysis into different categories, which in turn is a grouping of content sharing communality. Different categories should be able to distinguish the similarities and differences among one another. Categories may be created in advance based on previous research and theory as in theory-driven analysis or they may be derived from data as in data-driven (inductive) analysis. Creating and modifying categories is considered to be a critical point of the analysis (Elo, S. Kyngäs, H. 2007).

In qualitative research theoretical and conceptual understanding develops during an entire research process. Neither categorization nor coding completes a study on its own. The actual interpretation and understanding of the data is taken to its farthest potential and all findings are reviewed within context (Elo, S. Kyngäs, H. 2007).

Inductive content analysis aims to construct a theoretical framework from research data, meaning it allows for the analytic themes to emerge solely through the study of data. It involves a process where themes and categories emerge from the data through careful examination and continuous comparison. Deductive analysis on the other hand, works its way from the more general to the more specific, meaning it begins with generating concepts of variables from theory or previous studies (Tuomi, J. Sarajärvi, A. 2002). Deductive content analysis is therefore utilized when the structure of analysis is based on earlier knowledge and the purpose is to test theory.

The study utilizes content analysis, the method of analyzing written, verbal or visual communication messages (Tuomi, J. Sarajärvi, A. 2002). It is utilized to uncover the experiences and expectations of immigrant women giving birth and perceptions of Health Care personnel working at the Maternity and Labor Wards at TAYS.

Inductive content analysis, in this case would not be conducive to objectives of the study as the researcher does apply recognized theory to what is being investigated. An inductive study also presents challenges that are generally acknowledged, as there is already a tendency for the researcher not to be free of predisposition and assumptions in the initial planning of the study. It may be recognized, there has always been research

on the area of study beforehand (Tuomi, J. Sarajärvi, A. 2002), The same partiality has the tendency to apply to reporting the findings of a study as the researcher is to rely on recognized terminology and concepts in making ones findings known. This undoubted factor has been of influence in selecting the content analysis approach in this study.

Deductive content analysis would not apply to the study either as although recognized theory is applied in the planning of research and formulation of structured interview form, recognized theory is not followed in rigidity but applied in a manner that allows the bringing forth of findings comprehensively and purposefully. The planned research also allowed for the analytic themes to emerge from the study of the data when regarded as appropriate, meaning, for the purpose of conveying relevant findings. It is for the previously stated reasons, theory driven content analysis is utilized in analyzing research conducted during the study.

Analyzing research findings through theory-driven content analysis examined the results through the four dimensions of the model which are cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Cultural competence as an area of study may be considered quite abstract in character. It may not easily be enquired upon directly and is not easily and quantifiably measured. An abstract theme of this nature requires segmentation into comprehensive aspects of the field (Alkula, T. Pöntinen, S. Ylöstalo, P. 1994).

4.7 The analytical process

Once all the interviews were conducted they were transcribed. A total of 166 pages of transcribed data, of which 117 pages had been translated from Finnish to English, were analyzed. Preparation of data for abductive content analysis involved organizing, and simplifying it according to requirements of the study. Interviews were read a number of times to enable the identification of the most recurring remarks within the data. Predetermined themes were categorized further into subcategories or units of analysis. The extent of interview material made it undeniably clear every single aspect conveyed in the interviews could not be addressed. The researcher therefore selected the most

recurring themes and content in the researcher's view otherwise having significant relevance in the cultural competence context.

Once the different subcategories had been determined, remarks were selected from the texts that most comprehensively supported them. This meant reading the interviews again and again. During the study process, the titles of the categories changed to a certain extent.

The units of analysis were not directly linked to the PPT- Model as the aim was to view it from this context once the analysis per theme and the synthesis between the two groups analyzed had been conducted.

4.8 Management of Study

4.8.1 Key collaborators

As the study was conducted only once and the designated time frame was limited, the role of those collaborating in the arrangements of the study was of true importance. The Head Nurse of the Labour Ward had a significant role in planning the study from the initial stages. She also arranged the opportunity to discuss the details of the study with the Director of Nursing and the entire Team of Head Nurses of the Maternity and Labour Unit. The Head of the Hervanta Maternity Clinic had a significant role in assisting with informing each public health nurse working with pregnant immigrant women in the area and assisting in the process of recruitment.

4.8.2 Data handling and record keeping

All gathered data from the interviews as well as accumulated results were treated with strict confidentiality and were processed according to Personal Data Law requirements. Each interviewee was given a personal code and respective data was filed under the individual code. The recordings of the interviews were erased after interviews were transcribed. It is essential to note the transcribed interviews could not in any manner be

traced to any individual taking part without access to the Code Key Card in the possession of the researcher.

4.9 Ethical Review

Prior to beginning research for the study several authorizations had to be acquired. Although the proposed study was not requiring access to medical records of any kind the nature of the study required the plan for intended study to be reviewed by the Ethical Committee of Tampere University hospital. As the immigrant women were to be recruited from Hervanta Maternity Clinic, the city of Tampere also required the study plan to be submitted for review, accompanied by the authorization statement of the Ethical Committee at TAYS before any recruitment of candidates could begin.

The preparation for the reviews of the TAYS Ethical Committee followed stringent protocol and adherence to specific guidelines. The guidelines and necessary forms were available on their website (TAYS Ethical committee. Accessed 14.10. 2012) and the review process required an abundance of paper work over the course of four months.

The Ethical Committee review package consisted of study introduction leaflets and informed consent forms for interview phases I and II in Finnish and English languages respectively. Interview structure and content were required for thorough review and study plans in both Finnish and English languages, were to also be submitted. The entire ethical review process involved two separate TAYS Ethical Committee reviews and a single review by the city of Tampere prior to proceeding with recruitment. Upon authorization no questions or doubts remained as to ethical considerations being met.

4.9.1 Possible risks for study participants

The study did not pose any risk for those participating in the study. Measures were taken to ensure no participant may be recognized based on the study to be published. Although the interview themes for the women do not necessarily relate to any diagnosed illness, the issues discussed do relate to period in one's lifetime that may be considered

private, sensitive, precious and unique. Discussing ones pregnancy and delivery-related care is a delicate and highly personal matter. The utmost care was taken to ensure the interviews were conducted with the tactfulness and sensitivity required. It is the researchers view that the interviews were conducted successfully based on the spontaneous feedback offered by the participants immediately after the session.

It is to be noted, each participant was at liberty to revoke one's consent to participate in the study. The same may be stated for the staff interviewed. This was also an important factor in the midwives' interviews, as although they were conducted more from a professional point of view, they issues discussed did bring forward some highly personal perceptions as well.

4.9.2 Benefits and incentives to study participants, collaborators and researcher

There were no immediate benefits or incentives to study participants or collaborators for the study. Possible benefits could arise over a longer period of time possibly through enhanced multicultural and culturally competent Maternity Health Care services to immigrant women as a whole. The researcher was and remains non-affiliated with any of the collaborating counterparts. The researcher received no external funding for the study.

5. RESULTS

The findings of the study are initially conveyed and analyzed first for the immigrant women interviewed, followed by those for the interviewed midwives from the hospital. The findings related to possible similarities in perceptions as well as undetected differences between the two groups interviewed will be presented in Chapter 6 Discussions. A synthesis of the findings, as experienced by the immigrant women, will also be made from the PPT-Model context in the Discussions.

The interview remarks presented in the results are derived from 166 pages of transcribed content. Statements reflecting the views of the each group were placed accordingly under their respective theme categories. The aim has been to convey as condensed a view as possible and not overly simplify and therefore lose relevant aspects conveyed through the interviews.

Interviewee statements following are presented in italic lettering to enhance legibility from other text. The interviewee's remark is stated after the code number or letter designated respectively. The code for immigrant women ranges from A to H while the Midwives interviewed are presented from 1 to 10.

As the transcribed data even in its curtailed form is considerable the interviewer's questions, prompts and remarks have been deleted and only the key categories and subcategories are indicated. The different wards are not separated into subcategories but a chronological of statement findings, beginning with possible statements regarding admissions, moving on to the Labour Ward and ending with the Maternity Ward is maintained whenever possible. The researcher is of the understanding that this would further enhance legibility and make going over the findings a less time consuming undertaking.

5.1 The immigrant women

The immigrant women interviewed were all able to communicate in either English or Finnish. Their experiences and perceptions are conveyed from the culture of origin context. A total of eight women were interviewed. Four of these women were recruited with the assistance of the Hervanta Maternity Clinic. The remaining four were recruited through the referral via the interviewees who were kind enough to consult their network of friends and acquaintances for possible interest in participating in such a study. These women, along with the other four women, although they lived at different areas of the Greater Tampere region, had all given birth at TAYS.

5.1.1 General findings

The women interviewed were 26-34 years of age and had lived in Finland for 2-10 years. Three of the women chose to have the interview in Finnish although they had only had some training in the Finnish language. Having a Finnish partner did not appear as a criteria for having an interview conducted in Finnish. Five of the women were of Asian origin, the remaining three from Europe, with emphasis on Eastern Europe. Four of these women had Finnish partners, the others having partners from their native countries. Four of these women had given birth to their first born at TAYS and the other four had given birth to their second child at TAYS. Of those women who had given birth to their second born, half had also given birth to their first born at the hospital some years ago. These women had the opportunity to reflect on both their first and their second experience at the Hospital Maternity and Labour Unit.

The women could in general be regarded as well educated. All but one had Bachelor or Masters level degrees. Three of these women held permanent positions in companies where English was the working language. Two had held one or two temporary jobs during their years in the country. Three women were housewives and their partners, all of immigrant origin, were the breadwinners for the family. It is good to take note that although many had spent years in Finland and regardless of having a good level of education or a permanent job, in no manner did it guarantee the woman could speak

Finnish. Two of the women had clear plans on returning to their native countries in the coming years. Three indicated they may consider moving to another country than their native country in the coming years. Three of the women indicated had plans on staying in Finland indefinitely. It should be noted none of the women had come into the country on refugee status.

As for services prior to the onset of delivery, five of the women interviewed had a range of 1-5 appointments at the Maternity Outpatient Clinic. Purposes for appointments had to do with issues regarding high blood sugar, prolonged spotting, delivery planning and delayed onset of labour. These appointments were often of short duration and therefore interactions were more minimal contrary to admission to the other wards of the Unit.

It may be speculated that the nature of these appointments had some impact on how care was experienced and perceived. The Maternity Outpatient Clinic Midwives received undeniably favourable mentions in regard to clarity in forms of communication, level of attentiveness, sensitivity to personal concerns as well as professional skills. The favourable mention was unanimous with the five immigrant women. The finding was clear although all interviewed indicated staff was working under severe time constraints.

5.1.2 Physical environment, materials and resources

Finding ones way

Immigrant women have more of a tendency to have challenges in finding their way to the hospital. Signs leading to the admissions for example tend to all be in the Finnish language. Women may take a taxi, or have a neighbour drive them there. In any case and effort is made to locate the entry to admissions. Once inside the hospital the difficulty may continue as the information desk is easily overlooked. Some of the women remarked they were grateful their husbands could make better sense of the Finnish signboards than they could or that they relied on another hospital visitor's help to make their way.

There are also challenges in ones way out of the Maternity Ward. Visitors such as

grandparents may come in accompanied but make their way out on their own and get lost in the attempt. They may even end up wandering around because they cannot make sense of the sign boards.

E: "The thing I noticed that if I did not have my husband with me, who knows Finnish, it would have been very difficult to find our way. For example all the signs seem to be in Finnish....I don't think they even have it in Swedish much...really confusing!"

F: "On attempting to get admitted to the hospital we took a taxi to make sure we got to the correct door from our home. It is really difficult for someone who does not know Finnish to find the correct path to the delivery ward as well as Maternal ward, as was the case with my parents, who had great difficulty in finding their way both into the maternal ward as well as out of the hospital. They ended up going round and round before finding their way".

H: "One thing I would like to mention is upon arrival at the hospital with my friend. My partner arrived only later, we could not find our way to registration. We ended up wandering about for some time before we found a visitor to the hospital who could help us find the correct way. I found the signs to delivery really unclear and ended up getting really anxious because of this".

Admissions facilities

All the immigrant women coming for delivery through the Admissions Ward unanimously found these facilities the ones they would most prefer improved. Having to wait in the corridors was a bewildering experience to the majority. The standing around in a narrow and crowded corridor with all the others couples, the lack of waiting in private and having to watch other women in initial stages of labour as well as being themselves vulnerable for others to see was an experience many recollect permanently. To make things even more difficult, many recollected having to stand around in the halls for long periods of time without a clear idea of an intended plan.

A: "I'd like to really improve the admissions to the hospital the most. It was really bewildering to walk around the hospital waiting for the next examination and see all the women with their spouses waiting in the corridor all together in the midst of contractions. There was absolutely no privacy there; everyone was in the same place. And this was when we had already been examined once. It was pretty shocking when I think of it now. So there we were with all those people waiting and I really would have preferred more privacy".

B: "I ended up waiting in the corridor in between inspections for hours at a time. I did not need any pain relief so it meant that I had to wait in the corridor. We did not want to go home so we ended up having to hang around the hospital and wait in the corridor. There was no place to rest in private. It was difficult for me, I was really anxious".

H: "I hung around the halls really nervous as I waited for labor symptoms to pick up. Many hours went by and it was really uncomfortable with no place to go to away from the rest of the people. I kept coming back to the admissions desk regularly. All of the waiting in the corridors really wore me out".

Labour room

Women in general found the labour rooms to be alright. Most of them had been in rooms that were spacious and clean. Being alone in the room for a period of time made a few women anxious due to the clinical hospital setting. A few remarked that they found sharing a bathroom with another woman in labour somewhat uncomfortable and lacking in privacy. There was also the mention of the spouse not having a proper place to rest.

A: If one is in the labour ward for a long time it can be really difficult for the husband because there is no place to take a break. There isn't even a good place for him to sit in the labour room."

F: "I found the delivery room spacious and I really appreciated it being clean. Later I found out the toilet was being used by another woman in delivery next door. I would not have liked to share a toilet in such a situation".

G: "Being alone in the delivery room at first for a time, I don't know how long it was, the room was big and sterile, very clinical and I had to wait for my husband and for the midwife. I really wished it was more homelike, a more natural atmosphere. The room made me more afraid about what was going to happen and how I would be able to get through everything".

The maternity ward

In the maternity ward rooms, all accepted having to share with a roommate although a single room would have been preferred. Circumstances in the room improved when one had the bed next to the window and farthest from the door. Additional space was clearly required as when curtains were pulled all around one could not walk around the bed at all. Several of the immigrant women interviewed stated they were less comfortable in the room because when they came in or went out their roommate who was with their husband or a visitor had not pulled their curtains around the bed.

F: I found sharing a room with the other woman a bit of a challenge. There was so little space once curtains were drawn. You could not even go around the bed with the curtains in place. I'm really glad I was transferred to another room but that was really cold! I have no idea why it was that way, I really had to bundle up or else go into the common room to keep warm.

G: Finnish couples clearly do not have a need for privacy for personal behavior in the room. They don't mind other people. I would not care to be in the same room at that time, a single room would help in not feeling awkward."

H: "I shared a room with another woman at the maternity ward and on several occasions, when her husband and family was visiting and when I was coming in the room and going out, they had not drawn up their curtains! I felt watched and was uncomfortable because of it".

Sources of information

A number of the women had not heard about the open house held by the hospital for those having their babies arranged regularly prior to the due date. Several upon hearing that it was in Finnish did not attend and one of the women stated that as she found there would be no opportunity to visit the wards she did not feel it met her needs. If the woman had attended open house, she indicated it helped her in getting prepared as she had her husband acting as translator for her the entire time.

The majority of the women interviewed had prepared for pending delivery through reading books or by reading material obtained from the internet. Women reported discussing matters with acquaintances, usually other immigrants, in order to find out about the conditions at the hospital and to prepare better for what was ahead. Many had visited the hospital website but did not locate information for their purposes in English.

Leaflets and brochures distributed by the hospital were appreciated, yet a number of them would have preferred culturally adapted material more. A translated leaflet was not viewed to serve such a purpose. A few of the women during their stay at the labour ward went through the baby care DVDs repeatedly, although they could not understand the language. They felt it was beneficial as they were unable to remember the details of what had been demonstrated by the midwife earlier.

Several of the women raised the question of how those women who do not speak any English or Finnish cope with the lack of appropriate material. They wondered about it as they felt it was of vital importance to have some material to take home with them. Patient files received prior to departure were also discussed, the women generally would have appreciated being able to discuss them with a staff member.

C: "I did not attend the open house available as the public health nurse told me about the content and it did not sound like it would be useful at all. I heard we could not even visit the premises properly. I heard from friends it was really good many years ago before but it was different now. I relied totally on talking with my friends back home and researching the kind of delivery I would ideally like to have".

E: "We visited the open house with my husband. It was quite informative and we got more of an idea of the hospital. Had my husband not translated the important parts of the presentation, I would not have benefitted at all!"

F: "I began to prepare for the delivery, along with the visits to the maternal clinic, all the reading material I could get my hands on. I also had extensive discussions with women from my country who had delivered their babies in Finland. I was preparing myself mentally and physically for delivery during the entire pregnancy. I was made aware it would be really different from my delivery in my country".

E: "I wonder why there are only Finnish signs to the hospital and even on doors inside the ward. It might be really good if a nurse could show me where everything is in the maternity ward or at least if I could have a map showing where everything is, at least, and in some language I can understand... In general, I did not notice culturally adapted material offered at all. Even the internet gave really basic information and there was absolutely nothing about what kind of care a foreigner could expect. I think it would be really important to at least use the internet to help mothers not born here in getting help from the internet in preparing to give birth. This is something that could have been available. I wonder how do those mothers' cope who do not even speak English or who come from a culture that is so different from Finnish culture? How do they manage? Please don't get me wrong, I appreciate getting material in my language although it can never make up for personal guidance and instruction from staff."

D: "I received some patient files upon getting ready to leave the hospital. It was all very technical, was not able to really understand them although I've tried using different means. It would help if someone had gone through them with me at least. I experienced a lot in giving birth and would have been good if staff had discussed what had taken place with me before going home. There are things I still think about and would like to know about."

Interpretive services

The immigrant women interviewed had a reasonable knowledge of either Finnish or English so interpreters were not required. Several women, however, indicated challenges in expressing themselves during to their symptoms at the Admissions, during the onset of labour or while recuperating from delivery at the Maternity Ward although in general they are able to get along in either of the languages. One of them had been offered an interpreter from staff and this was greatly appreciated amidst the challenges.

Reference was also made by several as to the lack of signboards present all over the hospital in English, including the Maternity Ward. This made it difficult for the woman to find what she required at times as well as for visitors making their way around.

G: "My vocabulary vanished at times during labour. When I could not find the words to express myself during delivery, my husband stepped in as my translator. It was a relief to rely on his knowing the language."

H: "As it was pretty hard to speak Finnish when I arrived, with all the pain and being really nervous, I was told that staff speaking my language would be available, if I felt I needed it. I found this really reassuring even though I did not end up needing assistance of this kind. Normally, I can get along in Finnish but not at that time."

H: "Another important thing to mention was that anyone not knowing Finnish can have great difficulty entering the hospital and finding ones way out. All possible signs are in Finnish only. My grandparents made it in to visit me with the help of my Finnish husband but when they tried to leave the hospital, with my husband already gone earlier, they got really, badly lost in the hospital. It took them a really long time to find their way out as they could not find anyone who could escort them outside".

5.1.3 Forms of Communication

Verbal expression

The women interviewed had faced challenges while communicating with the Admissions Ward staff. Several conveyed they had not received instructions they had understood and were not sure of how to proceed from there on. Anxiety due to uncertainty as to what was communicated was experienced by many. They felt staff did not seem to realize they were unclear as to what was indicated.

During labour most women experienced understanding and being understood by the midwife although difficulties did arise at times. This did not mean the women felt communicating in a foreign language during labour was in any way effortless. One indicated she had particularly brushed up on related vocabulary during her pregnancy in order to cope better. It was indicated by several of the women that when the midwife had communicated with the husband about something, she might have been left out of what was being said, meaning translation had not occurred.

Also underlined, was the fact of communicating in a foreign language taking a lot of time and effort when one is in the recovery phase. Several wished the midwife would've checked more often if what was being said was actually understood or if they felt they had any more questions to ask. Several were caught by surprise upon receiving word of being discharged from the hospitals they still felt they had matters needing clarification. It was clearly communicated they were not to stay longer and therefore matters were unclear and questions remained.

H: "I remember well the midwife at the admissions who told me I need to return home to wait. I was really uncomfortable and confused I tried to discuss matters with her to be more clear. She simply would not answer me in a way I could understand. I kept trying and trying but it was no good because she was busy with other things after we talked. My husband hadn't arrived and I was afraid. She would not answer me, it was awful."

A: "I felt the midwife really understood me well during delivery. I feel this was partially due to my having practiced my Finnish and labour-related words a lot beforehand and had studied the subject carefully so that I could be better prepared."

A: "One thing I would like for staff to know is that for a foreigner, to speak Finnish or even English if it isn't one's own language, always, always requires a lot of focus and effort in labor and recuperating afterwards. If the woman is slow in communicating she isn't necessarily stupid, she just needs more time to get herself together." I've noticed staff doesn't realize this at all, they tend to think you're handicapped in some way."

D: (taking place while in labour) " Her communication was quite clear for me, yet some matters that she spoke to my husband did not get translated to me directly. This would have been helpful. I was too occupied to ask my husband or her to know what they were saying. "

E: About going home from the hospital I was pretty much caught by surprise. The nurse told me that if the doctor says it's ok, I may leave tomorrow. I told her I felt I had still many things to check out and practice to feel good about going home. She replied there were others coming and they needed the beds. She was pretty blunt about the whole thing and implied there was no option to stay.

Non-verbal communication

The findings of the interviews conveyed several instances at the Admissions as well as at the Maternity ward where non-verbal communication on the part of the staff member had made the woman uncomfortable. These women felt such experiences had an effect on their capacity to communicate in a common language with staff and heightened feelings of insecurity.

Remarks referring to non-verbal communication emerging during labour were made regarding some midwives coming across as distant and cold in some cases. There were also refusals to comply with the woman's requests by clearly ignoring them altogether. The women did not report any clear impatience, or frustration on the part of the midwife. It was more about their maintaining full, expressionless composure while failing to address a request in any way. One woman reported a midwife setting very clear boundaries for her and for example removing a grasp off the midwife's forearm without a spoken word. These incidents had left the women with some troubling memories, self-accusations as well as related questions.

