

# **Navigating Cultures**

## **A Literature Review of Immigrant Mothers' Experiences in Maternity Healthcare**

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Abstract  <p>As the foreign population in Finland grows, it will impact the health care services and require healthcare workers to have a greater understanding of intercultural care. Immigrant mothers' cultures reflect their own attitudes, values and beliefs in regards to pregnancy and birth. Healthcare professionals need to be aware of these cultural influences with regards to pregnancy, birth and parenting.</p> <p>This research reviews existing literatures to understand the experiences of immigrant mothers in maternity care. The results of this research provides insight into the aspects of the prenatal, postnatal and post-delivery care services that serve immigrant patients and their families well and the areas that need further development.</p> <p>The method of this study is a literature review. Eight articles dated from 2007-2016 were selected from CINAHL and PubMed. Content analysis was used to analyze our data.</p> <p>The following four major categories emerged from the findings: communication, culture and religion, isolation, healthcare services and interventions. There were mixed reviews in the research papers on whether the overall experiences of the immigrant mothers were positive or negative. Based on our findings, we made recommendations that can be implemented in the Finnish maternity healthcare system.</p> <p>With the influx of refugees and asylum seekers arriving to Finland, the results of the study may provide beneficial information regarding transcultural care to health care providers working within prenatal clinics, maternity wards, and other facilities providing prenatal, postnatal and post delivery services for immigrant mothers.</p>		
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# 1 Introduction

According to Statistics Finland immigration has been a growing trend in Finland, and with the influx of refugees and asylum seekers, the population of people with foreign origin continues to increase. During the year of 2015, Finland's population grew by 14,860 people, primarily due to migration from abroad. The number of immigrants was 11,900 higher than that of emigrants. (Statistics Finland 2015) As the foreign population grows, it will impact Finnish health care services. As the clientele is becoming more diverse with the emerging group of immigrant and multicultural families, who come from different ethnic, cultural, and religious backgrounds, and who speak a language other than Finnish. This change means that there will be a greater need of understanding for intercultural care among healthcare workers in Finland. Additionally, the majority of foreigners arriving in Finland are between the ages of 25-34 years old. (Statistic Finland, 2015) Females who are under the age of 32 are in their prime fertility age range. (Virtala, Vilksa, Huttunen & Kunttu 2011, 109) This is why we have chosen to narrow our focus to maternity care services.

We believe this subject is an interesting and timely topic, and we wish to learn more about maternity care within the Finnish health care system. There appears to be little existing research on this topic, therefore we believe this is a good subject to research more in-depth. The intention of this research is to get a clearer perspective on immigrant mothers' experiences on the maternity care health services provided to them. Examining their perspectives will aid us in understanding aspects of the system which function and areas that could use further improvement. Additionally, we would like to better understand the challenges of transcultural nursing which we will face in the years to come.

## 2 Transcultural Nursing

### 2.1 Defining Culture

Before understanding cultural competence, it is important to define the concept of culture. Culture is a complex term and includes several different definitions, one of which is a distinct group of people that share common behavioral traits and lifestyle

patterns that distinguishes them from others. Cultural differences can be identified through a group's views, beliefs, values and attitudes in approaching life that is passed down from one generation to another. There are several ways cultural influences can be seen in daily life some of which are through a specific group's mannerisms, taboos, rituals, customs and social etiquette. It is expressed through common catch phrases, myths, art forms, mind sets/ mentalities, religions, political and legal platforms. (Tseng & Steltzer 2008, 1)

Cultural aspects not only influence an individual's lifestyle but also influence their perception of their need for healthcare services and the health care services they seek out (Ingram 2011, 697). Different cultural groups will differ when it comes to their approach to healthcare, their concepts of illness/diseases, how they utilize the health care system, their ability to relate to their healthcare worker and their ability to comply with medical treatment plans (e.g. medications). The patient may be consciously or unconsciously aware of their cultural influences. It is also important to note that culture can change through generations and therefore there can be subcultures within cultures. (Tseng & Steltzer 2008, 1)

Usually the main focus of the healthcare community at large is to provide high quality care to their clients/patients. High quality care involves the ability to accurately diagnose a patient, to create and plan the patient's course of treatment, the ability to assess the effectiveness of this course of treatment in curing or helping the patient return to baseline functional ability, and convey to the patient that they are known and being cared for. Two crucial aspects of high quality care are to provide health care services that are cost-efficient and customer-friendly. The way care is delivered and perceived by the patient is important. Health care providers who are culturally competent are better equipped to provide high quality care. (French 2003, 252-255) Cultural competence involves a continuous attempt to gain a better understanding of the diverse values, beliefs, traditions and customs of different cultural groups (Ingram 2011, 696).

According to the *Finnish Act of the Status of Rights of Patients*, every permanent Finnish resident is entitled to health services without discrimination. A patient's rights include a high standard of care. This care must maintain human dignity and

respect a patient's personal convictions and privacy. The patient's native tongue, individual needs and culture must be taken into consideration as best as possible in order to provide quality health care services. (Finnish Ministry of Social and Health Affairs, 1992) Therefore, nurses in Finland are legally obligated to provide cultural competent services to patients to maintain high quality standards of care.

Regardless of this legislation, research has indicated that people of immigrant backgrounds have challenges in accessing and receiving appropriate health care services in Finland. This is the result of multiple aspects, one of which is the lack of cultural competency amongst health care professionals. (Repo, Vahlberg, Salminen, Papadopoulos & Leino-Kilpi 2016, 1)

Language is one of the ways cultures are expressed and communicated. Language does not only express direct meaning but also conveys underlying concepts, values and attitudes that may differ from other cultural backgrounds. The ability to comprehend one's culture through language can be quite difficult and present challenges especially if the language is different from one's own. (Tseng & Steltzer 2008, 1)

## 2.2 Cultural Competence in the Delivery of Healthcare Services

Cultural competence includes the ability to successfully and effectively function regardless of the cultural differences and diversity. Diversity in this context can refer to gender, race, age, ethnicity, religion and sexual orientation. Utilizing cultural information that is already known is essential to providing culturally competent care. For example, one's religious background or race can impact whether a blood transfusion is a possible course of care. However, it is important that healthcare providers do not make assumptions or stereotype different cultural groups. Everyone in a cultural group is also an individual and may not ascribe to all customs or beliefs of their cultural group. Furthermore, individual beliefs and values can change over time. Given the fact that there are so many cultural variations it's essential that the healthcare providers conduct their own assessment in order to better understand their patient's beliefs, why they believe the way they do and what role their cultural influences play in their course of treatment. A culturally competent healthcare

provider has an open mindset and is not just a database of facts and methods of medical interventions. (French 2003, 252-255)

There are several different ways that nursing literature defines cultural competent care. One example is the Campinha-Bacote model, which defines five key components of cultural competent care:

- **Cultural awareness** is the ability to examine one's own personal biases toward different cultures and examine one's cultural and professional background.
- **Cultural knowledge** is the education process where healthcare workers research reliable sources to gain a base knowledge of diverse groups.
- **Cultural skills** is the ability to gather relevant cultural data in regards to the patient's current situation, as well as being able to correctly perform physical assessments in a manner that is considered culturally sensitive.
- **Culture encounters** is interacting with patients of diverse cultural practices.
- **Cultural desires** are an ongoing desire of medical professionals to build their cultural knowledge and cultural awareness. This way they are receptive to acquiring more cultural competent skills and seek out interactions from diverse cultural groups. (Harris, Purrell, Fletcher & Lindgren 2013, 135-136)

Providing culturally competent care also includes the ability to notice areas of discrimination and challenge them (Taylor, Papadopoulos, Maerten & Ziegler 2011, 190).

