
**MATERNITY AND CHILD WELFARE CLINICS IN
HÄMEENLINNA**

Support material for English-speaking clients



Ammattikorkeakoulun opinnäytetyö

Hoitotyön koulutusohjelma

Hämeenlinna

Kevät 2013

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Lahdensivu
Degree programme in nursing
Public health

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Year 2013**Subject of Bachelor's thesis**

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Hämeenlinna – Support Material for
English-Speaking Clients

ABSTRACT

The purpose of this thesis was to provide English support material for the maternity and child welfare clinics in Hämeenlinna area which are frequented by English-speaking customers. The idea came from a maternity and child welfare clinic in Hämeenlinna, where the public health nurses stated that they were in need for an English material. The aim was to produce a folder for English-speaking customers. The folder would serve as a tool to help the interaction between the public health nurses and the families and thus it would improve the situations of multicultural interaction.

The thesis focuses especially on the field of culture and the Finnish maternity and child welfare clinic services, its functions and contents, and also reviews the history of public health care and described the organisation of the maternity and child welfare clinics in Hämeenlinna area. The theoretical base for this thesis has been collected mainly from Finnish literature and Internet sources. In addition, information was sought from the action plan of Hämeenlinna's children's and young people's services and development of early support services for the year 2013. Ideas for the folder's content also came from a local public health nurse working in a maternity and child welfare clinic.

When compiling the folder, practicality was taken into account. Since this type of folder was first of its kind in Hämeenlinna, a wide variety of topics were covered but not so much in depth. Many of the things mentioned in the support material could be discussed more thoroughly. In future, it is therefore possible to make more detailed, support materials in English.

For the thesis' development project, the folder was presented as a Power-Point presentation at a public health nurses' meeting in Hämeenlinna.

Keywords Culture, multicultural, public health nursing, maternity clinic, child welfare clinic.

Pages 38 p. + appendix 36 p.

Lahdensivu
Hoitotyön koulutusohjelma
Terveystenhoitajan suuntautumisvaihtoehto

Tekijät	Ina Oras Maria Raunio	Vuosi 2013
Työn nimi	Äitiys- ja lastenneuvolat Hämeenlinnassa – tukimateriaalia englantia puhuville asiakkaille	

TIIVISTELMÄ

Tämän opinnäytetyön tarkoitus oli tuottaa englanninkielistä tukimateriaalia Hämeenlinnan alueen äitiys- ja lastenneuvoloille, joissa käy englantia puhuvia asiakkaita. Idea tuli hämeenlinnalaisesta neuvolasta, joka ilmoitti, että heillä olisi tarvetta englanninkieliselle materiaalille. Työn tavoitteena oli tuottaa englantia puhuville asiakkaille kansion, joka toimisi apuvälineenä terveydenhoitajien ja perheiden välisessä kanssakäymisessä ja siten kehittää eri kulttuurien välisiä vuorovaikutustilanteita.

Opinnäytetyössä on keskitytty erityisesti kulttuuriin sekä Suomen neuvolapalveluiden järjestämiseen ja siihen liittyviin toimintoihin ja sisältöihin, tarkasteltu terveydenhoitotyön historiaa ja kuvattu Hämeenlinnan neuvolapalveluiden järjestäminen. Teoriapohja on kerätty opinnäytetyötä varten lähinnä suomenkielisestä kirjallisuudesta sekä Internet-lähteistä. Lisäksi tietoa haettiin Hämeenlinnan kaupungin lasten ja nuorten kasvua tukevien palveluiden sekä varhaisen tuen palveluiden toimintasuunnitelmasta vuodelle 2013. Ideoita kansion sisältöön tuli myös hämeenlinnalaisesta neuvolaterveydenhoitajalta.

Kansion kokoamisessa otettiin huomioon sen käytännölläisyys. Koska työ oli Hämeenlinnassa laadultaan ensimmäinen, asioita pyrittiin käsittelemään laajasti, mutta ei niinkään syvällisesti. Monia työssä käsiteltyjä aiheita olisi voinut käydä läpi perusteellisemmin. Aiheesta onkin jatkossa mahdollista tehdä yksityiskohtaisempia, englanninkielisiä tukimateriaaleja.

Kehittämistehtävänä kansion esitettiin PowerPoint-esityksen avulla terveydenhoitajien kokouksessa Hämeenlinnassa keväällä 2013.

Avainsanat Kulttuuri, monikulttuurisuus, terveydenhoitotyö, äitiysneuvola, lastenneuvola

Sivut 38 s. + liite 36 s.

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1 INTRODUCTION

At the end of year 2010 there were approximately 168 000 foreign citizens living in Finland. It is evaluated that the number of foreign people living in Finland might rise to around 288 000 in 2020. Most of foreign citizens living in Finland come from Russia, Estonia, Sweden and Somalia. (Asikainen & Siikamäki 2012.)

The Finnish law states in the act on the status and right of patients (1992/785) that a patient has the right to receive information on their state of health in a language they can understand. If there is no mutual language, the health care professional has to try to organise an interpreting service. The patient must be fully aware of their health, treatment and the effects.

In a couple of decades Finnish society has become multicultural. On everyday-basis public health nurses nowadays meet clients with versatile backgrounds. Language is often a barrier which both parties must try to overcome. The public health nurses in maternity and child welfare clinics in Hämeenlinna area have a large variety of guidance material in Finnish. To make using those materials with English-speaking clients simpler, the material should be in English.

The clients don't necessarily always speak Finnish or English as their mother tongue that is why this folder can also be used as tool to communicate through the interpreter. It is essential nowadays that public health nurses have skills and knowledge to face clients from different kinds of cultural background. Different models try to explain the development of cultural competence. The models also direct the implementation of multicultural nursing (Wellman 2009).

Families from different cultures are experts of their own lives but the public health nurse can strengthen their resources as a cultural interpreter. Families need information on Finnish methods; support in building social networks; emotional support in new situation in life; and guidance on how to bring up their children in Finnish circumstances. In addition, it is also important that the families have a place to go where they are heard. (Armento & Koistinen 2007, 393–397.)

2 AIMS AND PURPOSE OF THE THESIS

The purpose of this thesis was to provide support material for maternity clinics and child welfare clinics in Hämeenlinna area with English-speaking clients whose Finnish skills are poor. The thesis pursues the idea that all the clients in maternity and child welfare clinics in Hämeenlinna would have equal positions. In 2004, a Non-Discrimination Act (21/2004) was passed and obliges the authorities to pay more attention to the ethnic

minorities and immigrants' equal access to social welfare and health care services.