The women did indicate experiencing non-verbal communication of the caring, attentive and appreciative kind as well. Several of the women indicated that after a perplexing and anxiety filled period at the Admissions, meeting a compassionate midwife at the labour ward gave them a great sense of relief. In the presence of such a midwife difficulties with language soon evaporated and there was more of a sense of more openness, trust and acknowledgement. The calming effect of a sensitive and caring midwife was recognized and very much appreciated.

C: "When someone is caring for me I prefer to feel warm with that person. It's not that she was rude in any way, but it was all about her doing her job and pointing out everything is ok, she had a normal face, she was not laughing or smiling, she was not nervous with me, it was just straight line- like, her behavior

towards me. She was being a professional and that meant ignoring some of what I had to say. I think it would have been easier had she been warmer, kinder toward me."

E: "Everything got better when I finally was allowed to leave admissions and go into the delivery room. The midwife was able to calm me down again with her professional manner, kindness and clear way of communicating... I found that communicating in Finnish once again became easier and she could understand me. I felt she could even understand me if I could not find the words. She clearly showed me what to do and even was able to communicate during the entire delivery with my partner although they had no common language. She communicated using simple words and hand and body language. My partner was amazed at how he understood what she was saying".

A: "I've a memory of one thing during labour... my husband was out of the room and I was having a really hard time. I took hold of the midwife's arm without really being aware and she immediately took my hand and quite firmly made me let go. I don't think I hurt her in any way, she did not say anything but the way she did it was quite firm. I felt like I'd done something bad to her. I could not think about it for long but now I still remember it did not feel right. Anyway I had no bad intention; it was just difficult at the time."

Skills of perception

The women interviewed offered insights into the perception skills of staff at the Admissions, the Labour and Maternity Wards. Admissions staff came across as wanting in sensitivity and perception skills to the majority of the women interviewed. The researcher noted a number of women indicated an unwillingness to discuss their experiences regarding Admissions further. Clearly, it had remained a sensitive issue.

The Labour Ward staff indicated an acute sense of perception in most incidents interviewed. This referred to picking up effortlessly on clinical procedures required as well as of the cognitive and emotional kind. Most of the women were appreciative of the quality and stated how it not only made a difference personally but for their partner's as well. Picking up on the individual's body language, gestures and facial expressions easily and effortlessly was indicated. A few also mentioned appreciation for not being compromised when she wished to retain her composure and dignity as much as possible with the husband in the room.

Perceptive skills of Maternity Ward staff were indicated to not meet with expectations among the majority of women interviewed. The staff came across as busy and it was a general view that time was not taken enough for guidance and the answering of questions. In general, the working pace of staff was seen to affect the staff's level of perception significantly. It may be stated, there were exceptions, but they were mentioned only in two, non-connected incidents.

F: "The midwife receiving me in the labor room was surprised to find I'd not been tested for infection. She rectified the situation immediately and gave me the necessary medication. I'm so grateful for her quick response but still shudder at the continuous failure to deal with my situation earlier. This caused my husband and me so much anxiety".

G: "The second midwife was older than the first. She immediately was able to assure my husband all was well and I feel this helped me focus on the labor itself more. She kept reassuring me all was well and encouraged me in a wonderful way. I really felt she could understand what was taking place and what I was trying to communicate with her. I was so appreciating the way she kept asking what I required when I was gathering the energy to tell her something. I really appreciated how she did not assume anything of me but kept checking matters with me. I felt secure and also appreciated. She even seemed to be able to follow how my husband was doing. It was a challenge for him to be there. She was also so tactful in steering him into a position where he would not have had to view everything but could remain at my side. I am so grateful to her for how she took care of everything".

F: "I felt the staff was rather busy at the maternity ward. They did take time to explain matters and give guidance but as soon as they had completed their task they were quick to excuse themselves from the room. At times I found questions arising when they had already left the room. I did my best to ask the questions on the next entry into the room. It was a relief to me to find the same person entering the room again as did not need to explain everything again to a new staff member".

5.1.4 Interaction

Interaction with staff

The immigrant women interviewed indicated challenges of experiencing confusion, being overlooked or being dealt with in a hurried manner in their interaction with Admissions staff. Getting the required insight on present circumstances or possible causes of action at this stage, as one woman conveyed, required persistence and even significantly assertive behaviour on the part of the husband.

Experiences of working together instead of the midwife taking the clear supervisory was experienced and greatly appreciated by the majority during labour. There were incidents conveyed of a midwife just performing her job. A high sense of practicality in the task involved and speaking only the essentials with matters explained in a very professional manner was also indicated. A sense of calmness in interaction during labour was conveyed and appreciated by all.

The staff at the Maternity Ward was unanimously viewed as technically competent. It was clear they all had a good amount of knowledge to back up their actions. Immigrant women interviewed expressed a requirement to plan for what to do prior to staff entering their room. Preparing for questions in advance to make sure they were asked

before a staff member briskly departed was common. While student staff members were seen as somewhat shy, midwives behaved in a self-assured and straightforward manner, getting right to the point at all times.

Women often indicated they could not be sure when staff members left for the day and if they would be able to see them again. It was often indicated women waited to see a staff member who indicated more willingness for slower paced interaction. A sense of discontinuity in interaction and care received was prevalent as staff members caring for the woman had the tendency to change constantly. Interactions focused mostly on the baby and its weight. Although midwives were often in a hurry and in and out of the room quickly, they were patient in answering the bell on all occasions.

Women reported experiences of not being seen for whom they were or where they originated from. It was clear to each interviewed they were more or less regarded as one patient with a baby patient among masses of other patients. Impersonality was experienced as indifference. It was suspected that Finnish women could be more assertive in demanding more personalized and less hurried care. There was hesitation upon personally making such demands.

There were mentions in the interviews of two incidents regarding midwives at the Maternity Ward who utilized their time to be genuinely present and were comfortable enough to allow for genuine interaction while in the room. The women indicated they would have preferred to have these women caring for them more often.

The more general view was, however, that a lot of effort was required on the part of these immigrant women in the first instance, to get the attention of staff members and in the second instance, to be able to express themselves and their needs. What was of importance to these women was to be heard and have at least their most significant needs met.

F:” The staff did not at any point indicate they had an understanding of my culture by saying so or demonstrating it in their actions. I did experience them taking things for granted on several occasions, but most of the time I realized they did not have any idea of other cultural related practices that would have been preferable to apply. I feel it simply did not occur to them to ask. They were simply performing their duties. I don’t believe it was intentional. I just don’t feel cultural things were even considered.

I recall one staff member acting more friendly and telling me they would like to visit my country. Other than that very little discussion was conducted on other topics in general than those related to baby care”.

G:” During my first pregnancy it was really confusing getting admitted. I was at the hospital too early and recall not being so clear about everything I was being told. I was asked questions and remember the nurse not really explaining anything as to why she gave me the instructions she did. I was really worried and I think she didn’t notice this at all. There were moments where we did not really know what to do. The nurse was really busy. She mentioned things that we did not really understand even though my husband could speak the language. The second time in admissions (2nd delivery) the nurse was much more attentive in explaining what we needed to know and I guess it could have been because my husband would not give up on finding out. He was much more demanding the second time”:

D:” She did not talk a lot and just performed her job. I recollect her explaining about something in good detail. She was very practical with everything and answered our questions briefly. When I was not paying attention and did not have any need to talk, she talked to my husband in his Finnish, which I did not understand. She seemed capable of taking care of everything although she was really brief in everything she said. It was all very business-like and that’s OK but it was more like speaking at me than actually speaking with me.”

E:”In the first days I kept ringing the bell quite often as moving around was difficult and really slow. Sometimes the staff arrived quickly and sometimes I really had to wait a long time. I felt I needed guidance often. I felt they were patient with my calls, but they really did not have time to stay long. I felt I had to hurry to speak up with my questions so that they would have time to answer and that I would really understand. I did do my best so they would be able to get on with their work. Most of the time they seemed really busy. I would also have liked to know what time they leave work. When I was waiting to get a nurse the next time she had gone home and there was a new one coming in. It was confusing.”

G: “I also have to say I did not feel like I was really seen for whom I was. No one at the ward paused with me for such a moment. I guess they saw me as patient so-and-so in room so-and-so. I’m sure a mother if she’s of local origin or not would require enough time with a nurse to allow for questions to naturally arise. I noticed the ward was not completely full and yet the nurses were rushing in and out of the room. Why can they not pause in a room for enough time to actually face the patient? Why are they that way? Is it Finnish mentality or what?

Interaction with others patients or roommate

The Maternity Ward most often has the immigrant women sharing a room, most often with a Finn, as single rooms are limited. The tendency is that roommates have very limited interaction with one another. The regular greeting exchanged being the norm and curtains tightly drawn around one’s bed at all times. The women indicated being disturbed by practices of the roommate such as not being able to sleep because of their neighbour watching TV all day and even late at night. Telephone conversations, text message signals and phone vibrating tones were commonly experienced significant disturbances around the clock. There were indications of the women addressing arising situations but roommates not always taking these views into consideration.

A woman conveyed her roommate sleeping so soundly all the time that she had to be

the one to call for the nurse when the roommate's baby had been crying for a long time. Another had to listen to her roommate crying for long periods of time pondering on the right choice of action. To comfort her, ask for help or to leave the room quietly to allow for grievance in private. She recollects doing her best to come up with what would be expected of her in the situation and what would be considered acceptable behaviour. A general finding among immigrant women interviewed was the feeling of it being a necessity to continuously take the roommate into consideration and to adapt their behaviour accordingly. Relations with a roommate were never discussed with members of staff.

Although the majority of the women had issues regarding the capacity to relax with a roommate in the room, one of them indicated her roommate actually started helping her with her baby, after noticing staff was not assisting her enough and there were significant challenges in coping. She also indicated that as her condition improved they began helping one another with their babies a lot and this made up a great deal for her interaction with staff.

C: "My roommate kept the curtains drawn all the time. We did say hello once and that was it. She seemed to be a heavy sleeper because her baby was crying and she did not wake up and attend to the baby. I had to call the nurse to attend to her several times".

D: "One night I felt really bad and upset. I felt so sorry for my roommate who cried and cried all night as she had received some terrible news. I did not know how I should've behaved in such a situation and there was nowhere I could go so that she could be alone. I also found myself wondering if she expected me to do something for her. I felt very unsure on myself and what I should do."

E: "I was having such a hard time and it was such a relief to me that my roommate started helping me out. She would sooth my baby for example if I had to step out for a moment and could not return fast enough. She was a great help and really helped me with stress. We did not have a common language but she was so supportive and kind to me. I don't know what I would have done if it weren't for her there."

F: "One thing that disturbed me was that she kept watching TV when her baby was awake and when I was trying to sleep. I asked her to turn it off but she ignored my request. What also disturbed me was that although she had her cell phone on silent mode, the vibrating signal was so loud; it disturbed me all the time. She also spoke on her phone so loudly. I did not feel I could speak to the staff about this and only felt that I should bare it the best I can. Maybe they (staff) realized the situation, as I was put in another room....I could then relax a bit more and focus more on learning to care for my baby.... anyhow, it would be better if staff paid attention to how it is for the foreigner in a room with the Finnish roommate. I really had to be flexible with my roommate and do my best to adjust to her behavior. I don't think she thought of how uncomfortable I was with her".

Receiving visitors

There were several issues arising regarding receiving visitors at the Maternity Ward. A number of the mothers were surprised and although they could understand the restrictions involving visitation, most were not pleased by it. It was considered as rude behaviour by several of them to have to inform friends and family of the restriction as many came from backgrounds where the arrival of a newborn was an important event to be recognized within their individual relationships.

A number of these women were of a cultural background where the task of the grandparents or in laws was to take care of the mother in the first days, weeks and even months after giving birth. In laws and grandparents had taken long flights in order to accomplish the task. Some flying from far away to do what was culturally expected and accepted of them. The hospital protocol on visitation was inexplicable and highly unthinkable to these grandparents and women experienced additional anxiety from having to not only cope on their own but in having to expose their own parents or in laws to such protocol. Due to the nature of interactions with staff not one of them felt it appropriate to address the situation with staff members in any way. Grandparents and in-laws found alternate ways of caring for the woman through extending their stay at the ward as much as possible. They also sent all meals daily to the ward. This was, however only a small part of how they were initially intending to care for her.

Another significant finding was that many women interviewed felt it more appropriate to receive their visitors in the common spaces of the ward out of consideration for their roommate. Several of them reported Finnish women receiving visitors in their rooms and not even drawing curtains around their beds during the time. This left many feeling over exposed regardless of if they were breastfeeding or just being in bed. Many had the acute need to cover up to ensure privacy when the spouse of the roommate entered and this was not always possible to accomplish soon enough. The opportunity to be maintain decency and reasonable appearance at all times was important to a number of these women as some reported even the importance of maintaining appearance with their respective partners.

It would be of significance to convey several of the women expressing discomfort with having to witness their roommate's intimate interaction with their partners. This was

considered inappropriate and offensive behaviour. For these women it was not culturally acceptable to display the nature and aspects of one's marital relationship in public.

A: " What I'd like to change at the maternity ward is that when women who've just delivered share a room and the other's spouse comes in. I feel really exposed even though the curtain is partly closed. Breastfeeding or not, being very presentable when the other husband comes in and sees me is really, really uncomfortable. In my culture a woman prefers to be presentable to her spouse but especially in regard to other men. Not just lying in bed not properly covered up or with perhaps not completely cleaned up so quickly after giving birth. This can be too much to handle for women from my country. Everything is too open. Also to have to see your roommate in a private situation with her husband.... "

G: In my culture friends and relatives are free to come visit a mother at the hospital. In this hospital it was not possible. Only my parents could visit for an hour a day. Fortunately, my friends who live here understood this as part of Finnish culture. I would have enjoyed their visit a great deal. My parents had flown over from my country to be with their new grandchild. They found it difficult to understand they could only visit us for an hour each evening. It is so different to our culture and can be regarded as a really offensive rule. I did try to explain it to them as much as possible but I feel it was difficult for them to accept it. After all they had arrived into the country to receive their newborn grandchild.

D: " My parents arrived into the country to help with their first grandchild. I have understood people in this country do not have very close family ties. Could they not accept the importance of family in another culture? No questions were asked regarding my family members coming to visit me. I take it they just aren't interested. They don't see the importance of family like we do. My parents could only stay for awhile in the evenings and it was really hard for me to see how they felt about it"

5.1.5 Perceptions of procedures, health and recovery

Procedures

In terms of procedures conducted the issue of c-sections was raised on several occasions. Several had the view that once labour encountered more challenges c-sections were commonly resorted to as was the case in their countries of origin. Several wondered if the absence of a doctor had something to do with not having a c-section conducted or in the delaying or absence of intended pain medication. As labour pains intensified several questioned the absence of the doctor.

The availability of a doctor was expected by a number of women interviewed in all the wards of the Unit. Reasons for the absence of a doctor had not been clarified to these parents and several had been left with unresolved questions on the matter. Although male doctors would have sufficed for these women, many indicated preference for a woman doctor.

A: "I wondered with how difficult my delivery was; shouldn't they have done a c-section instead? My husband asked about it as he was so anxious but we still wonder because we never got a proper answer. I know in my country a c-section is often done in big hospitals if there are some things that make delivery more difficult. I wonder why I did not have one. There was no opportunity to discuss this".

B: "I wonder why they wait for so long to give me something for my pain (in labour). Was it because they could not get to consult the doctor? When I finally thought I'd get help it was too late to do it!"

E: "I remember wondering why with my labor getting more intense why the doctor wasn't called to attend to me. It was just the midwife repeating everything's alright. This increased my husbands and my fear about things going wrong if the doctor doesn't come on time. It was just the midwife who was assisted by another midwife, that's all. In my country, the doctor would be there immediately and even to just check up on things. I feel she was taking a risk although everything turned out fine in the end."

Medication

Issues regarding administered medication varied and in general involved the Maternity Ward. A general request was made that midwives find out about the woman's view toward different forms of medication and avoid making assumptions before doing so. While some were readily offered pain medication others had to overcome personal inhibitions in asking to be medicated more for ones pain. Another example was a woman indicating a personal need of taking all necessary precautions in order to avoid such medication as antibiotics. There was no such opportunity to discuss the matter with staff.

B: "I was readily offered pain medication. I did my best to take as little pain medications as possible."

F: "Could the hospital not find out what the mothers stand is on receiving different forms of medication before she is admitted? In this way the hospital could take precautions in order to avoid the use of medication such as antibiotics."

G: "I was in a great deal of pain at the ward and was not offered any pain medication after the first dose. I had to request for further pain medication. No one asked about my personal symptoms."

Breastfeeding

A number of women interviewed indicated not receiving enough guidance regarding breastfeeding. Most of them took time in having milk arise and therefore received very little or no guidance after the initial demonstration. Some women expressed receiving guidance at a point where they were not yet recovered enough to grasp what was being demonstrated to them. Several reported baby formula being administered to the baby with a brief mention or no indication beforehand whatsoever. This had troubled a number of women. Only one reported relief at automatically receiving formula for her baby. One of them indicating the midwife had gone against clearly indicated wishes and

had not been open to even discuss the matter with the woman. It was clear to her authority had been overtly asserted and it continued to trouble her.

Donated breast milk was something new to each mother and upon consideration most would perhaps have been more open to such an alternative should the midwife have taken the time to discuss matters patiently. Few women had the persistence to keep asking for more guidance on the matter. Immigrant women reported resorting to studying breastfeeding through the internet and through books together with their husbands once they had returned home in order to receive more information on how to begin breastfeeding.

C: "I did not receive much support in starting with breastfeeding. My milk did not come when I was at the ward and had to let practicing just be. Once the nurse came in and let the baby have some additional milk without asking me properly if it was alright. She seemed to assume I would find it OK. Or, maybe it was more her way of approaching the baby and behaving as an authority in the matter. There was clearly no good opportunity to more clearly say NO. I was not happy with this. Not even discussing it with me was really too much I think. I would have preferred to try and find another solution together with her. I don't know, did this happen because I was a foreigner? Anyhow, it was only close to going home that I got them to understand and accept I did not want the bottle for the baby and was finally able to have an option."

D: "I don't know what happened to the breastfeeding. I was briefly shown how to do it at first but since I had no milk they did not show me again later on. I received some books to read on the topic and a leaflet but nothing else. This worried me, but I wasn't able to try more to get them to realize I needed more help. Fortunately my husband and I did a lot of research on the topic and we managed to work things out once we got home. We read books and searched the internet a lot. We even managed to solve my problems of among ourselves!"

E: "The nurse popped in to see how I was doing. I was so surprised she suggested I breastfeed my child. After briefly looking at if it would be possible for me, I agreed. She quickly helped me in the bed to find a good position and then left the room before I had time for any questions. I then fumbled my way without much success and waited if she would come and check how it was going and give me further advice. I guess she was really in a hurry because she never returned. This made me a bit confused about the whole matter. Or maybe she felt I wasn't interested. I had just been through a life changing experience and felt I needed time to adjust. She probably meant well but I feel I needed time and patience in order to be able to adjust"

Baby Care

All women interviewed indicated they had a need for guidance in how to take care of their baby, regardless of if it was their first or second born child. Those who had just given birth to their second baby reported they had either forgotten how it's done or that they had not had to take care of their first born at all. In these cases the first baby had been cared for by the grandparents, family members and relatives. Although the woman indicated she had prepared herself psychologically prior to delivery, to care for her

newborn around the clock, she had experienced it as a highly demanding task. For this reason any help staff could offer was highly appreciated.

A few of the women utilized baby care DVDs to help in recollecting what the midwives had demonstrated. The DVD could not be understood but the demonstration on it was of great help. One mother indicated having watched the DVD over and over again to become clear on all the important aspects. It was clearly indicated by the women that there was hesitation in asking staff for more guidance as there was not often a sense they could be approached.

Involving the father in caring for the baby was a surprise for many interviewed as it was not common in the cultures of any of these women. Although the spouse was to learn these skills before the mother herself at times, the approach was welcomed. Several of them had no expectation of the father continuing the practice at home but felt it beneficial for the man to comprehend what was involved and all it entailed.

E: "I'm so grateful to that one nurse who saw how tired I was and offered to take my baby for me one night, when he was crying so much and I really felt exhausted. I actually could sleep a bit and when I saw her early in the morning she was so warm and kind to me and assured me everything was alright. She really made an impression on me at the ward as she was the only one in the staff who really cared."

F: "I had to ask the staff to guide me in caring for the baby several times before receiving guidance. It took some effort to convince them". As my parents in law were not able to be with me at the hospital I really had to learn to care for my baby 24 hours a day. Although I'd prepared for this in advance, it did surprise me how demanding it actually was."

F: "Another thing I found truly helpful was that there were DVD's that were playing non-stop where one could go over everything regarding the care of the baby. Although the staff went over the care with me, I could not remember everything in one go. I also did not feel comfortable in asking them to repeat the instruction. So, the ongoing DVDs being played were ever so helpful!"

Personal recovery

Actual personal recovery while at the hospital was a challenge indicated by each and every woman interviewed. Women experienced some pressure to conform to indications and expectations from staff immediately after delivery at the Labour Ward as well as while admitted to the Maternity Ward. Relying on the midwives assessment skills and ignoring one's own perceptions resulted in some unprecedented occurrences for one immigrant woman.

Women interviewed expressed anxiety over having to become so active so soon after giving birth. It was a genuine concern for most interviewed and many wondered on how practical efficiency at such a time would come more naturally to Finns. Immigrant women expressed a tendency for midwives to not have an openness and sensitivity in recognizing such challenges. It was clearly expected these women would be up to the same standard of performance as Finns. Women indicated a need to do their best to comply but felt they could not meet these expectations very well.

An immigrant woman interviewed indicated staff was so persistent and active with following up on how she and her baby were doing, she felt utterly overwhelmed by it all. Some of the questions asked required precise and elaborate answers even late at night. She simply could not in her condition meet the requirements of staff. Aside from being rather exhausted, this also caused her to suspect they were concerned about something yet the matter was never openly addressed. She recollected being relieved at finally getting some rest upon being dispatched from the hospital.

Women upon arriving at the Maternity Ward generally experienced difficulties in finding their way around the ward. For those who spoke only English, signs were not understood as they were in Finnish. Midwives had explained where facilities were usually upon arrival at the ward but the majority could not remember what had been indicated at a later time. The majority of women interviewed had issues regarding meals served at the hospital. This was mainly due to certain cultural views on what was appropriate for consumption so soon after delivery.

The majority of women interviewed had issues regarding not being examined properly upon discharge from the hospital. An examination by a doctor would have been much preferred in order to avoid complications in the latter period of recovery. Copies of patient files were offered but they could not be understood by the women, nor was there an opportunity to discuss what had taken place during ones stay at the hospital. As women still had unresolved issues at the time of the interview, many would have still preferred to discuss the matter with a competent professional preferably at the hospital.