A European study on intercultural education of nurses and health professionals concluded that practical experiences are essential in developing cultural competency skills. However, even with these intercultural practical experiences it does not automatically lead to learning. Therefore, medical professionals must be adequately equipped to deal with intercultural experiences. (Taylor et al. 2011, 194)

Furthermore, there is a need for continuous education for nursing staff to assist the development of cultural competency (Repo et al. 2016, 2-3).



### 2.3 Culture and Maternity Care

All cultures have the experience and process of giving birth in common. However, different women from different cultures can experience the childbirth process differently depending on their own personal culture. Cultures reflect their own attitudes, values and beliefs in regards to pregnancy and birth. Medical childbirth professionals need to be aware of the cultural influences when it comes to the experience of pregnancy, birth and parenting. In particular, immigrants from non-western backgrounds could have different norms and practices surrounding traditional medicine during pregnancy and birth. (Greene 2007, 33-34)

According to the World Health Organization approximately 70 % of births in 2006-2013 were attended by a skilled professional (doctor, midwife or nurse). However, there is a considerable difference within the different regions and the different social classes. Accessibility to maternity skilled professionals is the lowest within South-East Asia and Africa. The World Health Organization statistics state that within lower-income countries the attendance of a skilled professional at delivery is 46 %, whereas in lower-middle- income countries it is 64% and within the higher-middle-income countries it is 95 % (WHO, 2016). The majority of childbirth globally takes place outside of health care facilities. This can prove to be a challenge when immigrants who come from cultural practices like this are expected to give birth in the hospital and be cared for by medical staff who do not share the same understanding of their cultural values and beliefs surrounding pregnancy and childbirth practices. (Ottani 2002, 34)

One example of how pregnancy and childbirth culture differ comes from an American article on how American Arabs may differ in their approach to maternity care services and their different views on pregnancy and child birthing process. In Arab culture, preventative health services are rarely used because they do not see the purpose for it unless complications arise. Arab men do not participate in the pre-educational classes on child birth or the birthing process. It is recommended that medical staff should provide cultural appropriate care to these diverse patients by taking into consideration cultural sensitivity. (Greene 2007, 34)

### 3 Immigration and Maternity Care in Finland

#### 3.1 Immigration in Finland

Before 1980, more people were moving away from Finland than immigrating to it. They were usually seeking better work opportunities in other western nations. Sweden was the most popular country for Finnish migrants. (Heikkila & Peltonen 2012, 2) Finland is quite a late comer when it comes to immigration (Forsander, 2003, 55). However, in 1980 a larger portion of the population was immigrating than those who were emigrating (Heikkila & Peltonen, 2012, 2). The foreign-born population was still quite low in the beginning of this decade but by the end of the decade it had doubled. Typically, at this time most immigrants who moved to Finland were of Finnish descent. (Forsander 2003, 56) In 1990, the immigration rate was quickly beginning to rise (Heikkila & Peltonen 2012, 2) and by 2001, 1.7 % of the population consisted of foreign-born nationals. (Koehn, 2006, 4). According to Finnish Immigration services, 31,200 immigrants came to Finland in 2012.

Europe is currently having an influx of refugees and asylum seekers entering the continent (Cendrowicz, 2015). This is a result of the different civil wars that are currently taking place in the Middle East and Northern Africa (Cockburn, 2015). The Finnish government decided it was willing to double the number of Refugees in 2015 (BBC News, 2015). In 2014, 3,651 Asylum seekers came to Finland. Whereas in 2015 there were 32, 476 asylum seekers with 1,628 positive decisions made. By the end of 2015, Finland issued 20,709 first-time residence permits and 8, 281 citizenships. (The Finnish Immigration Services 2016)

Generally, immigrants are considered the vulnerable population who are at a greater risk for poor physical, psychological and social health outcomes and poor standards of healthcare (Derose, Escarce & Lurie 2007, 1258). One example of vulnerability can be the language barriers faced by foreigners. In 2010, approximately 4.6 % of Finland's population had a native tongue that was something other than Finnish or Swedish. (Eklof, Hupli & Leino-Kilpi 2015, 143)

### 3.2 Maternity Care Services in Finland

In Finland, maternity care is provided as part of the publicly funded national health care system. The maternity services are primarily delivered in maternity and child health clinics, known as 'neuvola' in Finnish. There are over 800 communal maternity clinics in the country and nearly 99.8% of pregnant women take advantage of these services (Degni, Suominen, El Ansari, Vehviläinen-Julkunen & Essen 2013). The Ministry of Social Affairs and Health is responsible for the development of maternity and child health clinics, and the municipalities regulate the practical arrangement of services offered to expecting families. The visits are free of charge, and the expectant mothers are entitled to obtain maternity care services provided by their municipal health centre, regardless of their financial situation. Expectant mothers should visit the maternity clinic on 11-15 occasions throughout the duration of their pregnancy. This includes appointments with a public health nurse, a medical doctor, and two ultrasounds where mothers are given the option to be screened for fetal chromosome and growth defects. (Sosiaali- ja terveystieteiden ministeriö 2016.) In addition, first-time parents are expected to take part in a parenting and childbirth education and preparation courses organized by the maternity clinic. Essentially, the aim of maternity clinics is to promote the health and well-being of the parents, unborn and newborn child by offering information, advice and support so that mothers can experience safe pregnancies and deliveries. (Lamminpää 2012, 35.)

Maternity care services are primarily provided by public health nurses as well as midwives. In the case of complications, or if further medical care is required, mothers are referred to specialized antenatal clinics and pre- and post-natal wards within the hospitals so they can be under the supervision of gynecologists or obstetricians. (Degni et al. 2013)

Hospital births assisted by midwives and an obstetrician/pediatrician is common practice in Finland. A partner or one support person may be present in the delivery room along with the mother. Post-delivery, the mother and baby are transferred to a postnatal ward, where midwives and pediatric nurses continue providing care. The normal length of the hospital stay for a vaginal delivery is two to three days. Post

discharge, the care of the mother and infant is resumed by the maternity clinic.  
(Wikberg et al. 2012, 640)

### **Maternity Grant**

The maternity grant was made available to all mothers in 1949. At the time Finland was not a wealthy country and infant mortality was high, however the maternity grant contributed notably to the decline in child mortality and an increase in prenatal care among pregnant women in the decades that followed. Today, expectant mothers are given a choice between receiving a government supplied maternity package or 140 euros in cash.

The maternity grant is available to expecting mothers (including those of an adopted child) who reside in Finland or who are covered by the Finnish Social Security System (KELA). There is an increased grant for multiple births e.g. twins, triplets. In order to qualify for the maternity grant, the expecting mother must be 154 days into her pregnancy and undergo a medical examination at the end of her four months of pregnancy to receive a pregnancy certificate from the antenatal clinic. (KELA, 2016.)