The basic theory can be used by public health nurses in maternity and child welfare clinics in Hämeenlinna area. In multicultural nursing situations it is important to understand the possible differences in other cultures, which is why the thesis mentions a few examples. The theory explains the history and the present situation of Finnish maternity and child welfare clinics and it is also the foundation of the support material folder, which can be found in the attachments (appendix 1). The folder contains information about the visits at maternity and child welfare clinics, vaccination program in Finland, nutrition and benefits from Finnish social insurance institution (Kela).

The idea for the thesis came for a public health nurse working at a maternity and child welfare clinic in Hämeenlinna. The support material in English is first of its kind made specifically for the maternity and child welfare clinics in Hämeenlinna area. The thesis is to be used as a tool between the public health nurses and their English-speaking clients. A development project completes the thesis of public health nursing degree. As a part of the development project of this thesis the folder was introduced in a public health nurses' weekly meeting.

3 MULTICULTURAL NURSING IN MATERNITY AND CHILD WELFARE CLINICS

Work at maternity and child welfare clinics, with clients from many countries and cultural backgrounds, is challenging and requires the employee to maintain flexibility and constantly check their attitudes and values. Multiculturalism should be taken into account when designing clinic work. (Armanto & Koistinen 2007, 397.) The Finnish Ministry of Social Affairs and Health (STM) recommends in their publication of guidelines for organizing child health care (2004:13) a small number of customers in areas with high numbers of immigrants.

At the clinics, public health nurses need more time to study the client's situation, the sensitivity to make observations, flexible approach to work and the preparedness to examine attitudes. The work, with clients from different cultural backgrounds, requires a lot of creativity from the public health nurse. Interaction is based on mutual respect and the work should be implemented in co-operation. People are different in how strongly they follow the ways of their culture or religious rules. Therefore, an individual approach to customers is emphasized. (Armanto & Koistinen 2007, 395.)

Too often, the attention is drawn to the differences in the person representing another culture. In the end, however, we humans have more similarities than differences. All parents are concerned about their children's health and success in life. The need to feel accepted and the fear of abandonment are also universal feelings. The cultural differences are in the

thinking of which issues raise strong emotions and how they are interpreted. (Armanto & Koistinen 2007, 395.)

Cultural differences affect for example in psychological tests. Misunderstandings in different situations might cause large and long-lasting conflicts. Using an interpreter can help but also be necessary to carry out an operation. Often things work out easier if people understand each other. (Etene 2005, 18.)

Immigrants should be informed of the policies of Finnish health care system. They need to know their rights to services, but also the rules, which must be complied to maintain the access to these services. But it is important to suit the rules to respond the needs of the health care service customers. Things to be taken into consideration are written and verbal instructions, booking service and interpretation. (ETENE 2005, 21.)

It is important that the immigrants are aware of the Finnish legislation and practices. For example, the immigrant families, coming to the child welfare clinics, can decide on nutrition issues and act as their own culture requires. On the other hand, all the clients must be told, for example, that in Finland female genital mutilation is a crime, and that corporal punishment of children is also prohibited. (Armanto & Koistinen 2007, 395–396.)

3.1 Culture

A person can not be separated from their cultural and social background so therefore, no health, disease or care issues can be viewed without taking the culture into consideration. Culture is partly something we do consciously and partly subconsciously. Some parts of cultures are visible to us, such as manners, language, dress style and food. Mostly culture is, however, invisible. The invisible factors are, among other things, communication styles, values, norms, attitudes, belief and understanding of right and wrong, appropriate and inappropriate. (Armanto & Koistinen 2007, 394–395.)

When discussing the cultural background, it should be noted that no culture is completely consistent. Individual differences arise from age, gender, educational background, wealth, beliefs and personal characteristics and so on. In order for us to understand why people behave, think or feel a certain way, it is necessary to understand their cultural background. People have some universal features that are found all over the world. In addition, there are collective also known as cultural characteristics, as well as individual, unique characteristics. (Armanto & Koistinen 2007, 394.)

3.2 Collectivist and individual cultures

Cultures are divided, among other things, into two categories based on their emphasis on either personal or community-oriented achievements. Most of the world's population lives in collectivist cultures where identity is, already from the early childhood, based on the person's social network. In such cultures the community's needs and goals are more than those of the individual. Honor is important to maintain and, if the individual fails to live up to the standards of the community, they bring shame to the entire group. In collectivist cultures, families work as guardians and social security for the individuals. Obeying and respecting the parents is very important. Relationships matter more than performances and duties. (Armanto & Koistinen 2007, 394.)

Individualist or "Western" cultures consider an individual to make their own decision and to be responsible for their actions and choices. The rules and standards are flexible and provide options and opportunities. A person represents themselves and can only cause embarrassment to themselves. Children have the opportunity for independence and their own choices. (Armanto & Koistinen 2007, 394.)

3.3 Concept of time

Another way to divide cultures is based on their attitude towards time. Monochronic and polychronic concepts of time determine how much time the people think is available and how the time is used. In general, the individualist cultures are monochronic and collectivist cultures polychronic. (Armanto & Koistinen 2007, 393.) However, it is important yet again to remember that the classification is indicative. Within all cultures, there are people with different attitudes towards time. Also, in many cultures, people are precise in formal situations (Turku 2007).

Monochronic, linear concept of time considers the time to have a beginning and an end. The time lived is gone and it will never return. Individual's earthly time starts at birth and ends with death so it is limited. Such concept of time is typical among religions such as Judaism, Christianity and Islam. The linear concept of time has affected the Western cultures in a way that it encourages efficient performance: Time can not be wasted and time is money. (Turku 2007.) It is common for people, with linear concept of time, to be systematic, work-oriented and punctual (Armanto & Koistinen 2007, 393).

According to polychronic, cyclical concept of time, time recurs all the time and it has no beginning or end. No moment is irreplaceable since time can not be lost. Human life on earth is repeated through reincarnations. Such concept of time is typical among religions such as Hinduism and Buddhism. (Turku 2007.) People from monochronic cultures tend to be extrovert, anthropocentric and forgive themselves and others for being late (Armanto & Koistinen 2007, 393).

The adjustment to the new society is made easier for the immigrant if the public health nurse explains them about the Finnish concept of time while appreciating that they may have their own. It is a disservice to the client, if special treatment is offered too easily and if it is suggested that the system's rules are not necessarily to be complied with. It is difficult to adapt to the culture where the rules are different in every place. (Armanto & Koistinen 2007, 395.) In addition, special treatment may create a ground for xenophobia (Vilen, Leppämäki & Ekström 2002).