It can generally be stated that discharge from the hospital was experienced as unexpected by some and premature by the majority of the women. A number of them felt they still had matters to clarify regarding care for their baby as well as themselves. There was an indication of having waited patiently for opportunities to ask questions and these opportunities never arriving in a manner that offered a genuine opportunity to clarify matters. Having a number of unresolved issues not only concerned the woman herself but caused anxiety in the spouse and grandparents as well.

A: "At one point the staff I felt was so active in my care that I almost thought it too much. They probably meant well, but I already was ready to rest and could just not take any more guidance. Answering their questions got to be a bit too much. I wanted to sleep already and it was nighttime. They wanted to inspect the baby at odd hours and I felt it was time to rest. I did not see the need for such concern. Perhaps there was something they did not let me know to not get me worried. I did not get the courage to ask them."

B: "Practical things at the hospital seem to come naturally to local women, for me they take a lot of getting used to. For example they ask you if you have certain dietary requirements for example. When you have just given birth you simply cannot think straight or remember everything as there is so much in this environment to take in. I felt overwhelmed by all the things I had to know at such short notice. Surely there must be a way of doing this for us foreigners. I don't think I'm the only one who would want to prepare for it. Also, if one went around the ward before and knew ones way around one would not feel so self-conscious and nervous to find everything when one really weak after delivery. I had to put all my effort into taking care of my baby. All those questions at a rather fast pace on when I have fed the baby or something else took a lot of effort to communicate in a foreign language. There was so much to adjust to and even recover at the same time. How could I possibly remember at what time I did what. I felt really stressed with all the performance expected."

D: "I feel the midwife in my delivery did not really understand my condition when she suggested I walk from the delivery room to the maternity ward. I realized it's a long way and couldn't even stand properly. It would have been easier to express myself had she first asked if I feel strong enough to walk. I felt embarrassed and it took effort to make her understand I was not strong enough to walk."

E: "I was asked to get up for the first time very quickly. I felt worried about this as it is not considered ok to do so in my country. Mothers stay in bed much longer even in normal delivery situations in my country. I felt pressured as my husband could not be with me at night and I then realized I was expected to start caring for my baby on my own. You see in my country the woman is never expected to care for her baby in the hospital and not even for some time after she returns home. It is the grandparents and siblings, aunts and uncles who help out with these matters. I guess they have no idea about this over here. I was worried on how I could cope. My parents, who had flown into the country for this event, were really concerned for me and their grandchild".

G: "When the time to check out of the hospital was near, the nurse came in and informed me I had to be checking out by a certain time. It was so unexpected. I was stunned. I felt there was no opportunity to ask any questions on my delivery and my own recovery by the time the reality of leaving had sunk in. I quickly hurried to pack and get the baby ready. It all happened so fast. I was still stunned about it at home. My mother and partner were really concerned at how checking out took place. Did they need my bed for the next person? The ward did not appear to be crowded at that time".

5.1.6 Assumptions, attitudes and values

Assumptions

Upon discussing assumptions on the part of midwives a variety of issues surfaced. In the first instance it was felt that staff placed a lot of trust in what the woman indicated at each point in time. An affirmative answer on the part of these women interviewed tended to be an indication of being able to cope in a variety of circumstances. Even when the reply was an uncertain affirmative and there was a tendency to overrate ones capacity for action. There was a general view that midwives had a tendency of overrating the woman's capabilities from the Admissions to the Maternity Ward. On several occasions the consequences were perceived as serious.

The women unanimously suspected Finnish women to be a lot more resilient, tough and more trustworthy in their indications. It was the researchers finding, women clearly conveyed that women capable of communicating reasonably with staff members were probably likely to be perceived as capable in a number of other aspects of what was expected at the wards. This also translated into staff assuming the women were more adapted to local practices and conduct. This was clearly not always the case and if there was some level of understanding it did not necessarily mean it was something viewed as acceptable by these women.

Several women interviewed during labour indicated they kept getting asked about how they were doing and if there was something they required for example to manage pain. Although this was seen to be a positive sign, they felt the challenges faced had more to do with becoming aware of all the options available at each stage of labour and how a choice would impact options available at a later stage. This information was not readily offered and women felt they lacked the means to initiate such inquiry.

Women interviewed were almost unanimously against having medical students present during their deliveries and appreciated being asked about it in advance and not feeling pressured to accept such participation. A woman conveyed she had years before had three medical students present, having not completely understood upon accepting, what

it would entail. The experience had been tremendously unpleasant for her as they were mere onlookers and did not actively participate in the delivery.

Another finding indicated came from women with Finnish husbands. They conveyed the perception of the midwife being affected by the father-to-be and not realizing the woman's cultural background and personal needs differed from the man's. This resulted in a number of issues being overlooked, one being the woman's dignity being somewhat compromised. Although the women felt the incidents had not left them overtly traumatized they would certainly have preferred the midwife not get carried away from the essentials and maintain focus on the woman and her needs.

It was a general view among immigrant women interviewed that they were not treated in any manner deviating from the care of Finnish women. They were not asked about their culture of origin nor were possible related preferences inquired upon. The midwives conduct was often conveyed as rather straightforward to the point of sheer bluntness. This created some disturbance and even attempts to keep interaction at a minimum, yet doing ones very best to learn the essentials required.

The majority of the women interviewed preferred midwives take a more active role in finding out ones preferences as there is true hesitation and a weaker state is not conducive in promoting active communication. These women implied that their being more silent did not indicate there were no issues to address or questions to be asked.

A: "My husband (Finnish) was at my side in the delivery room and the midwife got so excited about letting him feel the baby's head when it was coming out that he invited him to her side. I was really exposed! She did not cover me up in any way; on the contrary, she didn't notice my discomfort! They really do not seem to consider these things here!"

B: "The staff really seems to assume that a mother can cope with a lot of issues and trust that yes really does mean Yes. The midwives really have a lot of faith in the mother's capacity to cope and express herself right after delivery. Perhaps Finnish women are so tough and trustworthy that they mean what they say but in my case the midwife told me I could have a shower immediately after delivery in the labour ward. Since she suggested it, I felt I had to go into the shower but while I was there I nearly passed out or think I did for a moment. Good thing I didn't hurt myself in there. She clearly believed I was capable of it when I wasn't. She did ask if I'd cope in the shower and I told her I would. My husband was attending to the baby so he could not come and assist me that was a real shock to him."

G: "the problem was not that the midwife did not ask about how I was doing during labour and if I wanted something. The problem was that she did not explain what my options in each situation were, especially how it would affect my choices at a later stage in labor. It was as if she already thought I knew what the options were. Not realizing I did not. This made it really difficult for me. Why is it they assume a woman knows? Why can they not explain more about options? How can they expect a woman to know? Do Finnish women know so much or what is it? It's like she thought me to be a professional in the field or something like that"

C: "It would really be good if they took a more active role in finding out exactly what it is I want when I am clearly in a weaker state and can't express myself and be the active one. The staff especially in the maternity ward assumes that if I do not talk with them actively I have nothing to say or no preference in particular. This assumption was really wrong if it was made. It's hard for me to think if was intentional!"

E: "If I'm able to communicate through common language with staff it seems, they assume I'm acquainted with the way of doing things in this country, At time I found the behavior of staff assuming so many things. Did it did not even occur to them that I would prefer to be asked if I prefer something? Knowing a common language with staff and having researched caring for my baby beforehand does not mean I'm used to local behavior practices and find them acceptable. The staff I feel assume too much based on the information they have about me, maybe it's my nationality or something? Why don't they ask about my personal needs? This would not take much of their time. Or is it that they require everyone to adapt to their way of caring for patients?"

E: "Regarding being recognized and accepted as someone originating in a foreign country I'd have to say I was pretty much treated like a Finnish person except they had to use English instead of Finnish. The staff I found really work-oriented and everything was communicated in a straightforward manner. They did expect you to ask them a lot of questions and did not voluntarily offer a lot of information. They preferred to give me books to read. Their manner is very different to what it would be in my country. If I didn't understand Finnish mentality more I might have found it pretty difficult."

Attitudes

All women interviewed experienced at least a certain degree if not overt pressure to conform to local practices and hospital culture and to perform accordingly. The staff was seen to clearly expect it regardless of a need to recover physically, mentally and emotionally. Several of the women indicated a notion of these expectations perhaps not being intentional as they had more to do with lack of awareness and understanding.

In any case the women, in spite of their condition, felt they did their very best to meet these expectations and made the effort to communicate in a language not their own. At times this took a great deal of focus and effort.

The women conveyed several incidents of having come across clear attitudinal behavior. A woman interviewed expressed a clear ignorance of a preference she had indicated at a very early stage prior to the onset of delivery. The incident had left her troubled as there had been no opportunity to neither address the situation nor discuss it at length after delivery with any member of staff. She indicated the midwife caring for

her during labour was certainly doing her job and was clearly clinically competent but in terms of interpersonal competence, the experience had been nothing short of appalling.

Aside from being perceived as skilled and professional remarks were once again made on staff members coming across as distant, composed, work-oriented and serious. A lack of empathy made it more of a challenge for these women to get assistance. Several remarked on how their parents and in laws had also taken note of the same attributes in members of staff.

In terms of dialogue, the women indicated staff often had the tendency on relying on the individual taking the initiative to ask questions if any did arise. It was rare occurrences to have the midwife initiate any more extensive dialogue.

B: "I had already asked for the water tub in the maternity clinic to make sure I really got it because I really did not want to have an epidural. I got into the room with the tub and made it clear to the midwife. Instead of getting into the water tub she asked me to lie down on the delivery bed to be examined once again. I kept repeating I want to get into the water over and over again but she always said there was something else, I was not clear what, but I kept getting checked over and over. It was so frustrating for me and I could feel my willpower gradually melt away with all the pain and not being able to get into the tub. I was in such pain and eventually no longer had the strength to resist the pain relief that was offered to me. The midwife just did not listen to what I wanted and did not even give me any reason why I could not do what I needed to. We didn't have a single discussion about why I could not use the water tub. It was no use. Looking at the tub right next to me and I could do nothing! I think I was using every language I could to get the idea across. My husband also mentioned it to her. I was actually quite angry for not being in the tub. I do realize my language skills were at a minimum at that time, so I basically focused a great deal on communicating what was most important to me - the intense pain and the need of a tub, to be in water. She was just doing her job - performing the delivery."

C: "One thing I appreciated a great deal was that I was asked if student doctors could attend labor and delivery. I was not pressured into this in any way and was pleased I had the option to decline and clearly it was up to me to decide. It was respectful of them".

D: "The staff in the labor ward as well as the maternity ward is clearly very skilled and professional. I have confidence in their capability to care for patients. Most of them come across really distant, however. This can sometimes make a foreign woman hesitate in asking for help. It is cold enough in this country as it is, the staff does not need to add to it in its manner. For example my parents were totally ignored and they had come to visit the country for this particular purpose."

E: "They did often tell me to ask them questions. Being a newcomer to motherhood I found I did not know what to ask. I would have appreciated if they would have instructed me more so that the questions could arise from there. I feel they did rely on my asking questions a great deal. I think they might have taken my lack of questions as feeling I knew enough to not ask any but this was not so. Maybe they do not realize this.

F: "At the maternity ward the staff I was told to almost immediately get up and start taking care of myself along with the baby. I'd heard something about this, in preparing to give birth in the hospital, it was still surprising! After having followed instructions that were very practical and really to- the-point, I did

manage. In my country a mother usually rests for a long time after delivery to regain her strength. My mother was also really concerned for me but eventually at home she was able to relax about it more.”

Values

The requirement of mobility, activity and self reliance was noted by several women during labour and by all the women while at the Maternity ward. Several women conveyed they felt it was of cultural origin and required of Finnish women in general. Several had prepared psychologically for this requirement and yet found it to require a great deal of effort. Only one woman interviewed found this requirement to be quite alright once she got used to it and was able to therefore comply.

The immigrant women clearly indicated the midwives they encountered coming across as hard working and responsible in terms of clinical care. Their every action exuded a professional and straightforward practicality that focused to a great extent on the essentials. It was a rare occurrence for these women to actually perceive the personalities behind all the professionalism. The deviations from the norm were instantly recognized and truly appreciated.

Several women referred to a lack of appreciation among staff for good manners and of any kind. This was evident even when the ward did not to be filled with patients and a more relaxed work pace could have been adopted. The women interviewed conveyed they did the best they could to not take experienced conduct personally and reminded themselves repeatedly it was probably not intended to come across as offensive. One woman interviewed pondered if the staff members were tired of their work or stressed out. The majority of the women, however, had convinced themselves the behaviour displayed had more to do with Finnish mentality. Another decided she would need to get more acquainted with Finnish culture in order to deal with these issues in the future.

All women were doing their very best to cope with the conduct of staff at the ward. In general, women interviewed had come to the conclusion that there is not much taking into consideration of others, local couples do not value their individual privacy and the intimacy shared with a spouse. Another conclusion was that immediate and extended

family is not truly appreciated in this country. The findings were only enhanced by their experiences at the hospital.

B: Women are required to be so active and efficient in the maternity ward. So many responsibilities like in Finnish society too. It could be a bit more relaxed when one is recovering. For example, the important responsibility given to mothers in dealing with their rubbish. There were a number of containers and when you are tired and anxious you simply do not have the energy to go through the different instructions on what to put where. I really did not have it in me to deal with this at all. It took forever and eventually I just had to give up. Why does it have to be so complicated? Everything in good order, no matter what!"

D: "The staff probably had good work ethic....my involvement with staff was strictly on a practical and professional level. Their dealings with me were very much to the point, very task-oriented. It must be the Finnish way to stick to business and communicate only the essentials and nothing more. For someone not used to it, it comes across as cold and even rude. This how it was, even when there was no hurry. It's like the person is not there altogether. I did my best to not take it personally as they probably don't mean anything bad by it".

F: "I've come to the conclusion general good manners are probably not very important in hospitals here. Our departure went totally unnoticed. No one said goodbye to us. The manner of sticking to duties could maybe be a bit more relaxed. What about bringing in more appreciation of one another? At such an important event in a woman's and family's life, why do these things have to be handled with such indifference...I feel it would probably be helpful to know more about Finnish culture ... to be able to deal with what I come across. As staff here does not have too much of a clue maybe I'd be able to understand them more. This would probably have helped in dealing with my roommate too. She really made my husband and I uncomfortable"

H: "Also the local people do not have the same need to take others into consideration and they do not seem to require the privacy in their personal lives and their lives as a couple either. We could not be that way. It's not the way to be, where we come from".

F: "There is not much appreciation for family here. My mother in law and her husband had flown into the country to receive my newborn. They would have preferred to stay longer in the ward and were not happy to have to follow visiting hour regulations. This was difficult for them as parents in law as in my culture they would be acknowledged by staff and free to stay with the newborn as much as they wish. It is also the practice for them to participate in the care of the mother and newborn a lot".

5.1.7 General perceptions

Upon discussion related to general perceptions the immigrant women shared the view foreigners are not treated any different from local women. As a matter of fact midwives have a tendency to expect the same things from a foreigner as they do from a Finn.

It was also mentioned by the majority that although they could communicate reasonably well with the staff members they did require a lot of time to fathom what had been taking place and what was actually required of them. Taking time to act was at times misunderstood by staff as the woman failing to understanding what was communicated. Women were simply following the need to move forward at a slower pace and not able

to go along with the required efficiency even if they had wished to do so. This was clearly not always understood and the women felt a number of false assessments were made due to the staff not asking the appropriate questions in order to get a more accurate view.

D: "I got the general idea they do not approach foreigners in any way that differs from Finns. The woman's background does not mean anything in particular to them. For me the attitude took some getting used to and effort to keep an open mind, I did what I could to focus as much as I could in the situation and tried to understand their instructions and reasons for doing as they did. Feelings aside, I was happy to receive guidance and the advice that I felt was professional".

H: In general I felt I needed more time to process everything that was taking place. It was a new environment for me, a new baby, a new situation for my family. Everything took place so fast. I don't think the staff realized that I needed time. I also felt I was not able to indicate it to them or then they could not understand. I don't know, it was rather confusing, although I did manage, of course....I felt I needed to keep catching up to what was going on" They could have taken the time to check with me if everything was ok and not just assume based on what they saw".

Experienced satisfaction

In discussions related to experienced satisfaction, the women interviewed unanimously mentioned how matters were conducted in an organized and punctual manner once the Admissions Ward had been left behind. All of them were convinced they had not had to fear being in danger for the duration of their stay, however uncomfortable they may have been at a point in time.

The Labour Ward received favourable mentions in the majority of cases. Reference was made to caring yet highly skilled midwives, who took the time to support them as women not just patients. Smiles, encouragement, good interpersonal skills and levels of perception in addition to partners being included in a sensitive manner were among of the superlatives mentioned by most having a favourable experience.

D: "Everything is very well organized once you somehow make it through admissions."

H: "Such a caring yet highly skilled midwife at the Labour Ward! Taking my partner into account without them sharing a common language. In my country fathers aren't often in deliveries. It felt so wonderful that the midwife could read me like a book as well as communicate with my partner. She was attentive in every possible way. Her smile was encouraging and comforting. I felt respected and appreciated. She really made up for all the other not-so-good things before and after being in her capable hands".

Possible improvements

Upon requesting for views on possible improvements a couple of women mentioned the hospital offering special training for foreigners to enable them to better prepare emotionally, mentally and physically for what they would have to face at the hospital. They indicated the classes could prepare the women regarding hospital culture and the kind of behavior to expect from staff and what sort of behavior would be required of them while in the hospital. The training could also address issues regarding visitation hours, food and restrictions on privacy issues. They felt such information would be a good option should hospital management see it to be too much of a challenge to change the mindset of its entire staff.

A proposal also worth mentioning was allowing immigrant women to submit their questions and special requirements in advance directly to the hospital so as not to have to over exert oneself over details referring to diet and such upon arrival or at the Maternity Ward when one is not at ones sharpest and clear communication may present challenges.

Several women expressed wishes to be allowed to choose ones approach to delivery more freely and that one's preferences would at least be open for discussion and not ignored.

There were also requests made to improve the approach to breastfeeding by offering follow ups on guidance received and to offer supportive aides available for the purpose. The majority would prefer discussions on options to breastfeeding and not have certain practices enforced on them.

A number of women indicated the making available of a greater variety of foods more appropriately suited to meet their post-partum diet requirements as family members cannot readily make them available at the ward. These women would be willing to pay additional costs should such options be available.

One of the woman interviewed proposed a plan be made upon her arrival at the

Maternity ward and actually have it discussed with her so that she would have a better opportunity to prepare for what was to take place at the ward and be aware of the time she has to obtain the skills and gain more confidence in going home.

All midwives indicated a preference for enhanced interpersonal skills and a capacity for staff members to pause enough for them to be able to express themselves in a foreign language and in a foreign environment more appropriately. A slowing down and breaking out of routines at least occasionally would be much appreciated.

The majority of the women requested for a thorough examination, preferably conducted by a doctor, prior to being discharged from the hospital in order to avoid uncertainty and possible complications once at home. They also request for an opportunity to discuss their experiences of delivery with midwives prior to going home as the patient records are not understood enough.

A request was made to staff members of the Maternity Ward to consider frequenting the same staff members to foreigners more. As they viewed it, there was already a great deal to adjust to in the hospital environment without having to interact with so many different members of staff. They all felt it could reduce the level of anxiety involved in interaction, in understanding and being genuinely heard.

A: From my two experiences at the hospital I can say I believe they are skilled in performing the technical part of the job. It's clear the staff doesn't see enough of the importance of recognizing the needs and feelings of a foreigner. It seems they believe everyone should be treated in the same way, meaning the Finnish way, being the right way. If the hospital management cannot find ways to improve the situation with staff, how about arranging special classes to foreigners in helping them prepare emotionally, mentally and physically for what they are to face at the hospital. The class could prepare the women about hospital culture and as to what kind of behavior to expect from staff, what kind of behavior is required of them while in the hospital, address issues regarding visitation hours, food and restrictions on privacy issues. I believe this would lessen the shock many experience because the women would know more of what to expect. A number of women I know share my view."

C: "I would wish to improve is the way staff approach breastfeeding. I feel a new mother would need a lot more support in breastfeeding than what I received. Also they should make the different aides available to mothers so that they would not get too anxious and discouraged when everything does not go so smoothly. Also to offer other options than bottle milk. I believe a number of foreign mothers would prefer to have options made available to them and not having to settle for what is the standard in the hospital breastfeedin. At least they should find out if the mother has a preference in something so important.... In general I believe the knowledge of the staff must have been good. I suppose it would be too much to ask for the maternity ward staff in general to have a more caring approach as I am aware it is not in the Finnish nature to be that way. Another good thing would be to be provided with as much information about options in different stages as possible. The staff offers an option to choose yet for me,

to really be able to choose I need to be aware what the opportunities are to choose from and how they affect the care I'm given later".

E: "In our country it is the practice for women who have given birth to eat certain foods and only take warm things. My mother was concerned as she found out I was being offered cold things to have as desserts, yoghurt, cold juice and such. She sent me some warm meals every single day through my husband. I take it they are not used to it in the hospital? They might consider asking the woman if she requires a special diet, not just if she has certain allergies. Perhaps it would not be too much to make available a variety of foods. The patient would probably gladly even pay extra for them. Or perhaps allow more flexibility in the timing regarding delivery of foods, maybe...I would propose if there would be some kind of plan made for my stay and that it was discussed with me. In that way I could make plans on what can take place each day and prepare for it with questions and things like that. Also, I would have time to prepare to find out what I need to know, before finding out I was to go home and not have enough time in the end for everything."

F: "I feel a nurse should get close to the mother, show that she genuinely cares about the mothers and babies wellbeing and also understand that even if the mother is able to communicate in a common language it can be really challenging being in a ward, in a foreign culture and country. It is clear they were expecting for me to behave according to local culture even in a situation where I am recovering and cannot even have my family with me it can be really difficult to adapt. One can feel really rejected in such a situation and even though guidance would be really needed it would be better to return home fast, regardless of the situation".

5.2 Themes for midwives

5.2.1 Background information

The interviews conducted among hospital staff did not delve into individual patient files. There was no relevance in doing so at any point in time as arising themes were approached at a general level. Although perceptions of staff may often have been personal by nature, the interviews were conducted and maintained from a professional context.

As stated earlier, staff members interviewed were all midwives working in the wards of the Maternity and Labour Unit of TAYS. The majority of midwives had experience of working in more than one of the wards of the Unit. All interviewed were native Finns. The midwives work experienced ranged from short of a year to 18 with the strong majority interviewed having four years or over of work experience in the profession and at TAYS. All midwives interviewed had experiences of working with immigrant women. In addition to the Finnish language all indicated a reasonable proficiency in English.