### **Maternity Package**

The maternity package is a unique tradition that dates back to the late 1930s and was established to give every Finnish child an equal opportunity at the start of life, regardless of socio-economic situation of their parents. In the 1930s this package was a form of ensuring that a pregnant mother would seek medical treatment, because an expectant mother would have to enquire with a doctor in order to receive her maternity package. The contents of the package are revised and slightly updated annually, however the principal remains the same. The package contains a wide range of essential baby products for the first year of the baby's life, such as seasonal clothing, cloth diapers, child-care products, a book, a toy, bedding, and a fitted mattress to enable the box to be used as a crib. According to KELA, nearly all first time mothers prefer the maternity package over the money. (KELA, 2016.)

The Finnish maternity package has for several decades been the only one of its kind worldwide. However, in recent years it has gained international prominence. It has inspired copycat versions in more than 30 countries, including, as of January, a pilot

scheme of the program in the province of Alberta, Canada. (Counter, 2015) While the contents of the maternity package are valuable, it is not the box itself, but the wide range of Finnish public policies that exist to support the wellbeing of mothers and children that have helped the country secure one of the lowest infant mortality rates globally and topped the rankings with the world's happiest mothers, next to Norway and Iceland. (Save the Children 2015, 9)

### **Maternity, Paternity, and Paternal Leave Allowance**

When the parents are covered by the Finnish Social Security System, Finland's social security legislation entitles both parents to prenatal leave during the pregnancy and post childbirth. There is a paid maternity leave allowance for 105 working days for expectant mothers, and an additional five to six months of paid paternal leave allowance which can be claimed by either the mother or father of the baby, and lastly, 54 days of paid paternity leave specifically for the father of the baby. (KELA

## **4 Aim and Purpose of the Study**

This research aims to gather the experiences of immigrant mothers in maternity care, based on existing literature. The results of this research can be used to understand aspects of the system which function and bring attention to the areas in need of further development within prenatal, postnatal and post-delivery care services that are provided to immigrant mothers in the Finnish healthcare system.

In order to achieve the aims and purpose of the research, the following question will be addressed: Based on existing literature, what are the experiences of immigrant mothers with the maternity care (prenatal, postnatal, post-delivery) services they are provided with?

## **5 Methods and Implementation of the Study**

### **5.1 Literature Review**

"A literature review is a comprehensive study and interpretation of literature that express and address a specific topic" (Aveyard 2007, 1). We have chosen to do a

literature review to develop insight of the experiences of immigrant mothers within maternity care. Our study is not limited to one particular country rather we will use research from different countries. This will support the creation of an unbiased understanding of immigrant mothers' experiences with maternity care. The purpose of our literature review is to summarize previous existing research done on a certain topic. This way the reader of the literature review is given a larger body of analysed research in one compact text and they do not have to review numerous sources to acquire the same knowledge. (Aveyard 2007, 4)

Literature reviews should be compiled from academic sources and should summarize factual information and not be based on assumptions about the research topic (Dawidowicz 2010, 5).

A literature review consists of extensive research in attempts to rid all possible biases of information surrounding the topic of research. It also consists of providing relevant information, evaluating the quality of the research, and summarizing the findings using a scientific approach. A literature review must present a plan in which the criteria is clearly stated, the search strategies are identified, the process of selection is clear, a well-rounded evaluation of the quality of research and a comprehensive summary of the studies is presented (Bettany-Saltikov 2012, 9-10).

The common guidelines of a literature review is that the reviewer complies with strict protocol to establish a systematic review process to identify critical appraisal and find relevant studies to provide an answer to their research question. The reviewer then creates a comprehensive strategic search where they use all of their resources to gather the data and do not consider their search complete until their resources are exhausted. Following this strategic search, the reviewer critiques the literature based-off the pre-existing criteria to determine the validity and the quality of the research. Therefore, studies that do not meet the pre-determined criteria are excluded from the review. This ensures that only high-quality literature that is relevant to the topic is used in the literature review. Finally, the results from the different resources are present and combined using a systematic approach. (Aveyard 2007, 14-15)

However, a research of this capacity may not be possible for a novice researcher. Students who are doing their undergraduate or postgraduate studies are not required to produce a literature review to this standard. However, they are expected to adopt general principles and guidelines to produce a literature review that is systematic in nature. (Aveyard 2007, 15) We will use the following guidelines and principles listed above to write our literature.

## 5.2 Literature Search

The following electronic databases were used to find research on the experiences of immigrant mothers in maternity care: CINAHL and PubMed. The keywords “immigrants” and “maternity” were used in a combination to search for relevant information on the research topic. CINAHL search with those keywords produced 28 full text hits and PubMed search with those keywords produced 88 full text hits. From there the hits were filtered by fitting titles that seemed likely to answer the research question. From CINAHL, ten article titles seemed fitting for the topic and on PubMed eight article titles seemed fitting. Since, PubMed was our secondary search database, there were several duplicate resources which are excluded from the titles that seemed fitting. After narrowing down the articles by the titles, we reviewed the article’s abstract to consider its relevancy. Due to time consideration, this practical method was used. The abstracts were screened by both reviewers of this paper. From CINAHL database eight studies abstracts were read, from which four studies were selected and read entirely. From the PubMed database six studies abstracts were read and only two studies were selected to be read entirely. Inclusion and exclusion criteria was created to determine which studies would be used in the literature review. Then this process was repeated using different keywords in the CINAHL and PubMed databases.

Table 1. Data Search

Keywords	Database and Number of hits	Title Screened	Abstracts Screened	Full Text Read	Based on Inclusion Criteria
Immigrants/Mternity	CINAHL 28	10	8	4	3

	PUBMED 88	8	6	2	2
<b>Immigrants/Childbirth</b>	CINAHL 48	6	6	3	2
	PUBMED 91	5	5	2	0
<b>Immigrants/Antenatal</b>	CINAHL 12	2	2	0	0
	PUBMED 84	3	3	1	1
<b>Immigrants/Perinatal</b>	CINAHL 29	0	0	0	0
	PUBMED 157	0	0	0	0
<b>Immigrants/Postnatal</b>	CINAHL 36	0	0	0	0
	PUBMED 75	0	0	0	0
<b>Total</b>	<b>648</b>	<b>34</b>	<b>30</b>	<b>12</b>	<b>8</b>

*\*Duplicates are excluded from the table.*

Table 2. Inclusion and Exclusion Criteria

### Inclusion Criteria

- Research had an emphasis on the experience of immigrants within maternity
- English study publications
- Free publications and full text was available
- Published within the last ten years (2006-2016)
- Research used was qualitative in nature
- Geared towards mother's perceptions
- Valid research where scientific approach is presented

### Exclusion Criteria

- Editorials, letters, commentaries, reviews were excluded
- Does not center around maternity care (to specific a part of maternity care e.g. ultrasounds)
- Non empirical research
- Research older than 10 years so therefore did not reflected current information

## 5.3 Data Analysis and Synthesis

Evidence synthesis means combining parts of studies to make a whole in the form of an argument, theory or conclusion. The synthesis is done once all the data of interest



has been collected (Pope, Mays & Popay 2007, 15). We first read over the different research papers before generating our synthesis of data. There are several different ways of synthesizing data.

Content analysis is the form of analysis we have chosen to gather our data. Content analysis was created to analyze primary research. Additionally, it can be used to build upon results from published research in order to pinpoint the common themes within the collection of research and therefore formulates a generalization. We will use this approach to synthesize existing research into a simple form. It involves a systematic technique of breaking down the data into themes and determining how often they occur.