3.4 Immigration

The word 'immigrant' refers to all those, who for one reason or another, have moved permanently to Finland. The reasons behind immigration are versatile. Some have arrived in Finland to study, work or for marriage. Refugees have been forced to leave their home country because of natural disaster, war or political persecution. They may have experienced violence and torture or fear of loss of health and life. Most immigrants have come to Finland from Russia, Estonia, Sweden and Somalia. The main reasons for migration have been family ties, refugees, remigration from the former Soviet Union and work-related migration. (Armanto & Koistinen 2007, 393.)

If the immigrants are entitled to labour market support and are seeking for a job or receive labour market subsidy, they are also entitled to individual integration plans for three years from the date of their approved residency permit for Finland. (Kela 2011.) The goal is for the immigrants to acquire the needed working skills and other requirements to live in the society.

3.5 Interaction at maternity and child welfare clinics

The absence of a mutual language is a distinguished feature in the work with immigrant families. In many cultures, it is inappropriate to show if the listener does not understand the speaker's message. Apart from the spoken language, the employee must also examine expressions and gestures in order to determine whether the client understands the message. (Armanto & Koistinen 2007, 396.)

When working with immigrant families, interpretation services should be utilized as much as possible. The use of family-members as interpreters must be avoided. If the immigrant family is experiencing domestic violence and the husband acts as an interpreter during the clinic visit for his wife, it is clear that the public health nurse gets a very one-sided view of the situation. Using children as interpreters may cause problems in the parent- child relationship or normal family hierarchy. In addition, the child will have to take responsibility over something for which they do not have enough capacity. (Armanto & Koistinen 2007, 395.)

A female interpreter is often recommended in maternity and child welfare clinics. It could be difficult for the female client to talk about her gynecological problems through a family member as an interpreter. It is also good to make sure the interpreter knows their obligation to practise secrecy. (STM 2001:1.)

Written material, which traditionally is used at maternity and child welfare clinics to support health counselling, in multiple language translations is still quite rare. It is not customary in all cultures to use such pamphlets as sources of information, but a public health nurse may need to find different methods to give information. (Armanto & Koistinen 2007, 395.)

If a maternity or child welfare clinic has many foreign clients from similar cultural backgrounds, it is possible to form groups where health-related topics can be discussed. For some immigrant clients it is hard to take their children to special treatments or further evaluations outside the child welfare clinics. One possible solution for this could be an event held for the formed immigrant group. In the event a speech therapist, occupational therapist and physiotherapist could talk about their work through an interpreter. Hearing personal experiences of people from similar cultural backgrounds could also lower the threshold to attend recommended, special treatments. (Armanto & Koistinen 2007, 395, 397.)

3.6 Campinha-Bacote's process of cultural competence

One of the best-known multicultural nursing models is Josepha Campinha Bacote's model of cultural competence which reflects the nurses' cultural knowledge of the acquisition process and the actual use of the knowledge gained. Campinha-Bacote (2012) urges nursing professionals to ask themselves the following five questions to make contact with multicultural nursing:

- Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other "isms" in healthcare?
- Do I have the skill of conducting a cultural assessment in a sensitive manner?
- Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of biocultural ecology?
- Do I seek out face-to-face and other types of interactions with individuals who are different from myself?
- Do I really "want to" become culturally competent?

The model has been modified several times since its initial development in 1991. The previous version was described in 2002 as a volcano where the starting point was the health care professional's desire to achieve cultural competence. In that version of the model the desire began the process of cultural competence, which eventually leads to the possibility of using the acquired information in planning the customer care, implementation and evaluation. Campinha-Bacote's model changed in 2010 so that all begins and ends with the seeking and experiencing of many cultural encounters. Only through continuous cultural encounters a health care professional acquires cultural awareness, cultural knowledge, cultural skill and cultural desire. From this perspective, cultural competence can be viewed as an ongoing journey of unremitting cultural encounters. (Campinha-Bacote 2012.)

4 MATERNITY AND CHILD WELFARE CLINICS IN FINLAND

4.1 History

Maternity and child welfare clinic has a long tradition in Finland. The first maternity clinic was launched in Paris at the end of 18th century. Preventive health ideologies arrived in Finland from Europe in the 1920s. Arvo Ylppö's and Sophie Mannerheim's activities in favor of children and families were an initiative to the maternity and child welfare clinics in Finland. Those activities continued by the Mannerheim League for Child Welfare (MLL). MLL set up an education for district nurses in 1924 and in 1926 there was the first Finnish maternity clinic in connection with Lastenlinna hospital. (Haarala, Honkanen, Mellin & Tervaskanto-Mäentausta 2008, 14–16.)

From the beginning the aim has been to ensure child's healthy growth and development regardless of parents' education, wealth or residence. This target was also a key component in the establishment of the statutory child welfare clinics (The Law on municipal maternity and child welfare clinics, 1944). In the law above it is said that every municipality in Finland should have a maternity and child welfare clinic free of charge. There was also a new law considering the maternity benefit, which encouraged mothers to seek the services of maternity clinics. (Haarala et al. 2008, 14–19.)

In 1972 the law of Public Health Care entered into force. Work in maternity and child welfare clinics became more family centered. After the renewal of the health care system, district nurses became public health nurses. The law directed the activities of maternity and child welfare clinics until the 1990s. After 1992 government reform, municipalities had more rights and responsibilities to improve their services (Viljamaa 2003, 35–36). During that time other changes were made as well. The health care system became more society concerned. Instead of concentrating only on an individual or family, the health care professional's aim was to familiarize themselves with client's environments and living conditions. The experience and knowledge collected from community helps developing services in a particular area. (Armanto & Koistinen 2007, 19.)

In 1944 every third pregnant woman visited a maternity clinic, the number increased by 1950 when almost all pregnant women were in contact with a maternity clinic. In 1959 95,4% of all children in Finland were clients of child welfare clinics. Maternity and child welfare clinics have had a huge impact on child and maternal mortality. Because of that, these days Finns are one of the world's healthiest nations. For a hundred years, preventive health care has been recognized as an important theme in health promotion. The ideologies came from abroad, but got a unique form in Finland. (Haarala et al. 2008, 17–18.)

The work in child welfare clinics has been based on children's health checks. With regular inspections a child's physical, mental and social health and development have been monitored. From the early years of maternity and child welfare clinics, district nurses and later on public health nurses have educated, given help and vaccinated citizens to prevent diseases. (Haarala et al. 2008, 14–17.)

4.2 Maternity and child welfare clinic today

Today the unique maternity and child welfare clinics are part of the Finnish preventive public health work. Maternity clinics' services are used by approximately 56 000 pregnant women and their partners in a year. The number is more or less 97-99% of all pregnant women. (Armanto & Koistinen 2007, 33). Child welfare clinics are used by approximately 278 000 families with children aged 0 to 6. Maternity and child welfare clinics are used by almost all families in Finland, however visiting these clinics is voluntary. This is mainly due to the fact that it is free of charge and families consider visiting easy (Hakulinen-Viitanen, Pelkonen & Haapakorva 2005, 21.). Finnish maternity and child welfare clinic system is provided across the country. The services are designed for the citizens. By law and national guidelines quality and quantity of the services are controlled. (Haarala 2008, 280–282.)