A general profile of the immigrant women interviewed for the study was presented to

the midwives prior to initiating the interview. It was conveyed the women interviewed had the capacity to communicate in English or Finnish while being under care at the hospital and the good majority of women had a good level of education. The midwives were also made aware of the fact that none of women interviewed had arrived to the country on refugee status. They were asked to the best of their capacity to focus on immigrants with the previously indicated background.

A total of 10 midwives working at the different wards of the Maternity and Labour Unit were interviewed. The interviews conducted within the Unit were distributed as evenly as possible among the antenatal services consisting of the maternity outpatient clinic antenatal and admissions wards and the labour and maternity wards. The majority of the midwives interviewed had experience of working at more than one of the wards of the Maternity and Labour Unit as this was encouraged.

All of the midwives interviewed were native Finns and all, regardless of the extent of their work history, had experiences of working with immigrant women. Their work experience varied from a bit short of a year till 18 years with a third of the midwives having over 10 years of work experience. Half of those interviewed had between 4-8 years of experience as midwives. All midwives interviewed indicated at least a reasonable proficiency in English along with Finnish. One midwife upon being presented with the opportunity to participate in the study tactfully declined offering an immediate replacement for interview.

Prior to presenting the key findings of midwife interviews it should be noted the profile of the immigrant women interviewed was introduced to them. It was underlined that the women interviewed could communicate reasonably in either English or Finnish and the good majority of women participating had a good level of education. It was also indicated that none of them had come into the country with refugee status. The interviewer asked them if they would to the best of their capacity focus on how they perceived an immigrant with the above mentioned background.

5.2.2 Physical environment, materials and resources

Finding ones way

The possibility to discuss the issue of a non-Finnish speaking woman finding her way to the hospital and within its facilities was made available in the initial phases of the midwife interviews. Aside from a remark referring to immigrant women possibly resorting to ambulance transport more frequently than Finns, the issue was not elaborated on further.

Finding ones way within the Maternity ward in particular, according to midwives was ensured through verbal indication upon arrival at the ward. Several midwives mentioned they would take the immigrant woman around the ward should there not be a mutual language to communicate in.

2: *“I’ve never received feedback from foreigners about how they find their way here. I haven’t even given it any thought. One thing I’ve noticed, they may perhaps call for an ambulance to get over here even though there is no clear urgency of any kind. I don’t have an idea why it takes place, but they indeed perhaps make use of an ambulance more often, indeed.”*

5: *“Upon their arrival (to the Maternity Ward,) we do tell them where everything is in the ward - the extra clothes, diapers, the refrigerator and such. I take care to show them around, where everything is physically, when I do not have enough of a common language with them.”*

Admissions facilities

The Admissions facilities, in general were perceived as rather limited. The lack of privacy was noted and the challenges involved in receiving many women at the ward within a short period of time. It was indicated that limitations regarding ward premises were equally demanding for all women received regardless of if she was a native Finn or an immigrant to the country.

10: *“The facilities in the admissions, starting with the corridor is so narrow and it is not really suited to meet the needs of women with a variety of needs or backgrounds. We have women from different backgrounds with their own requirements for privacy. Our small spaces used for inspection and surveillance purposes are divided by curtains alone and this means their spouses and partners cannot join them there at all. The fathers have to wait in our narrow corridor or go outside while their women are being examined. Sometimes the women are in their small compartments for a really long time. Finnish men often present challenges as they are so concerned about their wives and tremendously protective of them and therefore not so aware of privacy issues that they may suddenly venture into the area where all the women are under inspection behind light curtains. The men of immigrant women tend to remember to mind the privacy of all the women a lot easier. They also often tend to display more trust that their spouses will be alright and not need to check up on them as regularly. It seems to be so clear to them that they treat the off-limits area as if there was an invisible shield between the corridor and the*

examination area. I do find they can be equally anxious as their Finnish counterparts but they do not often cross the line. It seems to come more automatically to them."

10: "Our facilities are rather small for what is required to receive all the women before they are admitted to the labor ward. Sometimes we are really challenged in how to receive all the women coming in. The evenings and weekends we do have an option for more privacy and more suitable premises when the adjoining prenatal clinic is closed outside regular office hours."

Labour room

Remarks regarding the Labour room facilities underlined a need for privacy. The facilities were seen to reasonably meet the requirements of immigrant women. Several midwives indicated the delivery rooms could perhaps appear less clinical although lighting could be adjusted to alleviate the situation. It was also noted the Labour ward facilities were not as suited for the spouses of immigrant women as they often demonstrated a tendency to spend significant time out of the delivery room as well. There was no other option for them than to wander about the corridors of the ward or go downstairs toward the main lobby.

3: "I'd think immigrant women find these facilities rather overwhelming, some of them at least. Everything's so hospital like and sterile. I'm sure it's intimidating for some of them. Of course it all depends on their background. I can't think of anything else regarding our facilities that would stand out."

7: "Many of the husbands of immigrant women tend to spend a lot of time out of the labor room. It's as if they're getting bored and sort of killing time in that way. The Finnish man however, will only briefly step out of the labor room, tend to what he needs to do, not looking around much before returning directly to his spouse."

9: "Some of our delivery rooms are suitable in size and others are too small. One room has a bath but in my experience immigrant women do not require a bath in the onset of labor very often. The doors to the rooms are situated well enough to ensure privacy but the small peeking windows on them are disconcerting to a number of women. As we have no partitions available mothers feel they are prone to curiosity of those in spending time in the hall."

The maternity ward

In general, the Maternity ward was seen to meet the needs of immigrant women. The significance of having the available curtains drawn around one's bed was well recognized as a need for privacy while in recovery. A requirement of privacy was perceived but could not be ensured.

5: "I've noticed they do prefer to keep the ward room curtains tightly closed especially if they're in the bed situated right next to the door. They do keep to themselves a lot. Many of them have food brought to them and do not really seem to eat too much of the food we offer them."

6: "I believe our facilities do not take a foreigner's needs into consideration. I'm sure many of them would require more privacy meaning a room of their own so they can be on their own and in peace. This is something I've noticed. When immigrant women share a room they tend to keep to themselves a lot. Some of them clearly do not feel well and this makes it more difficult to share a room with another."

8: "I believe these women do find our facilities - corridors, rooms and such as relatively easy to move through as they have been planned according to the needs required. I believe they will find our facilities as rather clutter free and suited for the purpose in most areas they are in."

Sources of information

Material originally produced in Finnish and translated into a variety of languages was seen to provide valuable information for immigrant women. The hospital website was also believed to be helpful for its English content. The available DVD's were not perceived very helpful to non-Finnish speaking women as they were only available in the Finnish language.

The majority of midwives interviewed had a tendency to perceive the availability of leaflets and brochures translated into a number of languages as sufficient sources of information. A need for culturally adapted and visually informative material was elaborated on in one instance. Interpretive resources such as vocabulary leaflets were utilized alongside interpreter services on-site as well as taking place over the phone for women with whom no common language could be shared. It may be noted Google translator was also mentioned as applicable by several midwives.

1: "Regarding material I do believe they are designed for those of a local background and a number of them have then been translated into a number of languages - Russian, Arabic, German, English and such. I do believe these are found really beneficial as the duration of their stay in the maternity ward is often really short and there's an abundance of information to take in during the short time they are here. I'd say they can come in handy when the woman has returned home and has a number of issues to focus on. I'm sure questions arise at that time. We do have some material for them to watch but basically I don't believe they're found as interesting due to the fact that they are in Finnish. "

3: "It helps if they've got a Finnish husband. I believe we've got a good amount of material online for these women if they only go and do their research."

5: "We offer these women printed hand out material, internet based information, instructions for caretaking after discharge from hospital, patient records regarding delivery: If they understand even a bit of Finnish they receive brochures. I'm also under the impression that they do print out material available online. Most of our material is in Finnish, however. We also distribute colorful bag sponsored by the X Company that contain child care product samples, also informative. Oh yes, everyone seems to know the commercial baby formula X. It's often requested by name. We do have some DVD's available for the mother but I don't feel they're too keen on watching them.

Interpretive services

The majority of midwives interviewed had a tendency to perceive the availability of leaflets and brochures translated into a number of languages as sufficient sources of information. A need for culturally adapted and visually informative material was elaborated on in one instance.

The general tendency was to reflect more on circumstances where no common language could be utilized. In addition to trying out single words along with gestures, facial expressions and touch, interpretive resources such as vocabulary leaflets were utilized alongside interpreter services on-site. Translations also took place over the phone for women whenever necessary. Spouses and other family members were used as interpreters, but generally avoided whenever possible. It may be noted Google translator was also mentioned as applicable by several midwives.

1: *“Some of the ways I use to get something relevant across is for example use Google translator if nothing else works as even a single, crucial word can make a world of difference. In addition I do make use of a good deal of gestures and may use touch as an indicator. Once I've found a good way of getting something understood I tend to repeat it whether its gestures, sounds, facial expressions, pantomime, whatever. When I notice the mother returns what I do in the form that replicates what I have been doing, I truly find I'm getting somewhere with her. Such a reply appears to take place quite spontaneously and the understanding of what is being communicated is pretty easy to verify. Once I notice something works I do use it again and again, often with success. I learn a great deal from these situations.”*

2: *“We do have small leaflets with foreign words and translations in different languages and we try our best to make use of them although they tend to be at a rather basic level.”*

31: *“We may call the husband if we know his English or Finnish is alright or on rare occasions call the woman's daughter if we come to the conclusion it's alright under the circumstances...If the issue requiring interpretation is on a very general level we may well call her up. For example if the mother needs to have a lab test taken at a certain time and she needs to return to the hospital, for instance.”*

4: *“Another situation may be where you may ask the husband to interpret something to the woman and then he may translate something really long and detailed using two words and that's all. This can be really frustrating, because one has to remain professional about it regardless if the woman gets to understand what is being communicated or not.”*

7: *“As a last resort I may get access to an interpreter over the phone and this can get matters sorted.”*

5.2.3 Forms of Communication

Verbal expression

Midwives interviewed conveyed patience and persistence in getting relevant

information understood by immigrant women. Several indicated the presence of a Finnish spouse to be of significance in easing possible challenges related to verbal communication. There were also indications of an immigrant woman's language skills varying according to if she was accompanied by a spouse or if she was on her own. A mutual language is spoken using simplified words and expressions. Speech is often significantly slowed down to promote understanding.

A general impression among midwives was that their manner of communicating made it easy for immigrant women to ask questions when a need arose. Midwives at the Labour ward recognized challenges involved in the capacity to communicate in delivery-related vocabulary in a foreign language for both, woman and midwife. Another tendency indicated at the Maternity Ward for example, after the basics of baby care had been demonstrated, was to assume and rely upon questions being asked according to necessity.

1: *"At times getting something relevant understood is rather time consuming, I know, but although there's not often much time to spare, I notice I tend to not give up. A kind of stubbornness in me, I guess. I'm not happy with giving up. At times I try and try and then take a breather go into the office and again go back and try another angle I've come up with."*

3: *"I do feel the language skills even a few words can make a difference in the woman's experience of delivery. I do not think the ones who're able to communicate with me at some level and those with a Finnish husband for example face as much of a challenge at all."*

5: *"I'd say I don't change my behavior toward the foreigner too much in comparison to a Finn. The thing I do, however, is I slow down my way of speaking with them pretty much. I use simple language and take care not to indicate a number of issues at one. I kind of communicate one idea at a time as much as I can. I feel this really helps in getting my message across."*

7: *"In general I do feel these women, on the whole, feel confident enough to ask me questions. Perhaps not the very first time we meet but thereafter I do believe it is relatively easy for them to ask any question of me. I also believe they do find my questions appropriate as well."*

Non-verbal communication

The importance of facial expressions, body language and hand gestures was recognized by all midwives interviewed in cases where there was no or little mutual language for communication. They were utilized to ensure the immigrant woman understood what was being conveyed as well as to better assess her individual experience and need of care. There were mentions of avoiding a monotonous tone of voice and leaning forward to check for the possible subtle indications that may not have been verbally conveyed.

A naturally arising tendency for immigrant women to often touch or hold on to the midwife during labour was conveyed. One of the midwives interviewed indicated she considered such behaviour to be an invasion of her physical autonomy and therefore could not allow for it. Another indicated acceptance and regarded its supportive function to be a natural part of her job.

A few midwives had taken note of immigrant women changing their behaviour to possibly accommodate staff members. When elaborated on, it was indicated these changes had to mainly do with experienced nervousness upon arrival or being related to levels of activity and wellbeing while in the Maternity ward. The presence of family members was also to influence perceived behaviour. There were no indications of reasons behind changes in behaviour being profoundly investigated or reflected upon. One midwife indicated the need to slow down and to demonstrably put in a reasonable pause while caring for immigrant women. She had recognized it to be a prerequisite to promoting open and favourable communication.

1: "I do believe a number of immigrant woman may change their behavior when they are at the maternity ward. They may have feelings of apprehension and be a bit nervous in coming here. I find they may be a bit reserved at first unlike most Finns. Yet, once they've been able to interact with me and uncertainty and even fear begins to dissolve I do see a change in their manner. At some point the woman's personality begins to shine through more. They can also assure me everything's alright and indicate they understand everything I say. Yet they may well just be doing this as to not demand too much from the midwife. This seems to be a rather common tendency."

3: "With immigrant women I have more of a tendency to pause more even if we do share a common language even a bit. Picking up on facial expressions as well as gestures and body language is a key part. I do use all my skills and being rather out going by nature it comes rather easily for me. I can put up a whole pantomime presentation for her if need be. I also can't say I trust any words I recognize especially if her body language or facial expression clearly contradicts with the words she is using to express herself. This does take occur at times. I'd say I trust body language the most."

9: "I've found, during my years of working as a midwife that one's ability to observe and pick up on the most subtle indicators is really important alongside being present for the immigrant woman giving birth. This is how I am able to gain her confidence and how well we are able to work together in order to have a newborn arrive. I also watch carefully not to assume anything even though I am picking up on the slightest of signals on the part of the woman at all times."

Skills of perception

A midwife interviewed indicated language barriers to be a reason for possible confusion in being sent home from the Admissions instead of being admitted to the Labour ward. Aside from having a male doctor attend to them and the possible need for an interpreter,

immigrant women in general were not perceived to have any special requirements, pertaining to them alone, while at the Admissions. Another assumption regarded the indication of pain. General protocol in Admissions was to inspect the woman as soon as possible. It was felt the body language or verbally conveyed state could not be relied upon as it did not follow the characteristics Finnish women demonstrated upon arrival.

It is a general view, all women regardless of where they came from, receive the same level of care but the manner of going about it varied. Communicating with immigrant women was perceived to require a lot of patience and a readiness for repetition in instruction. A midwife conveyed the demand for patience on the part of the caregiver but also underlined such patience to be required from the receiver of care, the immigrant woman.

A significant finding among midwives indicated a tendency for viewing care giving as a more non-reciprocal task. There were indications of viewing the woman more as a receiver and a tendency to overlook a more interactive approach. There was also a reliance on the woman's capacity and willingness to verbally clarify matters if left uncertain about an issue that had been demonstrated previously. This does not, however, mean that sensitivity to needs of immigrant women is completely overlooked by midwives. There were also remarks about picking up on more subtle signals from the women and experiences of successfully perceiving such indications more frequently, the more often the midwife was assigned to care for her.

A rather general view among midwives was many spouses of immigrant women not being too eager to participate in deliveries. There were at times indications of being uncomfortable with the idea, yet the feeling of being compelled to attend.

Midwives interviewed had come across a number of practices originating from the woman's cultural background, some of them being so contrary to what was locally commonplace. Several indicated not being able to contain astonishment yet not being able to comprehend or moved to find out about the motives or reasoning behind such practices.

Sensitivity in discussing private issues had been noted by most interviewed. Several indicated they did not have enough clarity on how to approach such issues in a non-offensive manner. While some midwives avoided discussion about intimate issues with the spouse present altogether, others saw the importance of including him, regardless of possible propriety issues.

One midwife interviewed had perceived immigrant women to have a tendency to be more hesitant and even alert regarding hospital rules. She had taken note of women seeming to consider their actions more while being admitted. Hesitation to behave in an inconsiderate manner or overstep boundaries was occasionally evident.

In general midwives interviewed had not given much consideration to how immigrant women and their spouses had experienced the care they were offered and especially how midwives had been viewed as communicators. Upon reflection a majority of them indicated they had no idea about how these aspects of care had been perceived.

2: *“Aside from the use of interpreters and the requirement often for a male doctor, I do not believe these women have any special requirements of something they specifically wish for that would differentiate them from Finnish women. I really haven't come across anything in particular I'd recall. As for expectations I have not come across anything in particular when they arrive or when they are being monitored here.”*

2: *“The immigrant woman can be quite expressive regarding the pain she feels. In these instances we've noticed that the parameters we use for Finnish women don't necessarily apply to the immigrants at all. We can really be misled if we assume anything (at Admissions) about her until we're able to examine her. If we don't do this to verify her status, her gestures alone would get her sent to the labor ward way too early. This is something we all have learned and so we make sure to examine her first and evaluate her needs based on that assessment not so much on what she may demonstrate through her behaviour. Then there are those with a cultural background where the tendency is to downplay any possible symptoms. We have found it is best not to take their word for it and examine them as quickly as we can as well.”*

3: *“If I had to think of how foreigners experience the care they give us I realize I don't really think about it at all. I realize I don't really know. I can't say much about it, really.”*

1: *“I find being prompted to be more alert with these women, when asking a question and getting an affirmative answer and then taking a slightly different angle to confirm the earlier has been understood only to find that I haven't actually gotten through at all. I do pay more attention from there on and automatically find a number of ways the express what I mean.”*

7: *“My experience is these women can be a bit more on their toes regarding what's allowed and what's not in a Finnish hospital environment. There may be timidity once they arrive. It's as if they may consider their actions a bit more at different stages of their stay. An example could be not daring to touch anything available to them unless permission is granted and things like that.”*

5.2.4 Interaction

Interaction with immigrant woman

A general majority of midwives perceived immigrant women to perceive them as genuinely caring. Should women find midwives somewhat distant and even uncaring in their interaction was mainly conveyed to be due to language barriers. It was generally indicated that fast and effective response to needs arising was an indication of caring.

Differences in temperament were seen to be due to cultural differences and several midwives indicated having taken note of a need for not only being close physically but psychological as well. There was also some understanding as to needs of maintaining decency and propriety, yet an awareness of not always following through on such requirements. It was viewed a challenge to meet such expectations when there was so much work to be done.

Interaction with immigrant women was in general conveyed to be reduced by limitations regarding time available. Interaction skills were perceived to be improved through an increased flexibility toward the new, unexpected and resulted in openness toward asking more questions regarding arising observations. One midwife acknowledged the obstacle toward such development to also be of the attitudinal kind.

A general tendency for midwives interviewed is the making of a plan for care for the woman on the grounds of her capacity to communicate in a common language. This aspect greatly defines the extent of guidance she is offered and the pace at which a midwife is able to proceed with her. Having a Finnish spouse is in general considered to be an asset in furthering care at the Maternity Ward. One midwife interviewed indicated how the Finnish spouse can also prove to be a distraction and precautions need to be taken to maintain sensitivity to the needs and expectations of the woman at all times.

One midwife interviewed expressed how she had found the key to successful interaction with immigrant women through being genuinely present in the situation, having regular eye contact and demonstrating empathy through each and every one of her actions. She also indicated allowing enough time and providing encouragement for questions to arise

naturally and get asked. She also recognized how circumstances have the tendency to overwhelm and significantly disrupt interaction of any kind.

1: *"I find women of foreign origin respond to me rather well. At times I may notice some hesitation in being straightforward and to the point with me and for example just have brief eye contact with me but as we get to know one another more I do notice them relaxing in my presence more and more. I've got the tendency of making an effort in winning their trust and I believe it pays off. I believe they perceive me as being real with them. "*

2: *"Of course there are things we can do to provide more decency but perhaps this does not occur to us enough to take particular precautions in this matter.*

3: *"I believe immigrant women consider us Finnish midwives to be warm and full of empathy but if there's a language barrier it may be they may probably see us as cold and uncaring probably. It all depends on if there's a mutual language or not. In general I feel they must regard us as fast to respond to what needs to be done, because that's the way we truly are. "*

5: *"I feel I could develop my interaction skills further regarding immigrant women. I do not see myself as a racist or discriminating in any way but I do admit that I could improve myself in terms of how open I can be towards things that are culturally new to me. There are things I could learn in helping these women. I do believe I could become more flexible than I currently am. I have to be honest in saying so. I do realize that countries and cultures in closer proximity to ours are easier to understand and come to terms with."*

7: *"When meeting an immigrant woman for the first time and having some background information on her I do find I need to adjust my behavior in a certain way towards her. I do my best to find the level of interaction I can have with her and to get an idea of how I'll go about matters with her. My behavior may for example change in for example the language I use and I do have a tendency to repeat the same things over and over again. If I do see she understands I feel I can move on a bit faster into the more important issues at hand. I do believe I can make a relatively good assessment of her language skills but I do need to take care that I don't rely on what the earlier midwife has told me as the assessment can change depending on the woman's condition. At times these women may also not let on so easily to the fact that they have not picked up on much that has been communicated to them as well. "*

Interaction of immigrant women with others patients or roommate

Interaction of immigrant women with others patients or ones roommate at the Maternity Ward is minimal according to midwives interviewed. Exceptions, however rare, do exist. Lack of a common language along with the short duration of stay was seen to hinder possibilities for interaction.

A preference for single rooms was recognized by some midwives interviewed although generally immigrant women were perceived to adapt to hospital conditions relatively well. A remark made conveyed that if significant adaptation to circumstances had to take place, it was on the part of the woman adjusting to the Finnish roommate's social

interactions and general behaviour. No mention was made as to an immigrant woman being troubled to the point of the midwife having had to resolve arising conflicts.

1: "Most of these women share a room at the maternity ward. We have little opportunity to offer single rooms. Usually they do adapt to the conditions pretty well."

1: "Some immigrant, Finnish roommates can get on surprisingly well even though they lack a common language. It is a wonder at times to figure out how they're able to interact so comfortably with one another."

6: "If they don't share a common language it makes interaction pretty difficult with a roommate."

Receiving visitors

The significance of visiting friends and family members was clearly noted by midwives interviewed. Visitors were generally noted to be many and their approaches related to hospital visitation protocol viewed as resourceful. Several midwives had observed the supportive function of relatives to immigrant women and conveyed such support was clearly more significant to these women than to Finns. Midwives interviewed were not moved to find out about visiting relatives or friends in any manner. It was clearly noted by the majority of midwives interviewed that relatives and friends of immigrant women were something to be kept an eye on as they often had a tendency extending their visitation outside designated hours.