The purpose of our qualitative content analysis is to analyze group concepts and themes. We will use content analysis technique to compress larger text into smaller content categories based off the rules of coding. When analyzing qualitative studies, an underlying theory may be needed to establish and determine the themes or categories into what result fits where and how to establish the relationship between the raw data and themes. (Pope et al. 2007, 48)

The main purpose of content analysis research is to identify characteristics of the studies by exploring who said what to whom and what is the effect. In this particular research, we will be focusing on immigrant mother's experience within maternity care by gathering data from the experiences that were shared within the research papers used for this literature review. Content analysis is an appropriate tool to examine multifaceted, important and sensitive phenomena that occur within nursing. If research is conducted on a topic that does not have known knowledge, this form of analyzing can be used to highlight common issues that reoccur in data. By us using this method, it is possible to not only analyze data but to also quantify data.

Our aim of using this approach is to characterize phenomenon in a conceptual form. The data being analyzed is a representation of text and phrases created to be seen, read and interpreted. Therefore, this must be approached in a manner of seeking out the meaning. This must always be taken into consideration when analyzing data.

However, it has been said various levels of interpretation have been applied to nursing research done by content analysis. (Vaisnoradi, Turunen & Bondas 2013, 400-401)

## **6 Research Results**

Eight research studies were used to compile the results for this literature review. The following four different countries are reflected in this review: Canada (three research studies), Finland (one research study), United States (three research studies) and Australia (one research study). The following four major categories emerged from the findings: communication, culture and religion, isolation, healthcare services and interventions.

### **6.1 Communication**

#### **Language Barriers**

Immigrant mothers indicated that language barriers made it difficult for them to ask for the care they needed, to express and articulate their feelings and concerns, and limited their ability to understand medical terminology and gain healthcare related information from healthcare providers (HCP). Making it difficult for the mothers to engage in well-informed decisions regarding their pregnancy, prenatal care or the labor and delivery process. (Higginbottom, Safipour, Yohani, O'Brien, Mumtaz, Paton, Chiu & Barolia 2016, 5; Reitmanova & Gustafson 2007, 107; Seo, Kim & Dickerson 2014, 309-314; Wikberg, Eriksson & Bondas 2012, 642; Wojnar 2015, 364.)

Consequently, immigrant mothers with limited language proficiency of the receiving country's language underutilized healthcare and community services available to them (e.g. prenatal classes). Primarily because of the language barrier and their inability or difficulty in understanding healthcare information (Higginbottom et al. 2016, 6-7).

For mothers with higher language proficiency skills and who had lived in the receiving country for a longer period of time, the language barrier was reduced. Nonetheless, communication barriers with HCPs persisted due to participants' limited knowledge of healthcare related terminology, and the HCPs use of medical

jargon. (Higginbottom et al. 2016, 5-9; Seo et al. 2014, 310.) For that reason, their questions remained basic, solely for the reason that they were unable to go in-depth the way they would have been able to if the HCP spoke their mother tongue (Lee, Landy, Wahoush, Khanlou, Liu & Li 2014). Immigrant mothers were also confronted with HCPs who insisted on speaking the national language, rather than speaking in the common language they shared with the women (Wikberg et al. 2012).

### **Lack of Communication and Information**

Immigrant mothers expressed that they did not receive adequate information regarding their healthcare (e.g. labour procedures and pain management) and they were not offered helpful information regarding additional benefits, healthcare and community services that were available to them. Often the mothers did not understand the information and nursing care they received, and they had to ask the HCPs for the information because it was not given to them in advance. HCPs did not take the time to thoroughly explain practices such as informed consent, and this led to misunderstandings and feelings of pressure to agree to procedures and treatment that mothers did not understand. (Higginbottom et al. 2016, 9; Lee et al. 2014, 5; Reitmanova & Gustafson 2007, 104-106, Seo et al. 2014, 310-312, Wojnar 2015, 364.) Additionally, they felt that healthcare related information was more accessible to the mothers who were nationals of the receiving country (Wikberg et al. 2013, 644).

When the information they received from the HCPs did not address their questions and concerns, the immigrant mothers were dependent on their family, friends, community, playgroups, internet etc. to seek and access additional information and support resources. (Lee et al. 2014, 5; Seo et al. 2014, 312-314; Reitmanova & Gustafson 2007, 104; Shafiei et al. 2011, 201).

### **Lack of Interpreters and Preference for Linguistically Competent Healthcare Providers**

Although mothers had interpretation (e.g. telephone translation service or a family member or friend), others expressed their concern over not having someone interpret for them and felt that the services were underutilized or unavailable to

them throughout the duration of their entire pregnancy and childbirth experience (Higginbottom et al. 2016, 5-7; Seo et al. 2014, 309; Shafiei et al. 2011, 201). Immigrant mothers, lack of interpretation services resulted in not receiving follow-up care after answering incorrectly to a misunderstood question, emotional distress during the labor and delivery, and misinformed consent for a serious surgical procedure (Higginbottom et al. 2016, 9; Seo et al. 2014, 309; Shafiei et al. 2011, 201). Despite the HCPs effort to display nonverbal communication, when the immigrant mothers had no common language with their HCP and an interpreter was not arranged, they felt removed from the relationship and there was a lack in receiving and exchanging crucial information, which is an integral part of care (Wikberg et al. 2012, 642). Additionally, lack of interpretation services effected the immigrant mothers' motivation to participate in prenatal classes, and lead to early withdrawal. On the other hand, immigrant mothers who received interpretation were able to appreciate what was being taught to them, and considered the classes very beneficial. (Higginbottom et al. 2016, 6-7; Lee et al. 2014, 5.)

Having an available interpreter at all times proved to be a challenge, which is why mothers opted to be cared for by a HCP who spoke their language and to attend private prenatal classes taught in their mother tongue. However, HCPs were not always accepting new clients and were available primarily for immigrant mothers living in major cities. If a HCP was available, they often had limited space and time for clients, therefore those who found a suitable HCP were subject to long waiting times, short prenatal visits, and were unable to build a good relationship with their HCP. (Lee et al. 2014, 4; Seo et al. 2014, 311.)

## 6.2 Culture and Religion

### **Male Healthcare Providers**

Immigrant mothers, specifically those who followed the Muslim faith, believed it was unacceptable to be cared for by a male HCP (especially physically examined). (Higginbottom et al. 2016, 8; Reitmanova & Gustafson 2007, 105; Seo et al. 2014, 311; Shafiei et al. 2011, 201-202; Wikberg et al. 2012, 644) That being said, the mothers agreed that although it would make them feel 'bad' and 'uncomfortable', they would make an exception if no other options were available to them or in an

emergency situation. Others would not make that exception. This cultural and religious barrier was so strong, that it prevented them from using the maternity healthcare services that were available to them. (Higginbottom et al. 2016, 8; Reitmanova & Gustafson 2007, 105; Wikberg et al. 2012, 644.) There were both negative and positive reports regarding this issue. Immigrant mothers reported instances where male HCPs entered their room without any notice or they were cared for by a male HCP. The women involved felt disrespected and such instances were very upsetting, bringing up feelings of vulnerability and shame. (Reitmanova & Gustafson, 2007, 106; Shafiei et al. 2011, 201.) On the other hand, other mothers reported that requests for preferred female HCPs were respected and sufficiently arranged. One Muslim mother expressed that although she had to undergo longer wait times for her regular checkups, a female HCP was always arranged. In addition, a female interpreter whose services were used during the labor and delivery process was also arranged. (Shafiei et al. 2011, 202; Wikberg et al. 2012, 644.)