Ministry of Social Affairs and Health directs legislation and provides recommendations for maternity and child welfare clinics. The social and health care authorization and supervision offices' (VALVIRA) aim is to improve the quality of legal protection and services in maternity and child welfare clinics. Regional Agency for the Management directs and supervises the municipal and private health care. Health and Welfare Department (THL) is part of The Research and Development Department which operates under the Finnish Ministry of Social Affairs and Health (STM). It controls municipalities and researches and develops maternity and child welfare clinics. (THL Kasvun kumppanit.)

It is said in the law of health care (THL 1326/2010) that municipalities have to organize maternity and child welfare services for the residents. While arranging the services, the municipality should co-operate with early childhood education, child protection, social services and other required parties. The law requires that the following services should be included to the visits at maternity or child welfare clinic. In maternity clinic the most important things are monitoring and promoting foetal healthy growth, development and well-being as well as supporting and observing pregnant women and women having given birth. In child welfare clinics the focus is on child's healthy growth, development and well-being. The law includes also children's oral health inspection every two years. It is also important to support parenthood and the whole family welfare. It is necessary to evolve healthy living environments and families' healthy lifestyles. The health care professionals should discover those children and families who are in need of special support and to guide them to further examination. (THL 2:15§.)

Health promotion is the foundation of maternity and child welfare clinics. It includes preventing illnesses by improving health of individuals and their communities. The aim is to increase people's activity to influence their own and their environmental health. The work at the maternity and child welfare clinics is based on population responsibility. This leads to the idea that when promoting health, it has long term effects on the whole community's health. (Armanto & Koistinen 2007, 20.)

Maternity and child welfare clinics co-operate with many municipal and other partners. The collaboration with early childhood education, for example day care or nursery, is important as the personnel in nursery works with the child almost every day. Alliance has many forms and it needs parental consent. The base in early childhood education is the same as in child welfare clinic; children's and families' needs. Maternity and child welfare clinics implement multi-professional co-operation with other health care professionals. Child guidance and family counselling clinics as well as child protection purpose is to help children and families who have some kind of problems in their lives. There are also other factors who participate in the family work. For instance parishes, voluntary organizations, Federation for the Protection of Children, Mannerheim League for Child Welfare, Federation of Mothers and Child Homes and Shelters are agents who work with families with special needs. (Armanto & Koistinen 2007, 26–30.)

The monitoring at maternity and child welfare clinic should follow national recommendations. Following the recommendations the nationwide equality and uniformity in assessment of children's development and supporting families is enabled. There are qualitative objectives in maternity and child welfare clinics, thereby evaluating the work done at maternity and child welfare clinic is essential. Qualitative targets relate to the content, implementation and methods as well as the physical conditions at the maternity and child welfare clinic. The available tools, such as the measuring devices and scales, must be professional and they should be maintained and calibrated on a regular basis. (Armanto & Koistinen 2007, 118.)

5 MATERNITY CLINIC

Maternity clinics are part of Finnish primary health care system. Maternity clinics provide services to families during pregnancy, delivery and postnatal period. The purpose of maternity care system is to prevent any prenatal disorders, establish disorders at an early stage and refer to treatment if necessary, prepare parents for the delivery and puerperium also supporting the family in a new period of life (Haarala et al. 2008, 287). Public health nurse's duty is to respond in the needs for support and nursing on the way from pregnancy to the puerperium. The aim is to secure the normal course of pregnancy and the whole family well-being at the same time strengthening parenthood. (Armanto & Koistinen 2007, 33.) While maternity clinic is being a place for the whole family, it is important that the guidance is addressed not only to the mother, but also to the father. It is studied that pregnancy is a vital time to change behaviour and manners to a healthier way. (Haarala et al. 2008, 284.)

Working methods at maternity clinic are made to meet the individual requirements of the client. Customized health inspections, which contain health screenings and empowering discussions, and family planning, originate from the customers' needs. A public health nurse can also give guidance over the telephone and make a home visit. Family and childbirth sessions as well as other peer support groups are carried out in specific groups. There is also service available in the Internet. Through an online clinic service a public health nurse can answer questions ask by families and give general information. (Haarala et al. 2008, 291–292).

Usually a pregnant woman contacts the maternity clinic when reaching the 8-12 weeks of pregnancy. The path as being a customer in maternity clinic comes to an end when maternity clinic doctor does the post-delivery inspection to the mother. (Armanto & Koistinen 2007, 33.)

5.1 Monitoring visits and screenings at maternity clinic

The latest recommendations for screenings and prenatal care are from 1999 (Stakes). Maternity clinics have recently confronted major structural and contentual changes. Relevant is the increase of the average age of par-turients, morbidity, substance abuse and mental health problems, and multiculturalism. Inconsistencies in organizing services put customers in unequal positions. There is a new expert group set up by the Health and Welfare department, which aim is that the new recommendations for maternity care will be completed and established in 2013. (THL 2013.)

Health inspection at maternity clinic includes maternal and foetal health examination. In an extensive health inspection more attention is paid to the wellbeing of the whole family. Families which are expecting their first baby will receive an oral health status canvas. The extensive health inspection also includes discussion about the upcoming baby, the expectations and possible fears for the changing family structure as well as family's social relationships and resources. Clarifying the family's wellbeing is based on parents' description of the family situation, their needs, resources and concerns. To sort out the family's living conditions, parents' health and wellbeing, relationship and parenting, there are nationally recommended structured questionnaires. For example the role map of relationship and parenting, family's resources and early interaction forms. The aim of the interview is to support parents' interaction and early interaction. (STM 2009:20.)

5.2 Visits at the maternity clinic in Hämeenlinna

When woman's periods are missed and the pregnancy test is positive, she should contact the local maternity clinics public health nurse. Services in maternity clinic are free for the citizens of Hämeenlinna. The maternity clinics services will usually begin in the early phase of pregnancy, approximately during pregnancy weeks 8 to 9. The visits to the maternity clinic will continue thru the pregnancy, which takes about 40 to 42 weeks. The customership ends after 12 weeks from delivery. Then the family is transferred under the child welfare clinic. (Hml 2013.)

The process starts by making an appointment and after that the family will receive information about the pregnancy, early pregnancy screenings and a form to be filled up. There are approximately 18 visits to the maternity clinic, of which three are made to the doctor. To those families who are expecting their first baby, will be organized a family preparation session. Also dental care is organized during pregnancy. There are several forms and questionnaires which are used in maternity clinic. (Hml 2013.)