1: "the one thing they do much more is have visitors and preferably big groups of them. At times this can present a challenge for others in the ward. For example we have grandparents visiting hours for one hour in the evening and we may find it is the woman's young friends coming to visit. They do have a tendency to test the boundaries, many of them. Visiting relatives and friends can be really resourceful and persistent in visiting and staying at the ward and we really have to keep more of an eye on them as our facilities are so limited."

2: "The women seem to require the support of their families, moreover the mother or other family member in addition to the spouse much more."

5: "The family members, I'd suspect are not too pleased with our visitation regulations in this hospital. They may arrive at any time assuming they'll be able to stay at the ward. Yet we have to begin with let the immigrant woman know of our visitation rules and hours. These regulations are constantly tested and we, the staff have to regularly hold our ground on this matter. I feel grandparents no matter where they come from do not end up being too disappointed in our regulations as mothers are generally discharged quickly, usually within 2-3 days and they can spend time with the mother and her newborn once they are home."

5.2.5 Perceptions of procedures, health and recovery

Procedures

Some midwives interviewed indicated an immigrant woman's sense of propriety and her personal physical boundaries to require a more keen sense of perception compared to Finnish women. Performing examinations required more consideration regarding circumstances involved in the Labour room as well as at the Maternity Ward. Discretion was often desirable in the presence of a spouse. In the Maternity Ward curtains were to preferably be maintained carefully drawn. Requests for consent regarding presence of male students in the labour room according to some midwives may not even be inquired upon so as to not put unnecessary pressure on the woman to acquiesce.

A challenge several midwives indicated involved explaining certain procedures comprehensively due to language barriers. The challenge was there regardless of if there was a mutual language or not. It was also at times not possible to clearly convey possible restrictions that were due to procedure protocol. Following up on such information actually being comprehended adequately enough to translate into individual actions or precautions taken was often not possible. Several midwives interviewed indicated often coming across requests and expectations for doctor's consultations, especially by spouses, during their stay at the Maternity and Labour Unit.

The majority of midwives interviewed conveyed the perception immigrant women felt supported and cared for during procedures. It was a firm belief women were aware of the midwife not performing procedures impersonally or as routines but having a more individualized approach.

1: "One really needs to become aware if the roommate is there and take care that the curtains are tightly pulled around the bed before conducting any kind of examination whatsoever. The father cannot also be there at this time...Naturally, there are always some procedures that are difficult to explain because of related complexities and those can be challenging to explain to any woman, common language or none. For example PKU which involves a number of steps to follow. How to get that process communicated accordingly so that it's actually followed through. Often these women are and remain clueless of what is involved no matter how hard we try. "

3: "There are however procedures I must adhere to for example monitoring the baby prior to being born at a certain frequency and depending on the stage and received medication and such. I can't allow the woman to go wandering around if she feels like it and she has to stay in the room."

4: "We usually may have a medical student in the room but nowadays we only allow them in one at a time. I do have a tendency to keep the male students out of the room quite often with immigrants as they

do have a tendency to stare without saying a word. I feel many of these women would find it highly inappropriate and therefore I don't even ask if they'd consent so that they would not feel compelled to give such permission and feel tremendously uncomfortable with the whole affair. If I do feel someone would be open to having a student along I ask the student to go and ask for permission personally. I feel it is even better for the woman when it's done in such a way."

7: "In some immigrant groups it is more likely than in others that they request for a doctor at some point of the delivery. Often it's the spouse who requests for one. They do seem to accept the presence of a midwife but especially when their wives are in visible pain that only endures they seem to come to a conclusion that a doctor can be of more use in the situation. They may even head for the corridor and ask why a doctor is not attending to the wife and at times the situation can actually become a bigger issue."

Medication

A clear view of midwives of the Labour Ward was the often evident difference between immigrant women compared to Finnish women regarding the manner in which they experience labour. While Finnish women's deliveries have a tendency to focus on adequate and timely pain management the immigrant woman may be more open to receiving a wider variety of supportive aides. Offered pain medication may not always even be accepted and the midwife must for this reason focus on supporting her through other means while individually facing possible challenges of tolerating clearly expressed pain and anguish.

A general view in the Labour as well as Maternity Wards was immigrant women, with occasional exceptions noted, have a tendency of requiring less pain medication all together. This was seen to be due conscious choice but also resulting from a lack of understanding. A midwife conveyed she would repeatedly recommend the taking of post-delivery pain medication and not necessarily be met with compliance.

4. "There are cases during delivery where the woman may for example keep smiling bravely at me any I know I could help her but she doesn't appear to receive what I'm trying to offer her. With Finns you easily get used to women whose care focuses on pain and its proper management throughout delivery. It easily tends to be all about pain management and that's it, it seems. With these immigrants it's sometimes a challenge to indicate what's on offer in this sense while evaluating if she needs pain relief or not. It's not always an easy call to make if the woman doesn't express herself, common language or none. I'm on my toes a lot as I don't want to find I'm going against any possible preferences the woman may have."

3: "Some of these women come in, the more educated ones, tend to demand a good amount of pain relief during labour just like the Finns do. This is not as often the case with more uneducated women."

7: "Many of these women do not ask for additional pain medication when they're at the Maternity ward."

Breastfeeding

Midwives interviewed had clear views on breastfeeding tendencies and practices of immigrant women. They indicated the women in general have no need to breastfeed their babies in the initial stages and are perfectly willing to wait for milk to arise before any attempt to feed their baby in this manner. Breastfeeding appeared to come naturally to the majority of immigrant women and complications were less often encountered. It was also noted breastfeeding to be considered a highly delicate affair with expectations of being able to do so in total privacy.

The midwives clearly indicated immigrant women had the tendency to request for baby formula by its brand name immediately upon the mention of breastfeeding. One midwife reflected on the issue further in wondering if such an approach could in some cases actually have to do with avoiding the highly sensitive issue of being subjected to breastfeeding guidance all together. She indicated suspicion of attempts at breastfeeding made more for the purpose of demonstrating compliance. Donated breast milk was recognized as being a less favourable option to a number of these women.

1: "Another pretty regularly occurring factor is that they do not have any need to breastfeed the baby at first stating that they do not have breast milk. Then in some way, that is really unexpected, their milk starts to rise on the third day even though they do not really try and breastfeed earlier. I see this taking place all the time, and I'm amazed. We simply need to make sure the baby's weight is developing as it should and there are no blood sugar issues to consider. In general they have the tendency to do better. In some way many of them really just have the milk arising and without practice and without any commotion. It amazes me. They seem ideally suited physiologically too and we tend to not need to demonstrate the different approaches and tactics we generally do to many of these women."

5: "Many foreign women would prefer to breastfeed in privacy and if the roommate's husband is present they may be uncomfortable. Of course we have the curtains they may use but one can tell they would perhaps prefer to be in the room alone while breastfeeding. It is especially evident in the bed right next to the door where there one may be more visible to those entering the room. In terms of facilities I cannot think of anything else that causes some kind of disturbance in these women."

7: "They may begin to breastfeed their infant as Finns often do but do it only for brief moments and then move on to asking for the commercial product. A lot of the time, for example they tell me they don't have any milk for the baby and they immediately ask for milk for the baby. A significant number of them indicate the preference for the breast milk substitute. This is something I already tend to expect from them and."

Baby Care

Caring for the baby was perceived to be of secondary importance while at the Maternity Ward and taking the opportunity to care for oneself appeared to be significant for a

number of immigrant women. This was viewed as highly contradictory to how Finnish women conduct themselves while at the ward.

Midwives interviewed generally viewed spouses of the women to assume a more passive role in regard to baby care. Care is clearly taken to involve fathers as midwives indicated it to also be the father's task and duty in Finnish culture. A midwife indicated she often felt immigrant women viewed it the midwives duty to take charge of caring for the baby in order for her to have the opportunity for enough rest. Several interviewed indicated women to be somewhat surprised when they find out they are expected to care for their babies independently. The reasons behind such expectations had not been profoundly investigated or reflected upon.

1: " It comes across as these women not being as much about the baby and their taking advantage of the opportunity the opportunity to care for themselves. With Finns one sometimes really has to make an effort for them to rest. It's the opposite with these women...The fathers of these women may somehow prefer to not be as active and prefer the mother takes charge of changing diapers for example. It's up to the midwife to get them involved and certain more assertive approaches have to be employed. Not many of them decline altogether, however. Most have a go at caring for their newborn. "

4: "We may often come across the spouses of these women clearly distancing themselves from caring for their baby. Being the way I am I do get them to participate. I simply tell them to get on over here and do what's required of them. That's the way I am. The mother looks on often with a chuckle and allows me to do my job. The man complies as I don't give him a choice. It's the thing to do with these men. They may resist all they can but I let them know it's their baby and they've simply got no other choice. I've seen how the mothers are pleased and often chuckle along at my assertiveness. The way I see it, I may not be able to change the traditional roles between spouses when they get home but at least the spouse cannot say he doesn't know how it's all done, once they're at home. "

5: " I find it difficult to come up with an idea regarding any expectations immigrant women would have of the staff here when they come to the ward aside from the phenomenon that we'd be here to take care of their babies. And that they feel we're here to serve them. That's how I feel anyway. One indication for this is that a number of them are fairly surprised when they find out we expect them to be rather self-reliant in a number of ways. They do not seem to realize we are here to help not do things on their behalf. I m not sure we're actually regarded as servants but they certainly expect us to do a lot for them. "

Personal recovery

There are also clear expectations perceived on the part of immigrant women to be personally cared for and attended to while they are in recovery. Midwives conveyed these women to be clearly less independent in their actions and clearly not being as accustomed to being self sufficient. They are often clearly in need of more rest and are perceived to also require more time in getting matters underway. Sending their babies

off for the night and being bottle-fed is not something to be avoided among these women as it generally would be among Finns.

Women in recovery may indicate some expectation to see a doctor prior to being discharged although it is not viewed as a strong demand by midwives of the Maternity Ward. It is the general view of midwives that for the majority the examinations offered are perceived as adequate to the women as there is a doctor inspecting the baby prior to discharge.

Several midwives interviewed indicated sensitivity was required in addressing some issues involving continued recovery once the immigrant woman is dispatched from the hospital. While a midwife indicated women refusing to discuss certain issues that were clearly perceived as highly personal and private, another underlined the significance of circumstance sensitivity and above all timing. In such instances it was recognized words and expressions had to be selected with care. Although it was recognized the presence of a spouse was not seen as appropriate in such circumstances, a midwife conveyed she was compelled to disregard such views in order to ensure the wellbeing of the woman to the best of her ability.

1: "They do have expectations on being cared for themselves more than the Finns. They make sure they've got the opportunity to rest for example and expect us to make it possible for them to do so. The idea of being self reliant and independent comes as more of a surprise to them. They're glad to send the baby off to the midwives care at night and let them be bottle fed... We do expect all that as we do from Finns. So the overall attitude we tend to have when a woman of foreign origin arrives is that we have to urge and encourage her to be independent, self reliant and care for herself and her baby. We are not prepared to serve her, attend to her every need automatically. We don't do this unless there's a good reason for local women either."

3: "Regarding going home, they're already prepared for it when they initially arrive at the ward or at latest the next day. Occasionally there's some indication that the being discharged may come as a surprise to them although they've been informed of this at the start. I'm not exactly clear on why this is so. Perhaps they lack the opportunity to rest at home or something like that."

5: "An immigrant woman, especially with their firstborn will tend to stay in bed a great deal longer. They also expect to be cared for while in bed and clearly indicate an expectation of their baby being cared for while they are recuperating. In these cases we may have to motivate them more to get up and get into practicing the care of their baby... The major difference between a Finnish mother and an immigrant mother aside from the language issue would be perhaps the reluctance to get on with things while at the ward. This can be seen as a lack of self sufficiency and self reliance, I'd say... Women do not ask to see a doctor for their babies and this takes place in any case before being discharged from the hospital. Regarding themselves I've not noted any expectation or inquiry to see a doctor. Just like the Finnish women."

7: *“There actually may be a difference in the immigrant woman wanting to rest more and therefore appreciating a quieter atmosphere...I feel they do trust the capacity of the midwife in evaluating the condition of the woman herself and after all a doctor does inspect the baby.”*

5.2.6 Assumptions, attitudes and values

Assumptions

Aside from language considerations, it was conveyed immigrant women perhaps had the tendency to report more frequently to the Admissions prematurely with the idea of making sure everything was alright. As immigrant women’s behaviour often differed to that of Finns upon arrival it was more of a challenge to evaluate the woman’s status and possible onset of labour. Examinations were conducted for clarification purposes as rapidly as possible.

Managing the delivery of an immigrant woman was perceived as far easier when a common language was shared. In addition, several midwives indicated the presence of a Finnish spouse to also offer some indication of the woman being more knowledgeable or at least inclined toward a Finnish mindset and manner of communicating. Such factors were viewed as alleviating challenges regarding communication during labour.

Several midwives interviewed often indicated hearing the arrival of a foreign perceived name automatically resulting in assumptions being made as to the possible nature of work that lie ahead. Having a common language to communicate with was regarded a crucial factor as to the amount of effort caring for an immigrant woman required.

Midwives conveyed a need for strategizing on forthcoming care of a woman on several occasions upon having preliminary information and prior to initially receiving her. Lack of a common language often translated on to a focus of guidance regarding only the very key essentials required. A commonly shared language was easily assumed to translate into communication on an equal footing and to bring about more of a balance from overly submissive, noncompliant, or even domineering behaviour on the part of the woman.

Should the immigrant woman have at least some knowledge of Finnish or English the task would immediately be perceived as significantly easier to accomplish. A general perception of midwives was a good level of education, being locally employed or a Finnish spouse often translating into the woman being more integrated into local society and having adapted to local ways. These women were in general perceived to be more self-reliant, be more perceptive and have a greater level of endurance while in recovery.

Another assumption indicated by midwives referred to the duration an immigrant woman had lived in the country. The shorter the time spent in the country was seen to be a contributing factor to the amount of service required from staff. It was also noted by several midwives immigrant women preferred to spend longer times in recovery at the Maternity Ward prior to dispatch from hospital. A general perception indicated was the assumption these women eagerly anticipated dispatch from the hospital in the same manner Finnish women did.

A midwife indicated immigrant women would in general feel more comfortable if they made the effort to become more proficient in the Finnish language. Language was clearly viewed as the key to adapting to local culture within the hospital as well as in a broader context. Another conveyed knowledge of the Finnish language to eventually translate into being less domineered by the spouse and enabling more freedom as a woman.

2: "If I'd have to compare a Finnish woman and an immigrant woman at their most stereotypical and leave out the lack of common language factor, I do find these women have a substantial amount of so-called unnecessary visits to the admission at the final phases of their pregnancy. Hard to say of course as there are way more Finns than there are foreigners, but this is how I somehow feel. Another aspect is that they can be highly expressive in their emotions and experienced symptoms and this makes the initial assessment more of a challenge. They need to be examined faster in order to really and truly evaluate the status regarding a possible onset of labor. This is usually not as much the case with Finns. I have not come across those of a foreign origin who would behave in a highly collected and disciplined manner or perhaps I have not recognized them to be that way by nature."

3: "In my experience it's far easier to be taking care of a delivery where there's a Finnish man and the woman has at least some knowledge of Finnish or English. It's easier for the reason that the spouse is from local culture meaning I've got an understanding of where they're pretty much coming from. It gets much easier that way. "

1: "There's a notable difference when the woman is transferred from the labor ward to the maternity ward. Once the name is given on the phone to make arrangements prior to the transfer, the first thing midwives want to find out is if the woman speaks Finnish and how much. If the answer is none, no

Finnish at all, I do prepare myself for what is to come. I start to focus on getting the essential points across and leaving the so called extras more aside. I prepare myself for keeping everything as simple as possible.”

1: “I do find that I tend to run around catering to the more minor needs of women who have been in the country for a short time and haven't had the opportunity to hold jobs while they've been here. These are the one's I'm referring to. They seem to need more attention and in general need to have a clearer understanding of what is possible and what isn't. They are rarely as self reliant...Usually immigrant women tend to prefer to spend more time at the hospital and not be in such a hurry to go home.”

5: “With some of them you clearly get the idea that they feel they can order us around while on the other hand we also have women of foreign origin who clearly submit easily to what we indicate they should do. It tends to go both ways and I believe a determining factor is if we share a common language or not. The better we're able to communicate the more we tend to interact as equals. This is my take on it anyway... Usually, depending on if there's a language barrier or not, they're told the day before departure that they'll be going home the next day if the doctor tells them it's alright to take the child home. Sometimes the baby is at the doctor's and then when everything's alright we let them know that when the husband arrives they are free to go. Usually they're pleased to go home just like the Finns are. So it's a nice surprise for them.”

Attitudes

Unless there is a need for an interpreter the country of origin in general is unanimously not considered a factor of concern for midwives. A clearly foreign name clearly has the tendency to indicate a greater addition to a midwife's workload. Another clear attitudinal aspect is the tendency to not reflect nor consider how immigrant women perceive personality and profession related traits of midwives they encounter during being admitted.

The general view of midwives in the Labour Ward is many spouses of immigrant women have challenges in spending their time in the Labour room. The phenomenon does involve midwives regularly having to direct the men back to their designated rooms.

A significant assumption by the majority of midwives involved relying on arising questions being asked should any such needs arise. There was also a clear indication of not being as familiar with the needs of these women in the same manner as with Finns. The idea was to wait for the immigrant woman to inquire and follow such a lead in evaluating the care she would be likely to require.

According to midwives not all staff members experienced caring for immigrant women as favourably. There was a subtle understanding of who these midwives were and a clear consideration if one midwife had reached a limit of tolerance in regard to a particular patient. Flexibility was indicated in designating responsibilities with the immigrant woman's comfort in mind. Care was clearly taken to avoid any possible negative experiences on the part of the woman whenever possible.

A midwife conveyed her observations regarding extensively accumulated work experience not necessarily translating into a beneficial attitude in caring for immigrant women. Immigrant women in general were considered to require a great deal more of effort in terms of care giving. In cases where delivery had been normal and there was a tendency for the woman to expect a great deal of service, she would be encouraged into more independent activity without much delay.

A midwife interviewed indicated how caring for immigrant women generally benefitted from the cooperation of all midwives concerned. The sharing of observations and findings among all caring for a particular woman was viewed as a valuable contributor to caring for her during the stay. Several midwives believed in maintaining a positive outlook amidst uncertainty and underlined the importance of persistence in getting to the bottom of issues that were difficult to comprehend.

5: *“Usually the country of origin is stated in the patient files and if for some reason it's not there and no need for an interpreter has been indicated I do not really have a need to find out where she's from. I do not really see much relevance. If I suspect we may have material she may be able to read I check with her if she can understand a particular language but that's pretty much it. I don't really see the relevance of it otherwise.”*

3: *“Many foreign men who are here at the labour ward have a tendency to spend time in the corridor quite a bit. They seem to find it difficult to remain in their rooms. They have a need to wander around quite a bit. The Finnish fathers stay in the rooms with their wives the most. Our entire staff takes part in directing them back into their rooms to be with their wives or to go downstairs for a break (to the general lobby of the hospital). They don't seem to understand us or of they just pretend not understanding. It can be tiresome and additional work for us.”*

5: *“I believe my strength with caring for immigrant women is that I've got a positive attitude towards them and I do want to get to the bottom of things with them. I don't give up easily in getting through to them, I know. I also do my best in accepting the habits they have even here in the hospital, although I admit it may not be that easy at times. And I believe a sense of humor is a definite asset, I've found it goes along way with these women and if I go in to the room with a smile on my face I usually end up leaving the room with a smile on my face as well. It does catch on I've found. They do have a sense of humor. It's no use going into the room with a frown on ones face. No use at all. Not all staff members share my*

attitude toward immigrant women. It can be seen for example in allocating patients among staff. The staff members whom we know to have a somewhat negative attitude simply aren't given foreigners to attend to unless it's absolutely necessary. It's pretty much a silent agreement we have at this ward. I can say I often get foreigners allocated and I feel it's only right to take these women into consideration and not intentionally give them a less favorable experience if we can help it in any way. I do believe if a staff member has an attitude problem the woman will sense it immediately as it is something that is not easy even for a professional to cover up."

6: *"Having experience helps in caring for immigrant women but at times it may not reflect on the attitude in a beneficial way."*

7: *"I do admit a foreign woman requires more of my time and energy in order to get the same matters taken care of. Sometimes it can be a true challenge to actually do everything required if one has many immigrants at the same time. Fatigue can set in and under those circumstances it can be tremendously challenging to do ones job really well. I do feel I would need to develop my skills to be able to better endure in such circumstances. I believe the more experience the more endurance is gained. The more I have exposure to working with immigrant women and the more I get to guide them through what is required of me, the more I can feel comfortable and be successful in helping them out the right way. I believe my communications skills can improve over time."*

Values

Midwives expressed observations on how they viewed the spouse to often behave in a more distant and restrained manner while at the hospital in comparison to Finnish men. Assumption made easily translated into perceptions regarding values of immigrant women. Views on the status of a woman in a partnership and within the family were perceived and there was an accentuated tendency for assessments made on the nature of relationships within the context of a midwives individual cultural background.

Several midwives indicated a tendency in many immigrant women for neatness and an appreciation for their appearance in the labour room as well as the Maternity Ward. Avoidance of indecent exposure also became clearly evident. Maintaining one's composure among some women at the onset, during and after labour was perceived by some midwives to be due to the same background and set of values. Behaviour of this kind admittedly presented additional challenges to assessment of needs for the majority of midwives interviewed.

A general view of immigrant women having a common sense and down to earth approach as to how they conduct themselves was not as commonly perceived among Finnish women. A lack of task oriented attitudes as well as no tendency to over exert oneself was also noted. An innate tendency to accept and be content as one is was evident. The contrast to the average Finnish women was defined as remarkable.

One midwife interviewed had perceived during her working career how immigrant women having their own values and beliefs did not necessarily reveal them during their relatively short stay at the hospital. She admitted to not really have a clear, comprehensive view of these women's values based on what she had observed over the years. Others interviewed indicated being aware of immigrant women not clearly indicating their feelings and expressing themselves in ways that could be interpreted intentionally.

1: "One thing that I've noticed, couples of foreign cultures appear quite distant in their relationship while at the ward. It's usually the Finnish man who will express himself openly and lovingly towards his spouse and newborn child, for example get into the hospital bed with them and openly demonstrate his appreciation for the two regardless of who enters the room. The spouse of the immigrant woman will enter the room and usually remain quite distant and just observe the mother and the newborn from where he is. I've never witnessed them get all close together. Sometimes it makes us wonder about the nature of the relationship of these people, being so distant with one another!"