Additionally, male participation in the pregnancy and childbirth processes did not only apply to HCPs, but in some cases husbands as well. Although some women felt comfortable with their husband's presence, others were troubled by the idea of a man's involvement. One immigrant mother explained that her husband attended her labor and delivery process (although she would have wished against it) because his English language proficiency was better than hers. (Wojnar 2015, 365.)

### **Dietary Requirements**

"For many immigrant women, Western diets and patterns of food consumption differ considerably from those in their country of origin" (Higginbottom et al. 2016, 11). Immigrant mothers expressed dissatisfaction with the food provided to them. A minority of the immigrant mothers' food preferences or dietary restrictions were addressed upon admission to the hospital, and mothers expressed their concerns regarding food not being prepared according to their dietary restrictions. As a result, some mothers had food brought to them by their friends and relatives in the case that there was not enough for them to eat or that they were unassured whether or not the food provided by the healthcare facility contained something that did not meet their dietary restrictions. (Lee et al. 2014, 5; Reitmanova & Gustafson 2007,

106; Shafiei et al. 2012, 201, Wikberg et al. 2012, 642.) On the other hand, other immigrant mothers felt that the portion size and taste of the meals met their standards. Mothers were pleased when HCPs recognized their dietary restrictions or traditions and ordered the women proper meals. (Lee et al 2014, 6; Reitmanova & Gustafson 2007, 106; Wikberg et al. 2012, 642).

### **Cultural Sensitivity, Awareness, Knowledge, or lack of**

Although immigrant mothers were willing to share about their cultural and traditional practices, and expectations, HCPs did not inquire about the mothers' cultural or spiritual needs. Mothers expressed that they preferred to be cared for by HCPs who had background knowledge of their cultural customs or religious beliefs, specifically those related to maternity care. (Lee et al. 2014, 4; Reitmanova & Gustafson 2007, 107; Wikberg et al. 2014, 642) However, other mothers did not expect that the HCPs should have knowledge on their culture or language (Wikberg et al. 2012, 642).

Immigrant mothers "reported some extent of discrimination and stereotyping based on one's phenotype, color, origin, age, and body size." They felt they weren't being looked upon differently and treated based on stereotypes specific to their ethnicity or cultural customs. (Higginbottom et al. 2016, 10). One immigrant mother felt insulted at the prenatal clinic when an HCP who was mentoring a student remarked that "these (nationality) women do not endure pain as well as (nationality) women" – taking this single woman's expression of pain, and turning it into a stereotype of an ethnic group (Wikberg et al. 2012; 643). The immigrant mothers from the study conducted in Newfoundland, Canada, felt that the HCPs were unaware of their maternity needs as Muslim women. When the mothers expressed that their cultural customs and religious practices need to be taken into consideration, the HCPs appeared to be irritated, and did or said insensitive things. For instance, one HCP wrongly assumed that a Muslim woman was concealing her body because she felt ashamed of her physical appearance. Others were given "remarks that were insulting, insensitive, based on stereotypes, and left them feeling embarrassed". (Reitmanova & Gustafson 2007, 106-107.) Southeast Asian women all throughout the studies complained that the HCPs were culturally insensitive to a common tradition

where mothers should avoid ingesting anything cold post-delivery (e.g. cold beverages), and may not apply anything cold to their body (e.g. icepack, cold shower etc.) and should keep their bodies warm in order to avoid negative health outcomes after childbirth (Lee et al. 2014, 5-6; Higginbottom et al. 2016, 11; Seo et al. 2014, 312; Wikberg et al. 2012, 642).

On the other hand, other immigrant mothers were satisfied with the equal care services that were provided to them, and did not feel that they were being subject to any form of intolerance or discrimination. Mothers acknowledged that HCPs made the extra effort to show an interest in their cultural background and customs. The immigrant mothers shared that they had positive experiences with HCPs who were aware and well-informed on specific cultural and religious practices, were eager and willing to learn from the mothers' customs and traditions, and who individually sought information. (Wikberg et al. 2012, 642-644; Wojnar 2015 366-367.)

### **God Has Control**

A study on Somali immigrant women conducted in the United States, revealed that the mothers' perceptions of pregnancy and childbirth leaned more towards religious beliefs; having faith in God or Allah and trusting His will for the baby, rather than placing their trust and belief into science. According to the authors of the study, the participants' comments revealed "distrust and doubt" regarding the American health care system and its methods of medical treatment and intervention. (Hill et al. 2012, 75-76).

### **Pregnancy, a Natural Part of Womanhood**

Results reflected that there were differences on the outlook of pregnancy. Immigrant women explained that pregnancy is a normal stage in life for women, not an illness, and that it was made out to be a big medical event in their receiving country. This contrasted with their view that pregnancy is essential and natural part of life for women. Therefore, their bodies can handle it and that they would just continue on with life. However, if they got sick then they would visit the hospital for that period of time. Since, it is a natural stage in life it does not require special medical treatment

like scheduling routine tests during pregnancy or making adjustments to one's diet. (Higgbottom et al. 2016, 7-8; Hill et al. 2012, 75; Wojnar 2015, 363.)

### **Freedom of Expression**

Immigrant mothers began to change their behaviors and thinking patterns. They felt a sense of freedom and openness to express themselves in their new country. They had come from countries where there were restrictions on women's rights and now did not feel those pressures. (Wikberg et al. 2012, 638.)

## **6.3 Isolation**

Immigrant mothers were missing the support they would receive from their extended family if they were in their homeland during the different stages: pregnancy, birth and postnatal care. Often, immigrant mothers who were far from their family support system felt anxiety and felt more vulnerable during childbirth. They were quite new to their receiving country, and felt isolated because they knew little about their new society, had no vocational education, were unemployed and had little knowledge of the local native language and few interpersonal connections. (Seo et al. 2014, 311; Wikberg et al. 2012, 64; Lee et al. 2014.) This lack of support influenced the delay of seeking maternity care or reflected on the irregularity of attending maternity care appointments (Wikberg et al. 2012, 7). However, other immigrant mothers hoped to get adequate support from their health care providers though visits with the doctor. These appointments were too short to develop a relationship and were even more challenging with the language barriers. (Seo et al. 2014, 311.)

## **6.4 Healthcare Services and Interventions**

### **Prenatal Classes and Checkups**

Immigrant mothers who had previous births outside of a western nation where these prenatal services and checkups were not the norm did not see the need for such classes and checkups. Usually, women from these backgrounds only visited a health care facility if there were complications in their pregnancy. Prenatal care which also included preventive care was not even a health services option in their native country and therefore they were unfamiliar with such practices. Women who



previously had successfully given birth outside of their receiving country could not understand the importance of prenatal services. (Hill et al. 2012, 75.) This contrasted with Korean immigrants' experiences, they felt they were receiving less care than they would in their own country. They felt that they had less ultrasounds, delay in their initial prenatal appointments and that these visits were too short. (Seo et al. 2014, 310.) The results also concluded that immigrant mothers did not take advantage of maternity care services because it seems like more of a burden than a benefit. There was no alternative care offered to mothers who already had children. Information was not always given on prenatal classes and the purpose of these classes was not clarified. (Reitmanova & Gustafson, 2007, 104.) The results revealed that immigrant mothers were unable to attend prenatal classes because of religious/cultural reasoning and that these classes did not respect the women's religious beliefs. In these classes there was both females and males in the same learning environment which was forbidden. (Reitmanova & Gustafson 2007, 104; Wojner, 2015, 363.)