In the following table the visits to Hämeenlinna's maternity clinic are clarified.

Table 1. Hämeenlinna's plan for the content of the maternity clinic visits. (Jäppinen, Tuomivaara, Mali 2012.)

Visit	Examinations	Content of the visit
The first contact	The client makes an appointment	Public health nurse asks about client's diseases, medications, previous pregnancies and deliveries and use of intoxicants. The mother to be is reminded of the importance of additional folic acid.
PHN 8-10 weeks	Samples taken in early pregnancy. Measuring the weight, blood pressure, haemoglobin, external examination and glucose tolerance test.	Discussion about lifestyle; smoking, substance abuse screening for the parents, nutrition, exercise, dental care, drugs, vitamin D, Father's role during the pregnancy and attendance to the visits, sexual health, and prenatal screenings.
12-13 weeks	Early pregnancy screenings at hospital's maternity clinic.	
Doctor 11-12 weeks	Gynaecological examination and foetus heart rates.	Doctor will discuss basic illnesses, medication and the laboratory results.

PHN 16 weeks	Examining the proteins and glucose of the urine. Measuring weight and blood pressure. External examination and foetus heart rate.	Discussion about family, relatives, friends and support. Sexuality during pregnancy. Understanding of the pregnancy and commitment to it. Foetal movements. Relationship.
20-21 weeks	Physical structures of the foetus by ultrasound at the hospital's maternity clinic.	
PHN 22-23 weeks (extensive health inspection)	Haemoglobin, protein and glucose of the urine. Measuring the weight and the blood pressure. External examination. Symphysis Fundus-measure (SF). Foetal movements and heart rates. Glucose tolerance test, if necessary.	Attention is paid to the whole family wellbeing. The family, who is expecting their first baby, will receive an examination of dental care. The parents will be directed to dental care, if it is necessary. Discussion about foetal movements and the signs of a premature labour.
PHN Doctor 27 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and haemoglobin. Rh-control.	Instructions to count the foetal movements for the risk group. Gynaecological examination by doctor.
PHN 30 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Foetal movements and heart rates.	Discussion about itching and hepatogestose. Fear for the delivery and referral to the hospital's maternity clinic, if necessary.
PHN 32-34 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Foetal movements and heart rates.	Discussion about breasts and breastfeeding, sleep, delivery, upcoming baby and new situation in family. Counting the movements of the foetus.
PHN Doctor 35-36 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. Foetal movements and heart rates.	

PHN 37-39 weeks (once week) a	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Swelling. Foetal movements, presentation and heart rates.	Discussion about mood and fatigue. Family situation. Smoking, use of intoxicants and their effect on the baby. Beginning of the delivery and going to the hospital.
PHN 40-41 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. Haemoglobin if necessary. External examination. Foetal movements, presentation and heart rates. Swelling.	Overtime and making the appointment to the hospitals maternity clinic weeks 41+5.
PHN Home visit after de- livery	Overall checkout of the baby; skin, bellybutton, mouth, eyes, colour, fontanelles, reflexes. Mother's examination; general welfare, breasts, breastfeeding, episiotomy, womb, bleeding, early interaction with the baby.	Discussion about delivery, mood, nutrition and rest. Possible concerns or troubles in breastfeeding, taking care of the breasts, going outdoors, family situation and childcare.

5.3 Family and childbirth preparation session

The purpose of Family and childbirth preparation session is to support the parents in the matters including pregnancy, delivery and new family life. One main goal is to strengthen parenting. Most of the families expecting their first child attend these sessions. Execution takes place in small groups which allows discussion, grouping and peer support. Early interaction is emphasized as early as during pregnancy. In the preparation session images of the upcoming baby are confirmed. It is vital that the parents have thoughts and associations of the baby, even though the baby has not been born yet. The contents of the sessions are several. Things that are discussed are for example; the progress of pregnancy and emotions related to it, stages of labour, variety of delivery methods and pain reliefs, puerperium, child care and breastfeeding, the fathers' role during pregnancy, labour and child care, the various forms of support and the importance of support during pregnancy, labour and parenthood. (Haarala et al. 2008, 310–312.)

Helsinki Social services department funded the Kontulan vauvaperhehanke, in 2005-2007. The aim of the project was to develop family and child preparation session, especially the family and child preparation session for immigrants. The target group was Somali families, but the model may be used for families from other countries as well. In some cities there is a need to organize separate family and child preparation session for immigrants. Culture, religion and language skills challenge both immigrants living in Finland and the professionals working with them. Taking immigrant families into account in the case of family and child preparation session, is not only customer-orientated or respectful behaviour towards the family in special needs, it is often reducing costs. Families' level of knowledge increases and it has an effect on the upcoming baby's development positively. Sharing knowledge in groups is effective, because the answers for one person's questions will benefit all participants. Also the usage of an interpreter is cheaper than in individual visits. (Laaninen & Lukka 2008.)

Family and child preparation session is a good place to give constructive and up-to-date information about the pregnancy and upcoming family life with children. At the same time families have a chance to familiarize with the Finnish health care system. In the sessions family receives important information about childcare and how to raise a child. Family and child preparation session process proceeds as the normal Finnish family and child preparation session, taking certain specific features into account. There might be a need for some extra information or paying attention to some particular subjects. (Laaninen & Lukka 2008.)

6 CHILD WELFARE CLINIC

When a baby reaches the age of six weeks the whole family transfers from being a customer at maternity clinic to a customer of the child welfare clinic. In many cases the same public health nurse works with the family in the maternity clinic as well as in the child welfare clinic, this kind of continuance assists public health nurse bonding with the family.

Public health nurse and doctor are the essential employees in child welfare clinic and they work in close co-operation. Public health nurse is a specialist in children and their families' health promotion. He or she as an expert in nursing is responsible for quality and up-to-date work in child welfare clinic. The doctor in addition to public health nurse is the only employee who meets each child and their families in periodic inspections. If necessary it is possible to make an additional appointment to the doctor.

In addition to public health nurse and doctor, the group working at child welfare clinic may vary according to municipal resources. It is appropriate that child welfare clinic has special professionals, such as a psychologist, a representative of oral health care, a nutrition therapist, a physiotherapist, a speech therapist and social work representatives from day-care, child protection or family counselling. (Armanto & Koistinen 2007, 113-115.)

6.1 The objectives and tasks

Child welfare clinics have a variety of objectives. The main aim is to improve children's physical, mental and social health as well as family well-being, especially in families with special needs. With this target it is possible to reduce inequalities between families. The overall objective is to achieve better health and parenting resources in the next generation. The primary goal is the best interest of a child and to attain this, early intervening to all threats to the child's well-being is necessary. One aim is to improve family-centred approach to work and to strengthen parenting by diverse counselling, education and support methods. In addition to the work done with children and families, the work at child welfare clinics consists of work with health centres, municipalities and the society. (Armanto & Koistinen 2007, 113.)