1: "The main difference I find between immigrant women and Finns is the fact that they often employ a great deal of common sense into what they are doing and why. They are clearly not as task oriented and do not tend to be over-achievers who've set targets and goals for themselves in terms of breastfeeding and baby care. The way I see it they tend to relax more and allow themselves to recuperate and get rest. It's actually a remarkable difference. They do seem more accepting of their vulnerability or frailty in these circumstances. They come across as natural and contented to be the way they are."

3: "I do have to say they've a tendency to be neater all in all. They take precautions not to be messy in the labor room facilities and wish to have everything as neat and orderly around them. Appearance is important for a number of them."

3: "An immigrant woman may at times downplay her experience even during labor because she feels compelled to do so in front of us. The experience of pain is a main factor as for some it is not revealed to the same extent as a local woman would. If I'm out of the room and listen for example, there may be a huge commotion going on and upon entering it may in an instant be replaced by silence and a smile towards me. I feel this is a clear indication of putting up a brave front for me whereas I'd be more inclined to working together closely with a mutual goal in mind."

7: "I do realize that immigrant women have their own values and beliefs yet I do not really feel they become visible during the care they receive while they are here. At least I cannot think of any such traits I could mention. Perhaps they just do not surface during the relatively short time they stay at the ward and I am not made aware of them in any way. I have not given the matter too much thought."

5.2.7 General perceptions

The majority of midwives interviewed were under the impression immigrant women felt they were in capable hands and safe while being cared for at the Maternity and Labour Unit of TAYS. Several indicated a general perception regarding expectations in maintenance of order to ensure decency and propriety. Discretion was a clear requirement for many immigrant couples particularly in the labour room.

Another impression shared by the majority of midwives interviewed involved a contrast between immigrant women and their Finnish counterparts. While immigrant women had indicated openness toward being cared for Finnish women had more of a tendency of being recipients of services while being admitted to the hospital.

The educational background was generally perceived to be an indication of having more similarities regarding expectations as well as in terms of mindset to Finnish women. Such perception often translated into offering more explanations as to the options available for care. Cultural aspects regarding care offered may also be conveyed more explicitly in such circumstances. Encountering immigrant women who automatically assume a passive role at the onset of delivery is generally perceived as challenging as indicated by several midwives interviewed.

Although there may be a sense of acceptance toward cultural diversity midwives may find themselves balancing amidst feelings of frustration when they become aware of all they can do to alleviate delivery yet finding the woman not being in a position to respond to alternate suggestions. On such occasions the midwife has to personally come to terms with accepting the fact of the immigrant woman possibly missing out on some of the options otherwise available to her. These perceptions are shared among staff members and it is generally acknowledged caring for these women requires more time and effort. Maintaining the same dedicated level of care for all and throughout ones work is a recognized and true challenge.

A midwife interviewed indicated she at times gets a sense of an immigrant woman going along with what is requested and making an effort to comply and even behave in a submissive manner, all the time knowing she will be resorting to her traditional ways once she is dispatched from the hospital. It was also indicated that immigrant women have less of a tendency to defend their individual rights according to personal conceptions than their Finnish counterparts. The reasons behind this had not been significantly investigated.

Although there is some indication of compliance in order to avoid creating any discord midwives had not been able to get such a notion confirmed nor refuted at any point in time. Another perception indicated was the lack of spontaneity among these women toward staff members. Behaving in an inconspicuous manner was particularly common among certain groups of immigrant women.

The majority of midwives interviewed expected immigrant women viewed them as straightforward and professional care givers and believed these qualities were appreciated. A midwife interviewed also mentioned the observation of particularly demanding women with great expectations to also eventually be clearly contented with care received and that such incidents only make midwives aim to please even more.

3: *"I do believe they feel safe here...being cared by Finnish staff."*

4: *"One interesting thing I've noticed is that when an immigrant woman may refer to being cared for her Finnish counterpart will refer to the same incident as being the recipient of a service. I feel this to be rather revealing in terms of how we are perceived."*

4: *"Educational background does affect the woman during the delivery. The more educated the closer her behavior seems to be to a Finnish woman. If I have a chance to discuss matters with the woman I'll also take time to explain what I can offer her more elaborately and even shed light on our cultural aspects in conducting deliveries. I do this, if there's a good opportunity for it as I feel it to only benefit the woman in the situation... We do share our experience (among staff) a great deal. Working with immigrant women is seen as more difficult more of a challenge and even more energy consuming and there are moments when one cannot be at one's best at all. I do feel it's better to own up to the fact instead of denying it exists. It's the only way to move on from where one is professionally, not matter who unpleasant it is to face...the biggest difference between a Finn and an immigrant is the acceptance they have toward the care we offer them. Finns tend to have such great expectations and they present themselves as experts on appropriate delivery although their knowledge may be rather superficial. Immigrant women rarely exhibit such attitudes or behavior patterns. These women are natural receivers of the care given to them."*

6: *"I do have experiences of an immigrant woman, for some reason, making herself less conspicuous while she's at the ward. Perhaps they feel they might be too much trouble for me at times and for this reason try not to stand out. I feel it would be a significant leap of faith from them to actually disclose something truly personal to members of staff. They may alter their behavior while they're here and not to let on too much to what they think and what their practices are. When we do get a glimpse of something, I feel it's more of an accident."*

10: *"In looking at Finnish women arriving to give birth and comparing them to immigrant women there are clear differences to how they conduct themselves at the admissions ward. In many cases the immigrant women will easily have the tendency to regard us as authorities and conduct is minimized to disable any possible discrimination opportunity on our part. This I believe to reflect possible partiality experienced in their countries of origin. Most immigrant women tend to have a respectful attitude toward us when they arrive however collected or however much they display themselves."*

Experienced satisfaction

Midwives interviewed generally conveyed perceptions of experienced satisfaction on the part of immigrant women involving the level of service they are provided for the duration of their stay at TAYS. There were indications made as to midwives having a capacity to adjust their approach according to the needs of the individual and the women themselves adapting relatively well to ward circumstances. Solid convictions were expressed regarding midwives capacity for patience, persistence and flexibility as perceived by the women. Actively involving the spouse in caring for the baby was also assumed to be appreciated by the immigrant women.

Midwives in the Labour Ward particularly conveyed their perceptions of immigrant women greatly appreciating being viewed as individuals with their own, unique needs as well as all the options available to them regarding the management of pain. More generally it was assumed midwives were viewed as highly qualified professionals capable of ensuring the woman she was in capable hands. It was also a firm belief immigrant women were able to be discharged from the hospital with a sense of self confidence, having received an adequate amount of guidance while staying at the Maternity Ward.

1: "I believe they are quite happy with the level of service we provide for them. We bring them their meals, we take care of their babies and we give them a chance to rest. I believe they're happy with this. I don't believe they feel they have to unnecessarily cope on their own that much. I also feel they adapt rather well and I feel I've had the capacity to help them by adapting my own practices according to their needs. I find this to be perfectly alright."

5: I'd believe they're probably pleased with the way we go about guiding them in caring for their baby as well as the guidance we offer regarding breastfeeding and that we provide sustenance for the baby in general."

6: "I believe they do remember afterwards the way a midwife interacts with them and that they appreciate the pain relief they been given. I believe they appreciate these things the most about their delivery here".

7: "I believe they are happy with the guidance we offer them all in all and I believe they have a sense of security upon going home. I believe they also appreciate how organized everything is over here and the level of cleanliness we maintain. I also do believe they trust our professional skills and hospital protocol issues as well. I cannot say for certain of course but I do believe we are viewed as competent professionals."

Possible improvements

Possible expressed needs for improvement by immigrant women were also discussed. The majority of midwives had to give these issues careful thought prior to response. Indications were made as to possible accumulated routines not allowing for enough of an opportunity to allow for adequately open interaction, with so many tasks to complete on the agenda. Possible dissatisfaction may also have been caused due to an immigrant woman not having been able to get enough rest while in recovery.

Several midwives recognized the need for more information on different cultures and related practices. A databank to be established for such purposes was also seen as helpful. Several midwives interviewed indicated it would be of great value to receive well constructed feedback on how immigrant women of different backgrounds perceive the care they received and their individual requirements while being admitted to the Maternity and Labour Unit at TAYS. One midwife conveyed she had already discussed such matters with work colleagues.

Several midwives conveyed they would, if provided the opportunity, redesign facilities in a manner to better accommodate the needs of these women. One indicated incorporating more common lounge spaces and rooms ensuring increased privacy as possible initial alterations made to accommodate the needs of immigrant women. Another conveyed changing facilities would perhaps not improve experiences of immigrant women as hospital protocol and guidelines were to be followed in any case. She indicated there was the tendency of these women doing as they please, something that could not be avoided in any case.

A midwife perceived immigrant women could benefit receiving more information about hospital protocol as well as general information regarding what to expect and what is expected from them at TAYS. Several indicated it would be relatively easy to produce more translated material from the Finnish material already on offer.

A single midwife during the course of the interview suggested the entire staff would benefit from social interaction skills training. She believed there could be room for significant improvements regarding perceived attitudes and skills in interacting with immigrant women and their spouses. Indications were made as to the benefits arising from an increasingly diverse ethnical background among staff members.

The possibility of re-evaluating visitation protocol for immigrant women to better comply with arising needs was mentioned. The suitability of meals offered could also be opened for re-evaluation. A midwife interviewed proposed immigrant couples could be encouraged to express their expectations and wishes more explicitly in filling out the electronically transmitted form when planning their eventual arrival to the hospital.

1: *“Dissatisfaction may be experienced regarding not being able to sleep enough or having to be so self-reliant and active and being woken up early for breakfast and other such issues, clearly. Or that visitors are not allowed unrestricted access to the ward.”*

3: *“I really believe we at the ward would really benefit from them receiving more information about how we go about everything here. To get more of an idea of what to expect. I don't think a change in our facilities would be a significant factor although there may be some advantages for these women. For sure, even if we changed these facilities according to our needs they'd still not be allowed to run around everywhere. We'd still have to take care that doesn't happen. It's the way they are. When I really think of it, I really wouldn't find a better way than basically providing them with information. I'd really think it would be good that the immigrant women themselves would have more information about what is required of her when she comes to deliver her baby here. I think it would help a great deal. She could adapt to circumstances more in this way.”*

6: *“To improve the material we have on offer here at the hospital, meaning to have the material translated into all the languages needed by the patients in the maternity unit. This would be something I'd like to improve immediately. I'd also feel the staff would benefit from training involving their interaction skills with these couples. I would like to see an improvement in the attitudes of staff. Not that it can be considered as poor, but improvement should take place.”*

8: *“I believe focusing on the common attributes of women all over is key as well as incorporating a truly positive vibe into what we are doing in our daily work would really go a long way. I feel we may currently focus on the differences way too much and instead bring out what is common to all women and have it stand out in everything we as midwives do. This I believe could bring out a wonderful change for an even better level of wellbeing at our different wards. I would also like to see an increased openness in our staff towards the more uncommon to us and I believe this can be achieved through longer term informative training.”*

10: *“A tool I'd find helpful would be an accessible databank with references to basic cultural practices, preferences and culture-oriented needs in addition to basic phrases in certain languages I could access in the midst of my work. The database could be developed and added to from our own experience as well and then be accessible to all of us working here. I feel it could be beneficial to us all. We also have the patient files sent to us via the maternal health clinics around the area where the mothers and fathers to be have also had the opportunity to contribute as to their expectations and wishes. I feel the compilation of these patient files could be put to further use by providing even more information about the patient than is currently being done.”*

6. DISCUSSION

In this chapter the main findings of Phases I and II are discussed. Possible similarities and differences between the groups' perceptions are also presented. Strengths and limitations of the study are discussed and conclusions presented. Implications of the study are brought forward and recommendations for future study presented.

As earlier indicated, there are very few studies conducted viewed from the perspective of immigrants as receivers of care and from the cultural competence perspective. There is an even greater scarcity of studies where such interviews are immediately followed by interviews of staff from the same facility on their perceptions of the care received by immigrants.

In review the objectives of the study were the following:

- To bring forth the experiences and expectations of immigrant women regarding the care they received during their stay while giving birth while being admitted at the Tampere University Hospital (TAYS).
- To uncover perceptions of Health Care personnel working in Pregnancy and Labor Wards, regarding the distinct needs of immigrant women giving birth at the hospital.
- To detect and examine possible similarities in perceptions as well as to shed light on previously undetected differences, as to how administered care is in actuality perceived by the receiver.

6.1 General findings on the immigrant women

As stated earlier in the inclusion criteria for the study, immigrant women recruited were required to be able to communicate reasonably fluently in the English or Finnish language. Due to the criteria, it became evident relatively early in the interviews that women interviewed almost unanimously had a high level of education and the majority of women had been employed permanently or temporarily while in the country. While it would appear naturally sequential to arrive at presumptions of these women not

deviating much from women of local origin giving birth at the Tampere University Hospital – TAYS, such a predisposition was early on found premature and even misleading. Supportive evidence was irrefutable.

The researcher had not anticipated as to how the interviewees would respond to the issues discussed with them. Some of the women had clear hesitation in communicating about a highly personal issue particularly at the beginning of the interview. It is to be noted the majority of the experiences conveyed would be considered highly sensitive, personal and private. Expressing oneself about experiences of giving birth in a hospital, in a foreign country and language, meaning English or Finnish, may not be viewed effortless by any measure.

Precautions were taken to help with difficulties. For instance, interviews would take much longer than planned and questions asked would be approached using alternate words, gestures or other mutually shared languages to ensure what was being asked could be discussed more comfortably. The approach proved successful as each woman during the course of interviews clearly demonstrated more sense of ease and an increased openness in her remarks. The clear majority of women expressed a true interest in the study. This was demonstrated in their willingness and even enthusiasm to be seen and heard and to authentically reflect on their experiences with the researcher.

Another general finding, previously mentioned and to be reiterated, refers to the Maternity Outpatient Clinic. The staff of the clinic received highly favourable mentions in regard to clarity in communication, level of attentiveness, sensitivity and professional skills among the group of women interviewed. Visits to the clinic per interviewed were few and of short duration. Consecutively only one midwife from the clinic was interviewed and although good insight into the care of immigrant women was provided, it could not be considered adequate for the establishment of a clear overall view on culturally competent care at the Clinic. The researcher, however, considers the findings highly informative and sees the possibility and significance of elaborating on them in the future.

6.2 Similarities in findings

Early on in interviews with immigrant women having given birth at TAYS and the midwives of the Maternity and Labour Unit, it became evident perceptions were shared as to how care giving had been perceived.

Both groups regarded the midwives to be professional, work-oriented and knowledgeable as well as having good clinical skills. The work load of midwives was also evident to both and the fact that all tasks were conducted with efficiency and accuracy in mind.

Both midwives and immigrant women regarded midwives as straightforward communicators. Small talk and other less task oriented interaction was not much engaged in. The main focus of care at the Admissions was establishing the status of the mother and baby to be born. The care and wellbeing of the baby was the center of focus at the Maternity Ward. Both groups interviewed had perceived the need immigrant women had to get a lot of rest after delivery.

The outpatient clinic was mutually experienced as offering good clarity in communication, level of attentiveness and sensitivity to personal concerns. Mutual remarks were also made regarding competent evaluation and procedural skills.

The requirement of privacy at the different wards of the Maternity and Labour Unit was recognized by both immigrant women and midwives interviewed. The perception of these women requiring more assistance in general and at all phases of their stay was also mutually recognized.

The issue of language was mutually addressed as a challenge, the underlying factors however varied. Both groups indicated the benefit of getting acquainted with one another's cultural background. The significance of visitors to the Maternity Ward was also recognized by both groups interviewed.

There was a general understanding between the groups interviewed that immigrant women were treated as equals to Finnish women. Both conveyed indications of being treated as Finns were.

6.3 Distinctions in findings

6.3.1 Factors to consider in reviewing contradictory findings

As indicated earlier immigrant women and the midwives interviewed did share a number of views in their remarks regarding care received and offered. There were, however, undoubtedly clear distinctions in the general findings and most particularly in regard to the significance of a certain aspect of care to the woman having been cared for at the hospital.

Prior to examining the distinctions in perception, one factor should clearly be conveyed. The interviewer, from early stages of interviews with staff members, made it a point to regularly direct interviewees toward the significance of focusing their perceptions more on an immigrant woman, who shared a common language with them. It was also noted that although there was a common language it would not be native to the woman.

The reminders were utilized as it was evident there was an innate tendency for staff members interviewed to generally view immigrant women in the context of certain more stereotypical attributes. A most natural tendency in discussing any specified patient group became evident through examples offered from the initial stages of interviews. Midwives in their accounts regularly and most effortlessly viewed immigrant women as not usually sharing much of a common language with staff. In addition, there was also the tendency for remarks referring to circumstances where the woman cared for had a refugee background or originated from a culture considered to be a remote one.

As the attributes of focus were repeated by the interviewer regularly during the course of interviews and upon indications of previously described context, it is the researcher's view the approach proved beneficial. It provided the means of bypassing the perhaps

most obvious challenge in care giving and enabled other aspects and challenges of care to be uncovered.

At first, remarks were often made from the perspective of a woman patient having a refugee background or otherwise originating from a culture that was considered remote. A result of the tendency, in the first instance, was to discuss language related, verbal communication challenges. It was evident to the researcher some interviewed had more challenges in becoming aware of such predispositions and communicating on issues beyond the perhaps most obvious language barrier. On a number of occasions it resulted in the midwife interviewed requiring longer pauses to uncover possible perceptions. At times it was not possible to go beyond language regarding the different aspects of care. In these instances it became evident there were possible aspects of care that had gone undetected.

6.3.2 Key distinctions in findings

Having recognized and acknowledged the challenges involved regarding the total lack of a common language midwives most generally continued to discuss the incapacity for proper communication due to enough knowledge of a common language. In discussing informative material available to these mothers there was usually a general referral to the translations available from Finnish brochures and reference made to the hospital internet web site. Often the different language versions were conveyed and an indication made that more would be required.

Immigrant women interviewed indicated that while the language translations were useful they would have greatly benefitted from material that had taken their cultural backgrounds into consideration and had offered insight including practical examples from such a context. Forms of information offering an explanatory approach to local cultural practices and values would also have been appreciated. Such a need was expressed regardless of how long one had lived in the country, their education, occupation, being married to a Finn or not. A perhaps obvious distinction, possibly due to the midwives' tasks being confined within hospital facilities, was the request to have

signs in languages other than Finnish leading to the hospital, Admissions Ward as well as on doors within wards.

Midwives indicated a strong work ethic and were clearly aware of their professional competence and clinical assessment skills. They considered themselves as attentive and straightforward communicators who focused on doing their job according to current care guidelines. These guidelines being generally adopted, independent and evidence-based clinical practice guidelines utilized nationwide ([www. käypähoito.fi](http://www.käypähoito.fi). Accessed 15.4.2012).

While the indication was accurate in both sets of interviews and the aspect was clearly appreciated by all women interviewed, it was generally considered to be but one cornerstone of the entire experience of care received at the hospital. The researcher's intention is by no means to underestimate such values and practices. It is clear, however, from interviews that immigrant women clearly and increasingly recognized the crucial significance interpersonal skills, enhanced awareness and sensitivity to cultural background played in the care they were the receivers of.

In cases where a midwife and immigrant woman share a common language it was generally the midwife's experience that caring for the woman involved less effort. Although this may have been true to an extent it did not necessarily translate into the receiver of care having a culturally identical or even adaptable mindset. To reiterate, words utilized may have been technically understood yet it did not necessarily guarantee a capacity to perceive matters communicated in the initially intended manner. The woman may have unknowingly perceived the words according to her individual cultural background.

It is probable both parties have innate tendencies of translating words used according to culture based perceptions. The findings clearly imply perception and understanding identically matching the midwives intentions was in a number of cases significantly unlikely. It is clear from findings that the pattern of perception has the tendency of

taking place regardless of language spoken, education or cultural background. The challenge being it is not always easily detectable.

The difference in cultural background between staff and immigrant women translated into a number of aspects. To indicate some of the most common findings, these attributes ranged from clinical procedures and experiences of resilience and recovery, to interpersonal communication and interactional experiences and expectations. There were also significant distinctions as to perceptions regarding personal boundaries, sense of personal and partnership related propriety and familial values. The distinctive finding from the interviews was the magnitude and significance of these factors to the experience of care received was in most cases at least underestimated if not utterly undetected.

A clear distinction evident was conveyed on the part of the women as to how staff members perceived the individual's level of having adapted to local culture. An immigrant woman may have been able to communicate with staff fluently and indicate a good level of knowledge in a number of related or unrelated areas of expertise. The women indicated such qualities were easily perceived by staff members as the individual having adopted a similar mindset and set of values to local culture. Midwives during the interviews may have referred to these women being less of a challenge as patients as they were perceived to have assimilated themselves into local ways. This was of course often true in appearance only and not fundamentally accurate.

In such instances the immigrant woman was often only doing her best to comply and conform to hospital culture and protocol and was skilled enough to convincingly behave in the respective manner. Regardless of what may have been perceived by staff members the circumstances and perceived expectations did add to anxiety experienced by the women. It may also be conveyed there was a tendency to occasionally make similar unfounded assumptions in circumstances where the woman had a Finnish spouse. Inaccurate assumptions may have even extended to the woman's individual sense of dignity, personal boundaries and propriety being compromised.

What may have been efficient and straightforward behavior on the part of the midwife may have easily been perceived as efficient but inconsiderate behavior lacking in sensitivity. Efficiency may have also been viewed as incapacity to actually pause and hear what the woman was moved to indicate whether they were requests, concerns, inquiries or needs waiting to be expressed at the appropriate time. Professionalism was easily viewed as lack of empathy and a tendency to make unfounded assumptions regarding the needs of their patient.

Midwives often indicated they were open to addressing any questions arising and even indicated this verbally to immigrant women. The women affirmed the invitation usually did take place, they however went on to indicate that staff came across as hurried and very rarely actually paused enough with the woman in order to allow for questions to naturally emerge. There was pressure to conform to the intense pace of staff members and this only increased anxiety toward getting matters resolved according to personal needs and expectations. There was a general tendency to conform and do ones best, however trying it may have been.

Although midwives interviewed clearly perceived how a number of immigrant women had expectations to rest and recover more than Finns did, not all of them realized it to be due to a number of cultural aspects, for example health related practices or perceptions of gender attributes or roles within an extended family. The staff clearly advocated self reliance, resilience and independence especially in the recovery period yet the women did not necessarily share the importance of adopting such qualities. They may not necessarily have even been experienced as favourable qualities as true women of their culture of origin.

Immigrant women perceived Finnish women as independent, highly capable and tough and some even used the term masculine to make the point clear. While some of the women admired the qualities and the fortitude required, they themselves saw it to be a challenge they were not too anxious to adopt for themselves.