On the other hand, immigrant mothers enjoyed and saw the benefits of preparation classes and prenatal checkups because they helped relax the mothers, provided a sense of reassurance of the progression of their pregnancy, offered information to the mothers and provided practical advice. (Hill et al. 2012, 75; Lee et al. 2014, 5; Wikberg et al. 2012, 643.)

### **Wait Time in the Waiting Room**

Frustration was expressed that they themselves were expected to be punctual even though they would have to wait upon their health care provider. This was found to be disrespectful. However, if the healthcare provider was apologetic this would help to re-establish mutual respect. (Hill et al. 2012, 78.) The organizational aspect of a health care setting contributed to the positive or negative feelings of immigrant mothers' experiences, for example long wait times for antenatal appointment (Shafiei et al. 2011, 201).

### **Accessibility to Maternity Services**

Transportation to maternity health care services presented a challenge to immigrant mothers especially, during the winter season and when the distance was lengthy (Higginbottom et al. 2016, 7; Lee et al. 2014, 5). However, when the weather condition was good, transportation was not such a burden (Lee et al. 2014, 5). Maternity services were not always in the same building and it required the mothers to travel to different places for procedures and appointments. These mothers preferred how in their own country these maternity services were within the same facility. (Hill et al. 2012, 78.)

### **Importance of Choices in Regards to C-section and Natural Birth**

The Somali immigrants believed a caesarean section (C-section) put the mother's health at risk and weakened future possibilities of fertility. Somali immigrant mothers emphasized the importance of a vaginal birth because then the mother would not be limited to a certain number of pregnancies and this way she would avoid possible complication due to surgery. (Hill et al. 2012, 76; Wojnar 2015, 363.) There was a concern raised that choosing to have an epidural would heighten a mother's chance of having a C-section (Higginbottom et al. 2016, 9). Immigrant mothers were pleased when certain medical interventions were avoided or carefully considered. For instance, caesarean section was not the first option for an expecting mother and was only implemented if something went wrong. An immigrant mother expressed how she was happy she was given choices. In her case her baby was breech and instead of having a C-section they were able to turn the baby. (Shafiei et al. 2011, 201; Wikberg et al. 2012, 643.)

### **Lack of Attention and Emotional Support**

The expectation for emotional support for immigrant mothers was not met and the lack of attention in their care made them feel unsatisfied. Physicians were quite busy and did not take the time to talk and address their patient's concerns. Immigrant mothers longed for more emotional support during the different stages of maternity care. (Higginbottom et al. 2016, 9; Reitmanova & Gustafson, 2007, 104, 105; Shafiei et al. 2012, 201.) Immigrant mothers shared that they were disappointed with their physician because they hoped that they would have the opportunity to develop a

relationship with them. However, appointments proved to be too short to develop any personal connection. (Seo et al. 2014, 311.)

### **Finances and Financial Restrictions**

Proper healthcare services were hindered for immigrant mothers who did not have comprehensive health insurance due to the fact that certain medications and services were not covered by universal health insurance (Higginbottom et al. 2016, 8). In addition, immigrant mothers without a comprehensive health insurance plan had limited options regarding choosing a physician and hospital (Seo et al. 2014, 311). These mothers found it hard to find information on eligibility and how to apply for financial support was difficult to access (Reitmanova & Gustafson 2007, 105; Seo et al. 2014, 311).

### **Female and Male Circumcision**

Female circumcision done in childhood was an important and common cultural and religious practice for Somali immigrant mothers. Sorrow was expressed and the pain they suffered from the female circumcision procedure that was done when they were a child in their native country. These women conveyed feelings of shame and fear of being mocked by HCPs because of their physical differences. They similarly expressed fear of having a HCP who would not have the skill set to perform episiotomy (Wojnar 2015, 364). Immigrant Somali mothers believed that female circumcision was beneficial by preventing tearing and helping to ease delivery because it loosened the vaginal opening that was lacking in elasticity (Hill et al. 2012, 76-77). The research paper on Muslim immigrant mothers in Canada found that immigrant mothers did not receive information on male circumcision which is an obligation in the Islamic faith. HCP during their post-delivery stage did not know information on this procedure even though this a procedure offered in Canada. (Reitmanova & Gustafson 2007, 106)

### **Postpartum Depression and Mental Health**

Immigrant mothers' cultural view was that mental health is a hidden issue. Emotional struggles are to be hidden or denied to avoid permanently being labeled crazy which would thus cause them to be rejected by their community. (Hill et al. 2012, 77) On

the contrary, other immigrant mothers mentioned that they would have appreciated in the pregnancy phase to receive more information regarding mental health changes (Reitmanova & Gustafson 2007, 104). Nevertheless, other immigrant mothers recognized the concept of postpartum depression but attributed it to stress. Fear associated with taking psychotropic medication was presented that there was a belief that this medication causes people to become crazier. (Hill et al. 2012, 77) The result found that immigrant mothers who experienced symptoms of depression did not seek out medical assistance or treatment (Seo et al. 2014, 311).

### **Consistency with Healthcare Providers**

There was an emphasis on the importance of having consistency with HCP for immigrant mothers. The immigrant mothers felt that when the HCP was familiar with them and their previous history it allowed them to trust that the HCP would implement what they had agreed upon. Having the same HCP for the duration of a mother's care allowed for a closer relationship. (Wikberg et al. 2012, 644) The results also presented a feeling of frustration stemming from having to repeat their history to HCPs. The immigrant mothers found this to be very time consuming. (Hill et al. 2012, 78; Lee et al. 2014) However, other immigrant mothers did not mind having an unfamiliar HCP as long as they received the care they required (Hill et al. 2012, 78).

### **Pain and Pain Management**

Immigrant mothers felt misunderstood if they expressed their pain loudly and felt that they were categorized as being highly sensitive to pain. On the other hand, Asian immigrant mothers who did not verbalize their pain ended up going unnoticed and their pain went untreated. (Wikberg et al 2012, 643) The immigrant mothers shared their appreciation that HCPs regularly checked their pain level and gave medication accordingly (Shafiei et al. 2012, 201). Immigrant mothers discussed that few of them received information during the labor and delivery stage on pain management. HCP had assumed that they were given information during prenatal class or by their physician which was not the case, leaving these women feeling unprepared for delivery. (Reitmanova & Gustafson 2007, 105)

### **Breastfeeding**

Immigrant mothers were pleased with the support and advice they received from HCPs on breastfeeding (Shafiei et al. 2012, 201; Wikberg et al. 2012, 644). Although there was one mention of an immigrant mother using the internet to receive teaching on practical techniques for breastfeeding (Lee et al. 2014, 5). Somali immigrant mothers learnt how to breastfeed not only from their HCPs but also from their family members. Often these women would begin giving supplements early on to the baby because they believed the baby grows better with the combination of supplements and breast milk. (Hill et al. 2012, 77)

### **A Difference in Standards in their Receiving Country**

Immigrant women valued their experience in maternity care in their new country in comparison to their homeland where there was a lack of facilities and resources. They appreciated that doctors and nurses were there to support them. (Shafiei et al. 2012, 202) Immigrant mothers saw the importance in technological resources especially mothers who experienced high risk or complication with their pregnancy (Hill et al. 2012, 75-76; Shafiei et al. 2012, 202). Also, private consultation pleased the mothers because often in their native country prenatal examination were done in the examining rooms where other patients were waiting for their turn. Furthermore, they noticed and appreciated that examining rooms in their receiving country were much cleaner. (Lee et al. 2014, 5.)