The work in child welfare clinics is family-centred and client-orientated. The purpose in family based work is that the client and the public health nurse work in collaboration. Co-operation means an interactive and long-lasting relationship that is based on voluntariness and confidentiality. The family is the specialist of their own life and the public health nurse's role is to listen, understand and give information (Haarala et al. 2008, 282). Child welfare clinic services are used by different kinds of families; including young and more mature parents, multiple, adoption, single, blended, rainbow and immigrant families (Hakulinen-Viitanen & Pelkonen 2009, 153).

The family's situation in life, cultural background, habits and environment are taken into consideration. Parents' needs and concerns lay the foundation for the visit to child welfare clinic. Customers are listened to actively and stereotypical solutions are avoided in the work. This kind of work requires from the public health nurse an adequate knowledge of the family, the sensitivity of the situation, respecting parents' rights and decisions as well as acquiring their trust. Child welfare clinics are intended to promote health, which increases families' opportunities to influence their own health and the underlying factors and as a result improve the family's health. (STM 2004:13.)

In 2008 there were 856 child welfare clinics in Finland and 99,5% of all families with under six-year-old children used their services. Every year approximately 400 000 children and 600 000 parents use child welfare clinic services. The percentage of the people who do not use the services of child welfare clinics is rather small, estimated 2 000 children and their parents in a year. Some of these families use private child welfare clinics; some families opt to stay completely outside the services. (Hakulinen-Viitanen & Pelkonen 2009, 153.)

6.2 Health inspections and screenings at child welfare clinic

Periodic inspections relate to the basic function of child welfare clinics. Monitoring and supporting the child's physical, mental and social growth and development allows recognizing any abnormalities as early as possible in these inspections. Reasonably the whole family should be taken into account during the health inspection. Supporting parenting and early interaction becomes possible within regular contacts. Child welfare clinics are given recommended implementations about periodic inspections, but the execution should be customer-oriented. (Armanto & Koistinen 2007, 114-)

Within health inspection it is vital to strengthen child and family welfare, their recourse and parent ability to function for the family. With all families their situation in life and habits concerning health, for example diet, exercise, substance abuse, time spent together and shared joy producing things should be discussed. It is important to discuss any problems related to the situation in life, for example partner and immediate family violence, substance abuse and mental health problems, housing and livelihood problems. Children and their guardians are given feedback about their skills and resources in the particular situation in life, special attention is paid to resources of parenting and supporting parents in their educational tasks. Parents should be clearly informed what a child needs from her or his parents to develop and feel well. (STM 2009:20.)

Health guidance is systematic and interactive communication aiming to promote children's wellbeing, strengthen responsibility and apply the knowledge to the practice (Hakulinen-Viitanen, Hietanen-Peltola, Hastrup, Wallin & Pelkonen 2012, 13). As in the regulation (338/2011 14§) is said health guidance should include evidence-based information. It has to support the individual and their family's health, including mental health and promotion of psychosocial wellbeing in the following areas; growth and development, vaccinations, nutrition and exercise, relationship as well as sexual health, violence and intoxicants.

Health inspection is an entirety, which may consist of several parts or a number of separate studies and interviews. Health inspection ends in the overall assessment of health status, and if necessary, plans for further examination, support and care needed. Estimation of health should be done in co-operation with a child and their family. Therefore it is necessary that in the completion of the inspection a public health nurse and a doctor will bring the results together in an understandable way. Thereby the state of health and the factors influencing it can be observed together and the possible need for further action or methods can be decided. (STM 2009:20.)

As in regulation (STM 2008a) is said the child's periodic health inspections are carried out as health examinations by a doctor, health examinations by a public health nurse and health examinations by both doctor and public health nurse. The last one is called extensive health inspection. Health inspections made by doctor must be organized in total of five before the age of six; three of these must be extensive health checks. Health inspections made by a public health nurse should be at least 15, of which five are made within the doctor's inspection. (Hakulinen-Viitanen & Pelkonen 2009, 155.)

Screenings are carried out in the context of periodic inspections and are designed to discover any deviation or disease symptoms in all children. There are several tests which are used in the screenings. The one who implements screenings should have sufficient knowledge and skills to understand the meaning of the tests and how to interpret the results. The most important way in screening is to listen carefully to the child and their parents. Execution of screenings, interpretation of the results and planning for further examination requires multi-professional collaboration.

Screenings can be divided in somatic, psychological and neurological screenings. Somatic screening includes growth monitoring, obesity screening, vision and hearing screening, heart defects screening, blood pressure monitoring, testicular descent screening and congenital dysplasia of the hip screening. Psychological problems are difficult to separate from other development disorders. When screening psychological problems, the age of the child, problems in child and parent interaction, self-regulation, attentiveness and behaviour disorders as well as wide-ranging development disorders, should be taken into account. Neurological screenings include for instance monitoring and measuring head circumference, development of gross and fine motor skills, progression of visuo-spatial perceptive skills as well as occurrences of regression and various seizures. (Armanto & Koistinen 2007, 114.)

6.3 Extensive health inspection

In an extensive health check a doctor and a public health nurse in cooperation with other professionals define the child's and the whole family's health as far as it is necessary for organizing the care and support. The need for care and support increases in cases of early interaction, parent's substance use, violence, mental health problems and relationship problems. There are several forms to help intervention in situations like these. (Hakulinen-Viitanen & Pelkonen 2009, 155.)

In addition to the public health nurse and the doctor, the participants are the child, both of their parents or at least either one of them. The subjects of discussion are child's, parent's and the whole family's wellbeing and health as well as the factors affecting them. These are observed with wide and various perspectives. Health inspection includes clinical research and other appropriate methods carried out to examine the health and functional capacity as well as the factors influencing health promotion. Detecting the state of health may require consultation and multi-professional co-operation. (Hakulinen-Viitanen et al. 2012, 14.)

It is possible to exchange information between the professionals attending the health examination, for instance between child welfare clinic and day care. Parent's agreement on this is unconditional. Before the health inspections, the family should be informed about the content and course of the inspection; the multiprofessional co-operation to assess health comprehensively; the welfare and health plans; services and flow of information; as well as the permits needed for the health professionals to access data. (STM 2009:20.)