Midwives at the hospital advocating an active and self-reliant approach at times were unable to recognize their patient not being up to what was requested. An affirmative was not always an indication of being up to a suggested task. In an attempt to conform they may have ended up overestimating their individual capacity and doing themselves more harm than good. Regardless of their educational or cultural background it was only natural for them to make the effort to comply with suggestions.

A significant finding not fully recognized by midwives during interviews had to do with visitors to the Maternity Ward. Although several indications were made as to the tendency of visitors to test the boundaries of hospital regulations and food packages being delivered. The underlying factors were not fully recognized.

Most of the midwives interviewed did not recognize the sense of family being broader to the locally perceived. Parents and in-laws for many women were the equivalent of the immediate family to Finns. Many grandparents had traveled long distances to be present in order to take care of the mother and her newborn. This was common practice in their individual cultures and they were only behaving accordingly.

A clear distinction was the immigrant women having to make a great effort to adapt to hospital conditions in a foreign culture while attempting to recover from delivery. Although midwives stated the women required a lot of rest in general it may have been less clear to them a number of mothers reported feeling rather dazed with all the new events in their lives in such an environment. Although they may have appeared calm, collected and perhaps slow to react or reply, there may have been great turmoil taking place within. This would not be evident to staff members rushing into the room, completing a task and then rushing out the door before the woman even had a chance to indicate a need or request or ask an important question.

The great majority of women indicated matters taking place so rapidly they could barely keep up with what was required. Upon gradually gaining their strength, staff had already completed their guidance activities. A clear barrier had been perceived by women resulting in hesitation to ask for another opportunity for guidance. Among a

number of other issues, it was also one of the reasons the majority of immigrant women had the experience of being discharged from the hospital much earlier than they would have personally been willing.

A final distinction worth mentioning was the perception of a number of the women interviewed regarding the very few or no incidents of doctors attending to them while at the Maternity and Labour Unit. Although matters had proceeded relatively well and women even believed no imminent danger had been present, the matter had raised a number of questions during the stay as afterwards.

6.5 Findings in view of the PPT-Model for Cultural Competence

The experiences and expectations of the immigrant women having given birth at the Tampere university hospital (TAYS) are to be viewed in the following from the Papadopoulos, Tilki and Taylor model for developing cultural competence context. The model was discussed in 2.7 of the Thesis.

The PPT model consists of four different levels, cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. It offers a perspective into the gradual process for developing culturally competent skills and enables their evaluation.

The researcher recognizes there may be a tendency to view the model in a manner of moving from one stage indicated to the next in chronological manner. It is therefore significant to recognize the model promotes a more flexible approach where in the individual is able to evaluate the level of competence through all its components at any point in time.

Prior to the discussion of the findings from the perspective of the immigrant women the researcher would underline that indications made at this point are generalizations on how midwives levels of cultural competence was viewed. It may be noted, the researcher was able to identify some relatively good levels of competence in certain aspects of the PPT Model for Cultural Competence model during some of the interviews conducted with the midwives of the Maternity and Labour Unit.

6.5.1 Findings as to level of cultural awareness

The first aspect, cultural awareness, focuses on the examination of the individual's values and beliefs. It recognizes their impact on health beliefs and practices. The women interviewed indicated staff appeared to have a distinct cultural identity in most cases. There were often remarks, however, as to perhaps not having adequate awareness of how one projected one's identity into one's environment. In other words, there was not much true indication of staff members being aware of how one's cultural identity had an impact on one's behaviour and both, explicitly and implicitly, expressed expectations.

The expectation indicated by midwives on occasion, assuming the woman would adopt a good level of activity and demonstrate a reasonable amount of resilience and independence clearly can be seen among a number of issues to also stem from local heritage and an adherence to such values. Ethnocentric behaviour was not uncommon as in the promotion of certain values from local culture. They were clearly projected as acceptable and even desirable in a number of ways. As an example, the immigrant women were well aware of the tendency in terms of how staff conveyed the idea of a woman's self reliance and the idea of equality in terms of duties is the norm in partnerships. It was clearly demonstrated as "the local way" and as worth coveting to these women.

Stereotypical categorization did not come across clearly from the interviews with women and it is the researcher's view, based on remarks made, they may not have recognized such indications. This became apparent especially when women had been left wondering about certain assumptions made about their preferences without being asked. The researcher recognized the tendency regularly from remarks made regarding for example communications skills, breastfeeding behaviour, social interaction, among a variety of other issues.

It may also be noted, although the profile of women interviewed had been discussed with midwives, referring to immigrant women they cared for, the first and foremost

tendency was often to regard her as someone not having a common language to the midwives and the tendency to view the immigrant from the refugee context. The view was regularly redirected by the interviewer.

6.5.2 Findings as to level of cultural knowledge

The willingness and ability to understand cultural aspects, their significance to the individual and their application in day-to-day work are aspects of cultural knowledge discussed in part 2.7.2. From the interviews it became evident a number of midwives viewed the immigrant women as having certain practices and characteristics. Upon attempting to uncover the reasons behind such phenomenon the interpretation may have been unfounded. There may have also been a reply as to the midwife not having given the matter much thought. Indications were particularly clear regarding breastfeeding, the level of activity while at the Maternity Ward, the occurrences regarding visitation, among a variety of other issues.

6.5.3 Findings as to level of cultural sensitivity

Cultural sensitivity, discussed in part 2.7.3 involves aspects of care demonstrating a capacity for empathy, acceptance, acknowledgment and a sense of propriety. Such behaviour is demonstrated by the command of well cultivated interpersonal skills, verbal and non-verbal. In regard to these skills, immigrant women regularly conveyed experiences that may be viewed as culturally insensitive. The researcher uncovered incidents where a remarkable level of cultural sensitivity was demonstrated although there were not many incidents of longer duration evident. Incidents of culturally sensitive, competent care, was evident from some accounts from the women particularly during delivery in the labour room.

6.5.4 Findings as to level of cultural competence

The final aspect of the PPT model for Cultural Competence requires a more profound synthesis taking place that translates into the application of acquired awareness,

knowledge and sensitivity. Significant focus is directed toward developing practical action from a more integrated standpoint. Cultural competence involves the enhancement of needs assessment skills, diagnostic and clinical skills. It was made clear from the accounts of women such qualities presented a clear challenge to staff members. In reviewing the transcribed interviews the researcher was reminded of two interviews where midwives expressed their views in a manner fitting the fourth level of cultural competence regularly throughout the interview.

It may be added, the cultural competence aspect also incorporates the capacity to address and challenge prejudice, discrimination and emerging inequalities. It may be stated, although women interviewed did not explicitly label experiences of such nature it became evident from the accounts conveyed.

Traces of certain confusing conduct were addressed on several occasions, preferably through open ended questions addressed to the interviewer. These indicated a reflective approach as to the reasons behind certain behaviour patterns perceived. Although not many, there were actual accounts of that could be considered if not outright racist at least discriminatory by nature.

In stating the above the researcher is well aware of how women, although they may have been open to discussing the sensitive issue of giving birth with an interviewer of related profession, may perhaps have been reluctant on delving deeper into the issue of discrimination. It may be noted such issues are often preferably hidden from view as there is a tendency for such incidents to awaken feelings of embarrassment and unworthiness in the one subjected.

Racism and discriminatory behaviour was not regularly touched upon by staff members. If it was, it had more to do with the idea of some midwives avoiding the care of immigrant women and the staff in general being aware of this. A silent knowledge appeared to prevail. This was not to be understood as condoning such behaviour but had more to do with taking precautions to ensure sure the woman would not be subjected to it whenever possible. This meant action taken had, as a general rule, less to do with

eradication of such behaviour and more to do with designating midwives regarded as having more culturally competent skills to these immigrant women.

6.6 Strengths of the study

There are several strengths to the conducted study. In the first instance, extensive planning and preparation went into the initial phase of acquiring authorization for the study. The study plan underwent rigorous review and evaluation by the Tampere University Hospital Ethical Committee on two occasions before authorization was granted. It was only at this point recruitment of potential participants for interviews could begin.

As mentioned earlier, a clear strength of the study would also be the finding of very few previous studies in Finland having been conducted in order to evaluate actual perceived cultural competence with immigrants as receivers of health care services. Interviewing immigrant women consecutively following through with health care personnel working at the same facility, within a short span of time, is a form of research that has not been conducted in Finland according to the researchers view.

A strength of the study would also be the number of interviews per group conducted. The aim during the course of interviews was to reach a form of saturation in terms of significant themes and experiences. Such a point was clearly attained as new information became more uncommon and repetition of certain themes more evident in the final stages of interviews

6.7 Limitations of the study

There are undeniable limitations to the study conducted. The first being the study conducted with limited resources, financial and otherwise.

The initial schedule although well adjusted to conducting and completing the study was rather optimistic in getting research underway. There is no denying the fact a thorough review on the part of the Ethical committee of the Tampere University Hospital

followed by approval by the city of Tampere was beneficial in ensuring a more solid study design and an ethically sustainable approach. The resulting challenge had to do with the actual implementation of the study being delayed by over two months in regard to what was initially intended. As the research had been predetermined for completion no later than early May 2012, this put a lot of demand on accomplishing all phases of research without compromising quality of the study conducted.

Recruitment strategy in Phase I required alteration with initially only half of the immigrant women interviewed obtained through the Hervanta Maternity Clinic. Snowball sampling had to be applied at short notice in addition to the initially utilized intentional sampling midway through recruitment. Recruitment continued through referrals from already interviewed immigrant women. Predetermined inclusion criteria for immigrant women, however, remained uncompromised.

The majority of interviews recorded were conducted in the Finnish language. All recordings were transcribed reaching an accumulation of 166 pages of text. The transcribed interviews also had to be translated from Finnish into the English language. Although great care was put into translation, there is undoubtedly the human factor that has to be recognized in both transcribing from recordings as well as translating them with accuracy.

A limitation to be recognized regarding findings of the study is the abundance of data derived from the interviews. Although it is the researcher's view the essential findings were recognized and addressed, it is clear the findings contained an abundance of information that could be analyzed further in the future.

The study involved interviewing immigrant women in English or the Finnish language. Women able to communicate in other languages were not included in recruitment criteria due to limitations of not having qualified interpreter services available. The limitation ruled out the possibility of interviewing immigrant women from a broader population of potential candidates. It is for this reason the findings of the findings of the study may not be considered to represent the more diverse population of immigrant

women currently living in Finland. It is the researcher's understanding based on the findings of the study certain indications are inclined to apply to a broader population of immigrant women.

6.8 Potential consequences of the study

The potential benefits of conducting the study are not likely to be immediate. Yet there can certainly be substantial benefit in researching and gathering data on the issue of perceived care among immigrant women as it certainly has not been adequately researched in this country at this point in time. Certainly, gaining a more profound understanding on the experiences and expectations of immigrant women regarding the care they received during their stay at the Tampere University Hospital (TAYS) can eventually translate into precautions taken and resources allocated into improving the care women receive.

It may be noted the researcher has taken all possible precautions to ensure there were no disadvantageous health consequences to those having taken taking part in the study. There was a mutual agreement with the immigrant women interviewed that either party would make contact should some part of what was communicated during the interview require clarification. An agreement that was favourably reaffirmed on the part of several women participating in the interviews through feedback received after interviews had been concluded.

A clear indication of the potential of conducting interviews of this nature came through several remarks from several midwives interviewed and were offered for the purpose of feedback. There was an indication of how they had not been given the opportunity to reflect on such issues in the manner offered by the interview previously in their working life. They indicated they saw the conducted interview in itself as a useful opportunity to gain insights on their own views and therefore enhance understanding.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Main conclusions

It is evident from the findings of the study that midwives at the Maternity and Labour Unit of TAYS are acknowledged for their strong work ethic, professional competence and clinical assessment skills. They were also considered direct and to-the-point communicators who worked diligently and efficiently. With the city of Tampere emerging more as a multicultural region in the years to come, the challenges of meeting the requirements and needs of women from a diversity of backgrounds is likely to only increase.

Experienced care may be viewed in relation to patient satisfaction. This study as other studies of a more general scope conducted indicate communication and interaction skills are a major determinant in the manner care is received and perceived. It is a factor reflecting on both patient satisfaction and in short as well as long term patient wellbeing. The most basic communications and interaction skills include courtesy, active information giving as well as genuine enquiry and the willingness to listen.

The giving of one's time and presence can go a long way in interacting with patients with diverse backgrounds. It is clear patient satisfaction and perceived care may be affected by the individual's expectations, yet it is the researcher's view, once an individual is given the opportunity to make informed decisions on the care received, such an approach may go a long way in the most challenging of circumstances.

On another note, it may often be easy to apply certain approaches that have been applicable in similar circumstances with certain individuals. While an approach of this kind may prove effective on several occasions, the reality of it is, it will not be likely to be effective on all occasions. One size does not fit all, as they say.

In cases where the duration of stay at a ward or hospital care unit are of relatively short, as was the case in the study conducted, the significance of culturally competent care does not diminish due to the time factor. On the contrary there appears to be a tendency for characteristics of such care being magnified in ones overall experience of care.

Different forms and aspects of care offered require the emphasis of a variety of interpersonal skills. While at times a more verbally oriented exchange is necessary there are other occasions where non-verbal exchange can prove more helpful. The challenge for the caregiver is to move fluently according to the demands of the situation and adapt ones skills accordingly. What is required at all times is a genuine willingness and capacity to find out from the receiver of care, how an experience is understood and received.

Prior to conducting the study it was supposed (Chapter 1) study findings could present a reasonable level of cultural competence at TAYS. It was also assumed immigrant women would undergo some challenges in being under care of and in interaction with health care personnel at the hospital. Finally, it was supposed findings were likely to indicate a need for more individualized, culturally adjusted care and support. Based on the conclusions above these assumptions may be viewed to have been proven accurate based on findings of the study.

7.2 Recommendations

It is the view of midwives interviewed that it is not possible to have enough of an understanding and knowledge about all cultures represented within a community. The researcher shares the view and would underline the significance of recognizing the right of an immigrant to receive care according to their needs.

An indication of respect regarding an immigrant patient's values, beliefs, practices or preferences may certainly be considered a good start but it may not yet guarantee the care offered to actually match how care is perceived and experienced. As conveyed by findings of the study, neither is it often enough for health care staff to indicate they are open for questions and make the general statement of all their patients being treated as equals.

Offering care that may be viewed as culturally competent is a long term goal that demands strategic and operational level changes in organizations. Without fundamental

changes even the most competent of individuals would be limited in their capacity to undertake their tasks in a culturally competent manner.

A prerequisite to such care would be the meeting of staff and patient as equals, with enough time allocated toward interviews in order to find out which approaches and practices available would be suited in the situation.

A culturally competent approach has members of staff approach a patient respectfully and effectively regardless of their culture, language, race, ethnic background, religion, or other diversity factor. Such an approach recognizes and affirms the values and worth of individuals and their families. Each patient has a sense of being protected and their dignity preserved.

This would require abstaining from making assumptions of any kind prior to them being confirmed personally by the receiver of care. The researcher would underline the immigrant woman in this instance, being the only authority as to the manner in how she perceives and experiences the options for care provided and therefore also be her own authority in matters requiring decisions on options available.

The issue of acting unquestioningly upon one's individual perception, without actually having it confirmed by the individual receiver of care can result in unfounded choices and inaccurate conclusions. This is well recognized from the study findings and is particularly valid in taking responsibility for the care of an individual originating from an environment the caregiver is by no means connected to.

It is the researcher's view that miscommunication or other unintended outcomes of care may often be indicated as due to cultural differences. Explanations of the kind do little to improve the individual's perceived quality of care. A result could be such statements actually leading to experienced challenges actually becoming more permanent attitudes of the working environment of a hospital ward if not addressed properly.

Acceptance and appreciation for patients regardless of their cultural background is a cornerstone for culturally competent care and a start in taking the necessary steps to achieving enhanced overall experiences for the counterparts, patient and caregiver.

Based on the interviews conducted and sources of reference reviewed in the writing of the thesis, the researcher proposes an approach for the individual health care professional to begin developing ones capacity for culturally competent care. The first step would be to examine one's own values, behavior patters, beliefs and assumptions through ones daily work and recognize possible patterns to ones best ability.

Another step could be to ask questions and attempt to clarify reasons for behavior and emerging attitudes. Indicating openness to learn and verifying what one perceives to be an understanding through the asking of questions has the capacity to correct inaccurate observations. Speaking clearly and using simplified language is often helpful as is asking for opinions from those of a different background in learning new approaches and skills.

A good approach could also be to regularly ask patients formally or informally on how they perceive care provided for them. Being genuinely present with patients enables them to share how they feel about what is taking place and how they understand their circumstances. Openness and warmth in interaction and a capacity for empathy enables the health care practitioner to perceive and understand diverse views and create a more conducive atmosphere for interpersonal exchange.

In closing, the aspects of how immigrants perceive the care they receive in Finnish health care at primary or secondary levels has not been researched extensively in the country to this day. A number of challenges do exist as was the case with this study. Yet, there are likely to be a great variety of issues benefitting from more extensive research and findings.

In considering the area of research in this case as an example, it would most likely prove beneficial to study other groups of non-Finnish originating women. For example the researcher excluded women who were not able to communicate in Finnish or

English languages due to reasons expressed earlier. Another feasible option could be to study similar experiences pertaining to a segment of immigrants, for example those having moved to the country under refugee status or regarding women of certain cultural credentials or backgrounds. More extensive findings could be obtained through conducting a nationwide study, with participation of all major regions of the country. A study of this nature would naturally require to be conducted over a longer period of time and require more extensive resources in terms of funding and personnel.

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REFERENCES

- Alkula, T. Pöntinen, S. Ylöstalo, P. 1994 : Sosiaalitutkimuksen kvalitatiivisia menetelmiä. WSOY. Helsinki. p. 80-82.
- Antaki, C. Billig, M. Edwards, D. Potter, J. 2002. Discourse Analysis Means Doing Analysis: A Critique of Six Analytic Shortcomings. Discourse and Rhetoric Group Department of Social Sciences. Loughborough University. Leicestershire, UK.
- The Act on the Status and Rights of Patients (785/1992). <http://www.finlex.fi/en/laki/kaannokset/1992/en19920785.pdf>, (accessed 13.3.2012).
- Anis, M. 2008. Sosiaalityö ja maahanmuuttajat. Lastensuojelun ammattilaisten ja asiakkaiden vuorovaikutus ja tulkinnat. Väestöntutkimuslaitoksen julkaisusarja D 47 Helsinki. p. 25.
- Berg, B.L. 2001. Qualitative research methods for the social sciences. Boston: Allyn & Bacon p.314-317
- Berry, J. 1992. Cross-cultural psychology: Research and applications. Cambridge University Press. Cambridge. England.
- Bucholtz, M. 2006 Transcription Issues in Current linguistic Research. Transcription and Identity: Dilemmas in the Written Representation of Speech and Speakers. <http://www.linguistics.ucsb.edu/projects/transcription/LSA2006.pdf>. p. 12. (Accessed 20.12.2012).
- Capell, J. Dean, E. Veenstra, G. 2008. The Relationship between Cultural Competence and Ethnocentrism of Health Care Professionals. Journal of transcultural nursing. April 2008 vol. 19 no. 2 p. 121-125
- Castaneda Anu. Maahanmuuttajien hyvinvointia ja terveyttä tutkitaan. www.thl.fi/thl-client/pdfs/c842357c-f065-4b49-bac2-598a0d852c35. (Accessed 9.11.2011).
- Centre for the Advancement of Health. 2011. http://www.healthlaw.org/index.php?option=com_content&view=article&id=345:measuring-cultural-competence-health-care-recommendations-national-standards-outcomes-focused-research-agenda&catid=45 (accessed 22-26.3.2012)
- City of Tampere 2011. www.tampere.fi/perhejasosiaalipalvelut/maahanmuuttajat/html accessed 12.11.2011

- City of Tampere 2011. Toimintaympäristö: Kielet ja kansalaisuudet.
http://www.tampere.fi/material/attachments/k/5yY5JKIVl/Toimintaymparsto_Kielet_ja_kansalaisuudet_11.pdf accessed 3.11.2011
- Clarke K. 2003. Welfare Research into Marginal Communities in Finland: Insider Perspectives on Health and Social Care. Research Reports Series A, No 8. Department of Social Policy and Social Work. University of Tampere. P.23-25.
- Creswell, J. 1998. Qualitative inquiry and research design. Choosing among five traditions. Thousand Oaks, CA: Sage.
- Cross T, Bazron B, Dennis K and Isaacs M. 1989. Towards a culturally competent system of care. (Vol. 1), Georgetown Centre, Washington DC.
- Culley, L. and Dyson, S. 2010. Ethnicity and Healthcare Practice: A guide for the Primary care team. London: Quay Books Division. p. 23-77.
- Dalrymple, J. Burke, B. 1995. Anti-oppressive practice. Social care and the law. Open University Press. Buckingham.
- Deville, W. Greace, T. Bogicet, M. et al. (2011). Health care for immigrants in Europe: Is there still consensus among country experts about principles of good practice? A Delphi study. <http://www.biomedcentral.com/1471-2458/11/699>. (Accessed 12.11.2011).
- van Dijk, T. Discourse in society. www.discourses.org/journals/das/whatisdiscourseanalysis/index.html (accessed 14.3.2012).
- Dogan, H., Tschudin, V., Hot, I. and Özkan, I. 2009. Patients' transcultural needs and carers' ethical responses. Nursing Ethics 16 (6), 683-696.
- Douglas, M., Pierce, J. Rosenkoetter, M. Callister, L. Hattar-Pollara, M. Lauderdale, J. Miller, J. Milstead, J. Nardi, D. Pacquiao, D. 2009 Standards of Practice for Culturally Competent Nursing Care: A Request for Comments. Journal of Transcultural Nursing 20 (3), P.257-269.
- Dowd, S. Giger J. Davidhizar R. 1998. Use of Giger and Davidhizar's Transcultural Assessment Model by Health Professions. International Nursing Review 45(4). p. 119-122, 128.
- Elo, S. Kyngäs, H. 2007. The qualitative content analysis process. Journal of Advanced Nursing. 62 (1) p. 107-115.
- Gashi, F. 2009. Seeking healthcare in the home country: Reasons given by Kosovar and Russian migrants living in Finland and by Finns living abroad. Master's Thesis. University of Tampere.