### **Referral System**

Immigrant women in Canada had to go through a referrals system to book an appointment with the gynecologist or obstetrician which they found difficult to navigate. (Higginbottom et al. 2016, 8; Lee et al. 2014, 4). In order, to get this referral they first needed a family physician which was challenging to find a physician taking on new patients. Due to a shortage in gynecologists and obstetricians, immigrant mothers received their first appointment well into their pregnancy. (Higginbottom et al. 2016, 8.) As result of this referral system, mothers were unable to choose their obstetrician. However, they overcome this barrier by researching obstetricians and calling to see if they were accepting new patients. They would then

make a request to their family physician to make a referral to that obstetrician. (Lee et al. 2014, 4.)

## **7 Discussion**

### **7.1 Discussion of Key Findings and Implication of Results for the Finnish Healthcare Services**

Content analysis methodology was used to collect data to answer the research question presented in our literature review (what are the experiences of immigrant mothers with the maternity care services they are provided with?). Since this study was qualitative in nature, the results do not indicate how many mothers shared the same experience. After reviewing the results, it is clearly evident that the immigrant mothers in the studies had different perceptions of what maternity care should look like and different outlooks on the phases of pregnancy, labor and delivery. Usually, their perceptions and outlooks were influenced by their cultural and religious backgrounds. Some of the research papers used in this literature review aims were not only to present the experiences of immigrant mothers in maternity care but also to identify challenges, obstacles, disadvantages, and barriers they faced. (Gustafson, Reitmanova 2007; Higginbottom et al. 2016; Lee et al. 2014) This may have influenced the results by giving a more negative outlook since, some of the research papers intended to find issues before even conducting their research. The literature analyzed considers four key themes: communication, culture and religion, isolation and health care services, and interventions.

Interaction with the HCP was extremely important in determining the satisfaction level for the participants in the research studies. However, the results reflected issues in the communication channels between HCPs and immigrant mothers. Common factors that hindered their communication were lack of communication, inadequate information and shortage of interpreters. Also some immigrant mothers who had higher language proficiency skills still felt that they were unable to clearly articulate or understand due to limited health care terminology. HCPs should try to refrain from using medical terminology, or if they do they should offer an

explanation of the terminology. Having a good level of communication plays an essential role on how the patient interprets the quality of care received.

According to additional research on communication conducted by Lehna (2005), a foundation of trust is established between the patient and their HCP during their initial interaction. Interactive communication encompasses trust and strong communication. Many immigrant mothers had poor language skills which is a fundamental aspect of communication. Language is considered a cornerstone of communication. When a patient and a HCP do not share the same first language, there is instantly a recognizable communication barrier which directly impacts clinical situations, course of treatment and choices available. Patients who do not share the same first language with their HCP tend to be less able to recall information and have less rapport with their HCP. Poor communication is frequently associated with a patient's limited understanding of their health condition and the treatment plan, and likely to have an unfavourable effect on the health status of a patient. Interpreters are commonly used to address communication barriers. Professional interpreters are crucial in supporting communication between the patient and HCP and assist in diminishing language challenges. (Lehna 2005, 292; McCarthy, Cassidy, Graham & Tuohy 2013, 335) Many of the participants did not always fully understand the HCP, which affected their understanding of their health status and course of treatment. Also, it made it difficult for the participants to establish a relationship with their HCP.

Our results found that there was a demand for more professional interpreters or even sometimes these services were underutilized. Sometimes a family member or a friend would stand in as an interpreter which raised other issues, like confidentiality, accuracy and cultural competency. This can damage the level of trust and the development of a relationship between the patient and health care provider. (Lehna 2005, 292) Lack of information was a common issue highlighted throughout the research literature. According to a previous study conducted by Goldberg (2009), patients have stated that they are receiving limited information regarding health interventions and alternative options, leaving patients feeling less involved in their health care decisions than they would prefer. HCPs have acknowledged that they often underestimate the patients desire to be involved in decision making, so they do

not take that into account when presenting information to their patients. In order to provide ethnically appropriate care, accessibility and availability to evidence based resources and information is a must. (33-34) Several immigrant mothers in the research papers felt that they were getting limited information due to language barriers or little amount of time they had with their HCP.

Finnish HCP should give information and discuss all treatment choices with their patients. Finnish HCPs should listen to immigrant women with openness, and trust them when they speak about their health related concerns and experiences. Additionally, they should ask the mothers about their cultural customs, religious beliefs, and the role their culture and religion play in maternity care. To meet this goal, the availability of interpreters needs to be improved.

It is essential that expecting mothers are informed about the Finnish maternity health care system. HCPs need to guide the mothers through regular checkups, procedures, and the options and resources that are available to them in Finland. Making sure that immigrant mothers are as well informed about their rights as a Finnish mother. Additionally, it would be beneficial if resources relating to maternity care (e.g. websites, brochures etc.) could be available in languages other than Finnish, Swedish and English.

Culture and religion was a popular recurring theme throughout the different literature research used in this review. Culture and religion sensitivity play a vital role in the satisfaction of the immigrant mother's perception of care. Our results reflected several challenges that occurred due to cultural and religious aspects, as well as different outlooks based upon culture and religion.

HCPs need to be continuously evolving as a result of a changing and adapting environment. The health care system has progressed substantially due to changes in social norms, expectations, advancements in technology and new pharmaceutical discoveries. Another area of development in the healthcare profession is to meet patients' demands for cultural competent care. (Flowers 2004, 48) The research findings indicate that there is a lot of room for improvement in cultural competent care. Immigrant patients from different cultural and religious backgrounds bring



different social norms, traditions, principles, attitudes, concepts of health and diseases, as well as ideas of medical interventions. These factors impact immigrant mothers' perception of maternity care services. It is fundamental that cultural competent care remains to achieve a high quality of care. One example of different views of maternity care with regards to cultural and religious beliefs is that for Muslim woman having a male HCP was forbidden unless of emergency situation.

A model for cultural competent care could be implemented into the Finnish nursing practice in order to improve care for immigrant mothers. Strategies to prevent racism, stereotyping, and discrimination should be developed and implemented within the Finnish healthcare system. Often culturally competent care has been criticized because it could permit individuals to be stereotyped. (Williamson & Harrison 2009, 762) Therefore, it is important to recognize that culture is comprised but is not restricted by age, gender, sexual orientation, occupation, social class, ethnicity, individual's migrant experiences, religious and spiritual beliefs and disability (Williamson & Harrison 2009, 766). HCPs could be educated on basic cultural and religious differences between Finnish people and the immigrant minority groups who are currently residing in Finland but also look at the patient as an individual. Finnish HCPs working in maternity clinics, as well as other health care settings, need to be open to the wishes and needs of immigrant mothers. It should be considered that the 'Finnish way' of maternity care may not be culturally appropriate and applicable to all mothers. Additionally, the findings demonstrated the importance of employing nurses with relevant experience and education on intercultural care as educators in the work place (e.g. organizing workshops on intercultural care for fellow nurses). Moreover, employing immigrants who have since become long-term Finnish residents in healthcare settings as educational assistants, consultants, and interpreters, could also be taken into consideration. This may help further the development of educational materials and educational lessons for Finnish HCPs.