6.4 Visits at a child welfare clinic

During the child's first year there should be a total of nine health inspections. Two of them made by a doctor at the age of 4-6 weeks, at the age of 8 months and at the age of 4 months, which should be extensive health checks. This means that the doctor meets the family overall three times during the baby's first year. Municipalities should organize at least six health inspections to a child aged 1-6 years. These should include two extensive health inspections at the age of 18 months and 4 years. This means that the doctor interacts with the child and the family twice and public health nurse in all of them. (Hakulinen-Viitanen & Pelkonen 2009, 156.)

During the baby's first year the public health nurse meets the family often and several times, therefore he or she will be able to follow the development of the child and family's situation in diverse ways. The public health nurse plans the health education included in the health inspection based on the needs of the family. It is particularly important to observe the early interaction and discuss breastfeeding, the needs of the child, mother and father's feelings and possible depression, parental wellbeing as well as their relationship. (THL 2013.)

Table 2. Hämeenlinna's plan for the content of the child welfare clinic visits. (Jäppinen et al.)

Age	Nutrition	Examinations	Content of the visit
1-4 weeks PHN 2 x 60 min	Vitamin D drops. Breast milk or formula.	General impression. Weight. Head. Senses. Skin, navel. Reflexes. Atmosphere.	Early interaction Family's resources Social relations Breastfeeding Skin care Outdoor activities Home environment Safety Smoking and drugs in the family (BCG reaction)
6-8 weeks PHN 20 min Doctor 20 min	Breast milk or formula	The baby: Growth. General impression. Medical examination. The mother: Haemoglobin. Urinary protein and glucose. Blood pressure. Weight. Gynaecological examination.	Psycho-social resources of the family, monitoring and support. The vaccination program Mood. Contraception. Baby care and mother's ability to cope. Breastfeeding. Intoxicants.
3 months PHN 90 min	Breast milk or formula	Growth. Development. General impression. Interaction.	Family's resources. Nutrition, breastfeeding. Introducing infants on formula to solid foods
4 months PHN 20 min Doctor 30 min	Breast milk or formula	Growth. Neurological general impression. Interaction. Medical examination.	Family's resources and concerns. Nutritional information. Wellbeing assessment of the whole family.
5 months PHN 60 min	Breast milk or formula Fruit, berry and vegetable purees (if necessary)	Growth. Development. General impression. Interaction.	Stimuli for the baby's psycho-social and motor development. The atmosphere of the family. Nutritional information. Baby's sleep. Applying for day-care.

Age	Nutrition	Examinations	Content of the visit
6 months PHN 60 min	Breast milk or formula Solid food + meat, chicken, fish, porridge, gruel. Finger food. Mug.	Growth. Development (movement, reflexes) General impression. Interaction. Vision. Hearing.	The atmosphere of the family. Smoking and the use of intoxicants in the family. Safety Nutritional information.
8 months PHN 20 min Doctor 20 min	Breast milk or formula. Coarseness and amount of solid food is increased. Two meat meals a day.	Growth. General impression. Hearing. Medical examination.	Stimuli and support of the baby's psycho-social and motor development. Family's resources and atmosphere. If necessary, the child's day-care arrangements and what happens if the child becomes ill. Reminder of vitamin D drops.
10 months PHN 60 min or 120 min	Encouragement to independent initiative. Tasting of low-fat, sour milk products.	Growth. Development. General impression. Interaction.	Supporting the psycho-social development. Books. Toys. Songs. Games. Shoes. Nutritional information.
1 year PHN 60 min	Feeding of a toddler (salt, sugar, fat). Breastfeeding. Low fat milk products.	Growth. Development. Hearing. Development of speech. Interaction. Haemoglobin.	Supporting psycho-social and motor development. Independent initiative. Outdoor activities. Family's atmosphere. Nutritional information. Toilet training. The word "no", boundaries.
1 year 3 months PHN 90 min		Growth. Development. Speaking.	Assessing the family's wellbeing. Audit. Violence.

1 year 6 months PHN 20 min Doctor 30 min	Feeding of a toddler. Bottles. Dummies.	Growth. Development. General impression. Interaction. Medical examination.	Family's resources and concerns. Encouragement to independent initiative. Assessing the whole family's wellbeing.
2 years PHN 60 min	Independent initiative. Bottles and dummies away.	Growth. Development. Speaking. Interaction. Appointment for dental care.	Supporting psychosocial and motor development. The daily rhythm. Obstinate age and boundaries. Toilet training. Family's atmosphere. Time spent with entertainment media.
3 years PHN 60 min	Nutritional habits of the family.	Growth. Development. Feedback from day-care.	Family's atmosphere and resources. Independence. Day-care. Obstinate age. Smoking and the use of intoxicants in the family. Safe environment.
4 years PHN 90-120 min Doctor 30 min	Nutritional habits of the family.	Growth. Development. Feedback from day-care. Blood pressure. Vision. Hearing. Medical examination.	Assessing the whole family's well-being. Child's health. Family's healthy habits. Obstinate age Family's atmosphere. Club activities. Playmates. Safe environment. Time spent with entertainment media.
5 years PHN 60 min	Nutritional habits of the family.	Growth. Development.	Psycho-social development and support. Family's atmosphere. Importance of friends. Games, play. Independence. Pre-school. Safe environment. Nutritional information. Bed-wetting. Time spent with entertainment media.

6 years PHN 60 min	Nutritional habits of the family.	Growth. Development.	Independence. Pre-school. Smoking and substance abuse in the family. Readiness for school. Safe environment. Nutritional information. Time spent with entertainment media.
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6.5 Growth and development monitoring

One of the most important things at child welfare clinic is to monitor the child's growth. It is also significant part of the preventive health care in Finland. The main goal is to find any illnesses or disease as early as possible and at the same time to collect information in citizen's health. Growth monitoring includes measuring the height, weight and head circumference. (Mäki, Wikström, Hakulinen-Viitanen & Laatikainen 2011, 17.)

Almost 80% of the child's growth is defined in the hereditary factors. This means that the children's growth follows the national standards. That is why there has been carried out a project (Kansallinen Kasvutietokantahanke), which has created new growth curve monitoring system. (Mäki et al. 2011, 17.)

If there are exceptions in either way in the child's height curve, the public health nurse should clarify if there were any symptoms of an illness or a disease in the family that might effect on the child's growth. If there is a remarkable change in the curve the child should be seen by a doctor immediately. Before sending the child to a special doctor, it is possible to state the basic diseases influencing on growth by laboratory tests. (Mäki et al. 2011, 18-24.)

The interpretation of the weight curve is similar to height monitoring system. If there is a change in either way or an exception in the weight curve, the child's weight should be examined more often for a while. If there any symptoms of a disease or there is some kind of illness in the family that effects on the growth of the child, the doctor should observe the situation immediately. As well as in the exceptional situation in the height curve, the laboratory examinations should be taken. Because obesity is an extensive problem nowadays and causes problems later on, the experts at the child welfare clinics should pay attention on preventing overweight. (Mäki et al. 2011, 25-29.)