- Gerrish, K. Papadopoulos I. 1999. Transcultural competence: The challenge for nurse education. *British Journal of Nursing* 8 (21), p. 1453-1457.
- Giger JN & Davidhizar RE. 2003. *Transcultural Nursing. Assessment & Intervention*. St Louis, Mosby, USA.
- Gissler, M. – Malin, M. – Matveinen, P. 2006: *Maahanmuuttajat ja julkiset palvelut: Työministeriö, Helsinki*. p. 123,126.
- Green, J, Thorogood, N. 2009. *Qualitative Methods for Health Research*. 2nd Edition. Sage Publications Ltd, London UK. p. 93-122.
- Hirsijärvi, S. Remes, P. Sajavaara, P. 2005. *Tutki ja kirjoita*. Kustannusosakeyhtiö Tammi. Helsinki.
- Kalvas A. 28.10.2011. Discussions on upcoming study held with Head Nurse of the Maternity and Labor Wards at Tampere University Hospital – TAYS.
- Korkiasaari, J. Söderling, I. 2007. Muuttoliike. In Koskinen, S. et al (eds.) *Suomen väestö*. Gaudeamus Helsinki University Press. Helsinki p. 239-270.
- Koskinen, L. (2010) in Abdelhamid P. et al *Monikulttuurinen hoitotyö*. Helsinki: WSOYpro Oy, p.18.
- Kunnat.net,Tietoja ulkomaan kansalaisista, vieraskielisistä ja maahanmuuttajista,<http://www.kunnat.net/fi/haku/sivut/results.aspx?k=maahanmuuttaja%20m%C3%A4%C3%A4ritelm%C3%A4>, accessed 13.11.2011, Suomen Kuntaliiton verkkopalvelu
- Käypä hoito. www.käypähoito.fi/web/english/home. (Accessed 15.4.2012)
- Lahtela, L. 2.11.2011. Discussions on upcoming study held Department Head of the Maternity Health Clinic of Hervanta in Tampere.
- Langer N, (1999) “Culturally Competent Professionals in Therapeutic Alliances Enhance Patient Compliance,” *Journal of Health Care for the Poor and Underserved* p. 19–26.
- Leard dissertation. <http://dissertation.laerd.com/articles/snowball-sampling-an-overview.php>. accessed 12.11.2011.
- Leininger, M (1995) *Transcultural nursing: Concepts, theories, research, and practice*. Columbus: McGraw-Hill. Ohio, USA. p.??
- Leininger, M. McFarland, M. (2006) *Culture Care Diversity and Universality - A Worldwide Nursing Theory*. Sudbury: Jones and Bartlett. Massachusetts, USA. p.13.

- Malin, Maili – Gissler, Mika 2006: Maahanmuuttajien terveys- ja sosiaalipalveluiden saatavuus, laatu ja käyttö oikeanmukaisuuden näkökulmasta. Teoksessa Hyvinvointivaltion rajat: Riittävät palvelut jokaiselle. Stakes, Helsinki. p.11, 79.
- Merriam-Webster Dictionary. (2011). www.merriam-webster.com/dictionary/migrate. (Accessed 29.12.2011).
- Narayanasamy, A. White, E. (2004) A review of transcultural nursing. *Nurse Education Today* 25 (2), P. 102-111
- Offredy, M, Vickers, P.2010. *Developing a Healthcare Research Proposal*. Wiley-Blackwell. New Jersey, USA. p. 152-175.
- Papadopoulos I., Tilki M., Taylor G., (1998): *Transcultural care. A guide for health care professionals*. Quay Publications. Dinton, Wilts, London, U.K.
- Papadopoulos I. 2003. The Papadopoulos, Tilki and Taylor model for the development of cultural competence in nursing. *Journal of Health, Social and Environmental Issues* 4 (1), p. 5-7.
- Papadopoulos Irena 2006. *Transcultural Health and Social Care. Development of Culturally Competent Practicioners*. Churchill Livingstone Elsevier. Edinburgh. P.7-23.
- Papadopoulos, I. Lees S. 2002. Developing culturally competent researchers. *Journal of Advanced Nursing* 3, p. 258-264.
- Papadopoulos I, Tilki M and Taylor G. 1998. *Transcultural Care: A guide for Health Care Professionals*. Quay Publications. Dinton, Wilts.
- Tuomi,J. Sarajärvi, A. 2002. *Laadullinen tutkimus ja sisällönanalyysi*. Tammi. Helsinki
- Pedersen, P. 2000. *A handbook for developing multicultural awareness*. 3rd edition. American Counseling Association. p. 34
- Peltola Ulla, 2005: *Asiakkaana maahanmuuttaja*. Kuntoutus 2/2005. Helsinki. p.68.
- Polit, D. Beck, C. 2003. *Nursing Research: Principles and Methods*. Lippincot Williams & Wilkins. p. 642-663.
- Purnell, L. Paulanka, B. (2003) *Transcultural Health Care - A Culturally Competent Approach*. Philadelphia: F. A. Davis. p.4.
- Phillips,K. Mayer, M. Aday, L. 2000. "Barriers to Care among Racial/Ethnic Groups under Managed Care," *Health Affairs* 19. P.65–75.
- Purnell L, Paulanka B, 2008. *Transcultural Health Care. A Culturally Competent Approach*.3rd Ed. New York:McGraw Hill. Medical Publishing Division

- Rauta, A. 2005. Selvitys maahanmuuttajien mielenterveyspalvelujen tarpeesta ja saatavuudesta. Sosiaali- ja terveysministeriö, Helsinki. p. 19-91.
- Ray, M. 2010. Transcultural caring dynamics in nursing and health care. F.A. Davis Company. Philadelphia. p.170
- van Ryn M. and J. Burke J. 2000. "The Effect of Patient Race and Socioeconomic Status on Physicians' Perceptions of Patients," *Social Science and Medicine* 50 p. 813–28.
- Sainola-Rodriguez, K. 2009. Transnationaalinen osaaminen–uusi terveydenhuoltohenkilöstön osaamisvaatimus. University of Kuopio. Kuopio p.27.
- Sarvimäki, M. – Kangasharju, A. 2006: Maahanmuuttajat ja julkiset palvelut: Pienten lasten hoito ja sosiaalihuollon avopalvelut. Työpoliittinen tutkimus 296. Työministeriö, Helsinki. p.23
- Markoff, J. Shapiro, G. Weitman S. 1974. Toward the Integration of Content Analysis and General Methodology. *Sociological Methodology*. CiteSeerX. (accessed 14.3.2012)
- Statistics Finland - Migration 2010. <http://www.stat.fi/til/muutl/2010/muutl_20010_2010_2011-04-29_tie_001_en.html. (accessed 14.1.2012).
- Sosiaali- ja terveysministeriö 2007. Seksuaali- ja lisääntymisterveyden toimintaohjelma vuosille 2007 – 2011 Sosiaali- ja terveysministeriön julkaisuja 2007:17. Osoitteessa http://www.stm.fi/c/document_library/get_file?folderId=28707&name=DLFE-3584.pdf&title=Seksuaali__ja_lisaantymisterveyden_edistaminen_fi.pdf p.17. accessed 15.10.2011.
- Taavela, R. 1999. Maahanmuuttajien palvelujen laatu Suomen perusterveydenhuollossa. Kuopio: Kuopion yliopisto. p.23
- Tiilikainen, M. 2007. Etniset vähemmistöt Suomessa – Kasvava monimuotoisuus on haaste hyvinvointiyhteiskunnan palveluille ja yhdenvertaisuudelle”, *Duodecim*, vol. 123, p.437.
- Tilastokeskus 2010 Population statistical data– www.stat.fi/tup/suoluk/suoluk_vaesto.html#vaestonmuutokset (accessed 12.11.2011).
- Ting-Toomey, S. 1991. Cross-cultural interpersonal communication. An Introduction. *International and Intercultural Communication Annual*. Vol. XV, p. 1-7.
- Tuokko, Tuula 2007. Hoitotyöntekijöiden kulttuurinen kompetenssi. Master's Thesis. Kuopion yliopisto. Hoitotieteenlaitos.

- Uusijärvi, A. 2003: Miten Helsingissä hoidetaan maahanmuuttajataustaisen lapsen mielenterveyttä? Selvitys maahanmuuttajataustaisten lasten mielenterveys-tilanteesta ja palvelujärjestelmän kehittämishaasteista. Mielenterveys-palveluprojekti. Helsingin kaupunki. p. 15-16.
- Vuori, P. ym. 2007: Kunta- ja palvelurakennemuutos - Pääkaupunkiseudun väestöanalyysi. Helsingin kaupungin tietokeskus. Tilastot ja tietopalvelu accessed 24.9.2011 <www.selma-net.fi/temporary/file.asp/data_id.../PKSvaennuste2025rap.doc
- Väestöliitto – The Family Federation. 2009. Toimintasuunnitelma: Maahanmuuttajien seksuaali- ja lisääntymisterveyden edistäminen. <http://vaestoliitto-fi-bin.directo.fi/@Bin/8e0eefcc675064db7154dd11c3febf2/1333808799/application/pdf/906852/maahanmuuttajien%20seksuaaliterveys.pdf>
- Starr, S. Wallace, D. 2009. Self-reported cultural competence of public health nurses in a Southeastern U.S. public health department. Public Health Nursing 26 (1), P. 48-57.
- TAYS Ethical committee. [www.pshp.fi/default.aspx?contented=1155#3Aineiston toimittaminen](http://www.pshp.fi/default.aspx?contented=1155#3Aineiston%20toimittaminen). (accessed 15.10.2011).
- Weber, P.R. 1990. Basic content analysis (2nd ed.) Newbury Park, CA: Sage
- The World Health Organization - WHO. 2008. Fact Sheet n° 31 "The Right to Health". <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>. (accessed 12.1.2012).

THEMATIC INTERVIEW FOR IMMIGRANT WOMEN

I. Background Information

Country of origin:

Range of ages

Language utilized with staff while at hospital

Did the interviewee make use of the Maternity Ward services prior to being admitted for the onset of labor and if so, kindly mention which ones you may recall?

Did you make use of any of the following services?

Clinic dealing with fears of giving birth, Clinic for planning of delivery, Clinic to follow up on special medical conditions related to pregnancy, Open house visits available to get acquainted with hospital facilities prior to being admitted.

Were you and outpatient?

Were you admitted to the ward prior to the onset of labor?

How many days were you in the hospital before being discharged after delivery?

II. Physical Environment, Materials and Resources

Informative material

How does the following reflect the taking into account of your cultural background?

printed hand out material, internet based information, instructions for caretaking after discharge from hospital, patient records regarding delivery, availability of woman doctor, availability of interpreter

Would you would have any requirements regarding these? Anything experienced as useful?

Physical environment

Would you like to let me know something about how you found the physical environment of the hospital?

admissions, maternity ward, private or shared room, delivery room, common sitting and general facilities

Was there something you would have required differently regarding the above?

Was there something you found particularly pleasing?

Would you like to let me know something about the procedures and clinical care that was provided or offered?

at the Maternity ward prior to the onset of labor, at the labor ward, pain management, monitoring, use of available facilities, administering of medication surgical procedures, at the Maternity ward after delivery – pain management, monitoring, use of available facilities, administering of medication

Was there something you would have required differently regarding the above?

Was there something you found particularly pleasing?

Resources

Did you make use of an interpreter at any point in time? If you like to let me know about how it was for you?

III. Form of Communication

Understanding and communication

Would you like to let me know something about how you were able to understand what was being communicated to you at the different points of your admittance to the hospital?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Was there something you would have required differently regarding the above?

Was there something you found particularly pleasing?

Would you like to let me know something about how health care staff members able to understand what you were moved to communicate with them?

prior to the onset of labor, during labor, after delivery at the maternity ward, upon dispatch from hospital

Was there something you would have required differently regarding the above?

Was there something you found particularly pleasing?

Scope of communication

Would you like to let me know something about the different topics you were communicating about with staff members?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something about how you felt the staff members were as communicators?

Would you like to say something about the methods they used to help with understanding?

IV. Social interaction

Would you like to say something regarding if anyone was with you in coming to the hospital or if you had someone with you during labour?

Would you like to say something about possible visitors you had while at the Maternity Ward?

If your husband or partner stayed with you prior to, during and after giving birth, would you like to say something about the experience?

Would you like to let me know about how you felt the staff accommodating to your needs of being with your partner, family, friends and possible relatives?

Is there something you would like to let me know about how you experienced interaction with the staff in areas other than dealing with clinical procedures, breastfeeding or baby care?

Was there something you would have required differently regarding the above?
Was there something you found particularly pleasing?

V. Perceptions of Procedures, Health and Recovery

Would you like to say something about how you felt during your stay at the hospital?

Would you like to say something about how your personal feelings of being well or not- doing- so- well was understood by the health care staff members?
prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something about being given the opportunity to make personal choices according to your beliefs regarding breast feeding?

Would you like to say something about your being able to choose whether you preferred to be mobile or more inert ?
prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Was there something you would have required differently regarding the above?
Was there something you found particularly pleasing?

VI. Assumptions, Attitudes and Values

Would you like to say something about how you felt that you were recognized and accepted as someone originating from a country other than Finland by staff members?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you had any experiences of having been required to do something according to values you would not have been comfortable with?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you felt there was the opportunity to undertake or do things that come naturally for you in your culture?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Was there something you would have required differently regarding the above?
Was there something you found particularly pleasing?

Would you like to say something regarding if you observed any other patient receiving treatment or care you witnessed she was not clearly comfortable with?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you experienced at any point in time that a staff member may not have had full confidence in your capacity to follow instructions – take care of yourself – act responsibly?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you experience at any point in time that you were being hurried with something you were not willing or able to do or to comply with?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you had the sense that hospital staff members were knowledgeable as to you culture, beliefs and norms? If so, how was this demonstrated?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you, at any point in time, felt that you were required to adapt to the practices and norms that seem to be inherent with local culture?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to say something regarding if you, at any point in time, felt that you had the urge to adapt to the practices and norms that seem to be inherent with local culture?

prior to the onset of labor, at the admissions, during labor, after delivery at the maternity ward, upon dispatch from hospital

Would you like to add something more to how all the issues we just discussed affected you?

VII. General Questions

How did you in general experience your pregnancy and delivery at TAYS?

Would you like to mention something you found pleasing about your stay there?

Would you like to mention something you did not find pleasing?

What are the main things that would have made you delivery at TAYS a better experience?

Should you have the opportunity to have another baby would you have it at TAYS?

Would you like to mention something in particular, you would like forwarded to the management of the hospital?

END OF INTERVIEW

THEMATIC INTERVIEW FOR HEALTH CARE PERSONNEL

(In Finnish)

I. Hoitoympäristö, jaetut aineistot, materiaalit, tilat ja palvelut

Minkälainen on arviosi siitä, mihin maahanmuuttajat kiinnittävät huomiota heille tarjottavissa materiaaleissa? esim. kirjallinen aineisto tai esitteet, internetistä löytyvä aineisto, kotiutuessa annettavat itsehoito-ohjeet, synnytyskertomus, naislääkärin tarve, tulkin tarve

Olisiko näissä edellämämainituissa asioissa jotakin, jota näkisit voitavan kehittää?

Mikä on arviosi siitä, minkälaisiin asioihin maahanmuuttajat kiinnittävät huomiota yksikön tiloissa?

Mikä on arviosi siitä, minkälaisiin muihin ympäristöön liittyviin mahdollisuuksiin maahanmuuttajat yleisesti ottaen kiinnittävät tässä yksikössä huomiota.

(mahdolliset hyvät tai kehitettävät asiat)

III Vuorovaikutuksen muodot

Miten arvioisit kykyäsi yleisesti ottaen ymmärtää, mitä maahanmuuttajasynnyttäjää sinulle pyrkii viestimään? Kuvailisitko tilannetta, jossa tämä on erityisesti tullut esiin? Oletko havainnut haasteita tässä asiassa? Minkälaisia?

Koetko, että kykenet saamaan maahanmuuttajasynnyttäjää hyvin ymmärtämään mitä haluat hänelle viestiä? Kuvailisitko tilannetta, jossa tämä on erityisesti tullut esiin? Oletko havainnut heidän kohtaavan haasteita tässä asiassa? Minkälaisia?

Oletko kokenut, että sinulla olisi jotakin, jossa voisit kehittyä kanssakäymisen suhteen? Jos on, niin millaisissa asioissa toivoisit kehitystä tapahtuvan? (esimerkkejä)

Minkälaisia vuorovaikutukseen liittyviä ominaisuuksia arvelisit maahanmuuttajan liittävän osaston henkilökuntaan?

IV. Yleinen kanssakäyminen

Oletko havainnut maahanmuuttajilla olevan joitakin kanssakäymiseen liittyviä erityispiirteitä tai erityistarpeita henkilökuntaan nähden? Jos olet, voitko kertoa esimerkkejä havainnoistasi?

Oletko kokenut, että sinun tulisi yleisesti ottaen muuttaa tapaasi toimia tai tapaasi viestiä jollakin tavoin maahanmuuttajasynnyttäjän kohdalla? Jo olet, millä tavoin tämä asiaa on tullut esiin? Oletko havainnut jollakin tavoin mukauttavasi tapaasi toimia?

(valinnainen, aiemmista vastauksista riippuen) Onko sinulla joitakin havaintoja tai kokemuksia siitä että maahanmuuttajasynnyttäjät ottaisi huomioon henkilökuntaa? Jos on, millä tavalla asia olisi tullut ilmi ja minkälaisissa tilanteissa asia olisi tullut esiin?

Onko sinulla joitakin havaintoja tai kokemuksia siitä että maahanmuuttajasynnyttäjät ottaisi huomioon muita osastolla olevia? Jos on, millä tavalla asia olisi tullut ilmi ja minkälaisissa tilanteissa asia olisi tullut esiin (esim. huonetoveri)

Onko sinulla kokemusta tai joitakin näkemyksiä maahanmuuttajien omaisten tai ystävien osastolla vierailun suhteen? Voisitko mainita esimerkkejä tästä ?

(aiemmista vastauksista riippuen) Toivoisitko vierailukäytäntöihin joitakin muutoksia nykyisestä?

Oletko havainnut, että olisi asioita, jossa olisit jollain tavoin valppaampana maahanmuuttajasynnyttäjien kohdalla?

V. Kokemukset toimenpiteistä, terveydentilasta ja toipumisesta

Koetko joskus haastetta maahanmuuttajasynnyttäjän yleisen voinnin selvittämisen suhteen? Kuvailisitko haasteita joita olet kohdannut?(fyysinen & psyykinen mahdolliset komplikaatiot, kipu, oma kuntoutuminen, liikkeellä oleminen.)

Onko maahanmuuttajien hoidossa sinulle tullut vastaan joitakin tabuja? Minkälaisia esimerkkejä tulisi nyt mieleen? (valinnainen : pyritkö näitä asioita yleensä selvittämään ja miten?)

Tuleeko sinulle mieleen heille annettavaan hoitoon liittyen joitakin erityistarpeita? Minkälaisia?

Tuleeko sinulle mieleen joitakin terveyteen tai toipumiseen liittyviä seikkoja, joita heidän on vaikea ilmaista? (valinnainen: Jos tulee mieleen, miten pyrit saamaan kyseisiä asioita esiin?)

VI. Olettamukset, asenteet ja arvot

Oletko yleensä selvillä maahanmuuttajanaisen alkuperämaasta? Onko olemassa joita maahanmuuttoon liittyviä asioita, joita pyrit selvittämään?

Jos asioita on, voitko kertoa millä tavoin asiaa ryhdyt asiaa selvittelemään ja minkälaisia yksityiskohtia pyrit saamaan tietoon?

Mitkä ovat kokemuksesi maahanmuuttajien kohdalla ilmenevistä arvomaailmoista, tulevatko ne sairaalahoidossa esiin? Voitko kertoa millä tavoin ne ilmenevät? (prompt: ovatko esim. vaikeasti selvitettävissä?)

Oletko havainnut, että maahanmuuttajilla olisi esiintynyt joitakin olettamuksia sairaalahoidossa ollessaan tai sairaalahoitoon liittyen? Minkälaisia?

Jos maahanmuuttajien taholta on tullut esiin joitakin olettamuksia ja asenteita, miten näkisit sen vaikuttaneen tapausi toimia hänen kohdalla?

Minkälaisia vahvuuksia tunnistaisit itsessäsi olevan kohdatessasi näitä olettamuksia tai asenteita?

Oletko tunnistanut mahdollisia olettamuksia ja ennakoasenteita kohtaamisessa sinussa itsessäsi. Olisiko sinulla esimerkki asiasta tai tilanteesta kertoa?

Minkälaisista asioista arvelet maahanmuuttajanaisen yleensä olevan tyytyväisiä synnytykokemukseensa liittyen tässä yksikössä?

Antaako maahanmuuttaja kokemuksesi mukaan herkästi myönteistä palautetta? Jos sinulla on kokemuksia asiasta, voitko kertoa esimerkin/-kejä näistä tilanteista?

Minkälaisista asioista arvelet maahanmuuttajanaisen olevan tyytymättömiä synnytykokemukseensa liittyen tässä yksikössä? Kokemuksia siitä, millä tavoin asia voisi ilmetä?

Oletko havainnut joitakin erityispiirteitä, yleisiä tai yksittäisiä joista haluaisit kertoa maahanmuuttajanaisen sairaalassaolo sopeutumiseen liittyen?

Minkä verran näkemyksesi mukaan maahanmuuttajasynnyttäjän olisi sopeuduttava suomalaisiin tapoihin sairaalaympäristössä? Kerrotko esimerkkejä tavoista? (jos vastaus ei: pyyntö perusteluille) (prompt: Minkälaisia näkökohtia siihen voisi liittyä?)

Onko toimissasi joitakin erityispiirteitä – yleisiä tai yksittäisiä, joista haluaisit kertoa omalla kohdallasi auttaessasi maahanmuuttajanaista sopeutumaan sairaalalolosuhteisiin.

VII. Yleiset kysymykset

Oletko mitenkään kiinnostunut vieraista kulttuureista? Jos olet, kerrotko tavoista, joilla sinulla ollut mahdollisuuksia tai tilaisuuksia selvittää niihin liittyviä piirteitä ?

Voitko mainita keskeisimpiä havaintojasi – yleisiä tai yksittäisiä - maahanmuuttajaisista sairaalan asiakkaina?

Onko maahanmuuttaja- ja alkuperältään suomalaisessa synnyttäjässä joitakin eroavuuksia, joista haluaisit mainita?

Voisitko mainita joitakin asioita, jotka koet omiksi vahvuuksiksi maahanmuuttajasyntyttäjän kohdalla?

Voisitko vielä mainita asioita, kielellistä kysymystä lukuunottamatta, jotka ajoittain tai usein koet haasteellisimmaksi maahanmuuttajasyntyttäjän kohdalla?

Tuleeko sinulle mieleen asioita, joita voitaisiin kehittää maahanmuuttajasyntyttäjien tyytyväisyyden ja viihtyvyyden parantamiseksi sairaalassa?

HAASTATTELUN PÄÄTTYMINEN