Isolation appeared within the research literature as causing dissatisfaction amongst immigrant mothers' view of their maternity care. Isolation stems from a lack of a sense of belonging, few social contacts, scarce social interactions and relationships. One definition of social isolation is an absence of individual relationships whether it

be with family, friends or on a broader perspective within society. (Alspach 2013, 9) Many of the participants in the data analyzed for the literature review experienced social isolation. Several participants were in a new country with few social contacts and the majority of their family and friends were living abroad. Many hoped that they could establish individual connections they desired with their health care provider, however that was not always the case.

In order to prevent isolation, the Finnish health care system can try implementing peer support groups for immigrant mothers and native Finnish mothers. This way immigrant mothers would meet others who are in the same stage of life as them.

The last theme reviewed in the literature was services and interventions. The results show that there was a difference of opinion with many of the participants and their receiving country on what maternity care should be or if it was even needed. For many of the immigrants, appointments for maternity services seemed useless because it was never practiced in their own native country. For several of the immigrant women it was common practice that child birth took place at home. Whereas, other women longed for emotional support from their healthcare provider and felt frustration from the lack of attention they would receive from their health care provider. Various immigrant women were against opting for medical intervention such as C-sections. For instance, one study stated that participants emphasized the importance of vaginal birth over C-section, due to the risks, complications and fear that it would limit the amount of children they would have in the future. Understandably, since this type of surgery is not often medically necessary and may put the mother or baby at short-term or long-term health at risk (Witt, Wisk, Cheng, Mandell, Chatterjee, Wakeel, Godecker & Zarak 2014, 84). Since, the health care system can look quite different internationally, it is not surprising that there would be challenges and differences of opinion with immigrant mothers trying to navigate in a new health care system.

If implemented to the Finnish maternity healthcare services, mothers who would like to participate in additional educational classes should be able to. These should either be available in a language other than Finnish, or interpreters should be available to those mothers who do not speak Finnish yet.

## 7.2 Ethical Considerations, Validity and Reliability

Presenting research is not enough. It is important that enough information is given to express the validity of the research and provide proof that a rigorous scientific manner was taken to produce the research. It is important to keep in mind when analyzing the validity of the research that the research is only as good as its scientific method. One piece of research is only a small portion of a topic and should be seen in combination with other research on the same topic. (Aveyard 2007, 44-45)

In order to avoid fabrication, falsification and plagiarism, we applied 'Ethical Principles for JAMK University of Applied Sciences' to our work (Ethical Principles for JAMK University of Applied Sciences 2013, 6). Because the literature review is based on already conducted researches, the ethical principles of researches were acquired already in the researches reviewed. Ethical considerations were taken into account in the literature used to conduct this research. Additionally, the work of other researchers was taken into account and the thoughts of the original authors are clearly presented in the research.

The research process was recorded in a conscientious manner, in order that the same results could be acquired by a different researcher (Gerrish & Lacey 2010, 24-25; Liambutong 2013, 16). Two databases were searched in order obtain all relevant data within the inclusion criteria, increasing the reliability of this research. However, although the data collection approach was done in a rigorous manner, this was the first research conducted by the two novice researchers. This may have affected the results and the reliability of the study.

## 7.3 Risk of Bias

A literature review may be biased and illustrate results that the writer wants to convey. Some literature review writers may carefully select the research they are using to emphasize the outcomes they already had ahead of time. Often this type of review can be called a critical review and does not follow a scientific approach in gathering data. Nonetheless, they are still considered important research providing an argument, sources of ideas, context and research. Literature review writers may be impacted by their own preconceived theories, needs and beliefs. These types of

literature reviews do not necessarily indicate the criteria in which research is compiled and therefore the result given may not be trustworthy. (Bettany-Saltikov 2012, 8-9.)

Biases are common in literature reviews, and may influence the validity of a research. The following types of biases relevant to our review included: selection bias, language bias, availability bias, and cost bias. In order to minimize bias and enhance the validity and reliability, the risk of each bias was thoroughly evaluated. The selection bias was avoided by determining both the inclusion and exclusion criteria before the initial data search was conducted. Additionally, two reviewers worked on the review in order to reduce the risk of bias. All of the studies used to conduct the research were in English, therefore the data search was limited to one language. As not all potentially relevant studies are translated into English, it is likely that relevant data on the subject was excluded from the final results. Lastly, all of the studies used to conduct the research were available for use free of charge, therefore greatly increasing the cost bias.

#### 7.4 Limitation of the Study

Our research findings were limited to free, full text literature which was available in English. During the literature search, abstracts were read that appeared to be fitting to our topic criteria, however, full free text was unavailable. Since these articles did not meet our inclusion criteria, they had to be excluded. Furthermore, if research from other languages were included in the literature review it would present a much broader perspective.

The majority of the selected studies focused on a specific ethnic background or immigrant group: two studies focused on experiences of Asian immigrants, two studies focused on Somali immigrants, one study focused specifically on immigrant Muslim women, one study focused on Afghan immigrants, and two studies were not devoted to a singular immigrant group or culture. Six out of eight studies made reference to the Muslim faith. Therefore, our research is predominantly influenced by the Muslim cultural and religious perspectives. Three studies were conducted in Canada and three in the United States of America, therefore the majority of our results are centered on the experiences of immigrant mothers within the North

American maternity healthcare system. Our research findings could have differed if we were able to find data which represented the experiences of Western Immigrants living in a non-Western society. Additionally, the scale of the participants included in the studies was relatively small. The research study participant scale ranged from 6 individuals to 40 individuals.

A select few of the studies opted to use an interpreter or the immigrant mothers' language of preference, however some of the studies were conducted in the language of the receiving country. This eliminated candidates who did not have the language proficiency to be interviewed, therefore valuable information may have been lost.

Since every woman is an individual, we are unable to evaluate each mother's level of integration within the receiving country. Moreover, the period of time the mother has lived in the receiving country varied throughout the studies. Therefore, these factors influence a mother's perception of the maternity healthcare system. Every research article presents its own biases and limitations.

## 7.5 Conclusion and Recommendations for Further Studies

Our research finding identified many challenges, barriers, positive experiences and negative experiences for immigrant mothers in maternity care. We shared our recommendations that could be implemented into the Finnish maternity health care system. However, further research could be conducted to also understand the experiences of the HCP who have worked with immigrant mothers in maternity care. This would not only reflect the experiences of the HCP but perhaps also give insight into areas of care that work well and other areas of care that could use improvement. The perspective of care would most likely be different from the HCP point of view. In order, to properly assess and make improvements in the quality of care it is necessary to obtain both the patient's and the HCP's perspective. Since, our results presented several challenges due to cultural differences further research could be carry out to examine the level of education HCP received regarding cultural competence care. HCP should also take the initiative to learn more about cultural competent care for their own professional growth.

## 8 Resources

Alspach, J., 2013 Loneliness and Social Isolation Risk factors long overdue for Surveillance: *Critical Care Nurse*, 33, 8-13

Aveyard, H., 2007, *Doing a Literature Review in Health and Social Care: A Practical Guide*, McGraw Hill House Open University Press, Berkshire, England

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