Baby's skull joints are fully separated until the age of six to twelve months. Head circumference is the only sign of arising brain pressure while the skull joints are separated. The head circumference is measured until the age of seven years. The child should be taken to additional researches if she or he has exceptional growth of the head and has any kind of other symptoms as bulging fontanel; the child has a squint or a sunset look, in addition the child is tired she or he eats poorly or is vomiting. (Mäki et al. 2011, 30-32.)

6.6 Vaccination program

In Finland children and young people have a good opportunity to receive vaccinations against eleven different disease, their complications and long-term problems. The vaccination program is presented in the subsequent table. The coverage of the vaccination in the program is excellent in Finland. Families who refuse to take vaccinations are very rare. (THL 2013.)

Vaccination is one of the most important, cheapest and most successful tools for health promotion. For instance Smallpox has been eradicated worldwide by vaccination. In Finland diseases such as measles, mumps and rubella have been eliminated by vaccinations. Nevertheless the vaccinations should be continued according to the recommendations, because it is possible for a non-vaccinated person to catch the diseases from abroad.

Finnish well-functioning child welfare clinic system and its employees, especially public health nurses and child welfare clinic doctors, have by their professional work together with citizens contributed to the vaccination coverage to remain high. It is a great privilege that the society offers the vaccinations at the local child welfare clinics. The vaccinations included in the general vaccination program are voluntary and free of charge. (Armanto & Koistinen 2007, 181.)

A baby's parents will receive a child welfare clinic card, which contains information on given vaccinations. The card is brought to the child welfare clinic with the child. The card will be completed after the vaccination. The child welfare clinic card is replaced with a health card, which contains all the received vaccinations. (Mentor Institutttet 2013.)

Vaccinating means administering a pathogenic microorganism or part of it in to the body in such a form that it provides a protection to the body. The question is about the active immunity that arises against the disease. The protection is achieved without the dangerous or harmful symptoms of the disease. (Armanto & Koistinen 2007, 181.) Infants will receive the vaccination injection usually on the outer side of the thigh. To a pre-schooler the vaccination is injected in to the arm. The needle is injected subcutaneously or intramuscularly after which the vaccine is injected slowly. Some vaccinations are taken orally. (Mentor Institutttet 2013.)

The general rule is that the vaccination should be postponed if the child has a fever. If the child has a cold but no fever, a child can be vaccinated. In special cases, such as the child having previously had some side effects from vaccinations, it should be discussed with the doctor. Some children may receive some kind of side effects from the vaccinations. For example local reaction occurs at the injection site as swelling, warmth, erythema and tenderness. The reaction disappears within two to three days. When vaccinating with the live diluted virus, for instance measles, mumps or rubella, the child can get a mild form of the disease, which he or she has been vaccinated against. However, much more moderate than if the child had the disease in its natural form. A child may get an allergic reaction after vaccination, for example nettle rash. Nettle rash is an intensively itchy rash that spreads throughout the body and disappears again in a short time. Nettle rash occurs immediately after the vaccination. All vaccinations can cause fever. (Mentor Institutttet 2013.)

In addition, children who belong to the risk-group are entitled to receive additional vaccinations. Vaccination against tuberculosis should be offered only to those children who have the increased risk for tuberculosis. Children whose health is under substantial threat by influenza, are given each year before the beginning of the epidemic season, seasonal influenza vaccination. Children under 5 years of age who belong to certain medical risk groups can receive pneumococcal vaccines. Pneumococcal vaccine has been part of the vaccination program since 2010. Every child from Åland and over three years old has the right to receive the tick-born encephalitis vaccination. The child who has an increased risk of acquiring hepatitis A or hepatitis B infection, because of living conditions, will be given hepatitis vaccinations according to the National Institute for Health and Welfare modifier. (THL 2013.)

Finnish vaccination program offers vaccination protection for the following immigrants; asylum-seeking children and pregnant women, the quota refugees, asylum-received, adopted children and other people who have moved permanently to Finland. If the information about the vaccinations given in the previous home country is missing, the immunization should be built from the beginning as if the person has not received any vaccinations. An unvaccinated child should be vaccinated with an accelerated schedule. (THL 2013.)

Table 3. Vaccination of children and young people. (THL 2013.)

Age	Which disease the vaccine prevents	Vaccine
2 months	Diarrhoea by Rotavirus	Rotavirus RV (Oral)
3 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
3 months	Diarrhoea by Rotavirus	Rotavirus RV (Oral)
3 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib

5 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
5 months	Diarrhoea by Rotavirus	Rotavirus RV (Oral)
5 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib
12 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
12 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib
12 months	Measles, mumps and rubella.	MPR
6-35 months	Seasonal influenza (annual)	Seasonal influenza
4 years	Diphtheria, tetanus, pertussis and polio.	DTaP-IPV
6 years	Measles, mumps and rubella.	MPR
14-15 years	Diphtheria, tetanus and pertussis.	dtap

6.7 Nutrition

Children and their families' eating habits are observed and estimated at the child welfare clinic. Especially it is important to clarify eating habits during the changing stages of life. Infant and toddlers nutritional education depends on the age and phase of development. A child's eating habits and needs for food evolve step by step with age and accumulating skills. Children have different kinds of temperaments and developing paces, this can be seen in differences in the eating process. The positive interaction between the child and their parents makes the eating situation pleasant and enables the support for the child according to the development pace he or she is in. (Armanto & Koistinen 2007, 215.)

Active basic metabolism and rapid growth affects a child's nutritional needs. The growth is most intense during the child's first year and then decelerates. Children's need for all nutrients related to body weight is high in comparison with adults. The assessment of an infant's nutritional needs is based on the composition of the breast milk. It has the best contents to satisfy the child's need for energy and various nutrients. Breastfed babies' growth and development is considered optimal. (STM 2004:11.)

Children's need of energy varies. There are factors that affect the need of energy, for example the child's gender, height, weight, growth rate and physical activity. A child's energy requirements can vary between the days. (Armanto & Koistinen 2007, 215.)

A healthy, regular and balanced diet is important for the growing child. Nutritional habits are learned at an early age. Parent's and the whole family's food choices and eating habits affect the small child. In addition to what the child eats, it is also important to pay attention to the way he or she eats. Healthy habits and lifestyle are also the foundation of the adult's health and wellness. (MLL 2013.)

A breastfed baby controls their energy intake via physiological sensations. During infancy, the child searches for their own way to grow. Individual growth monitoring, parent's observations and child's satisfaction as well as wellbeing helps with the assessment of the situation. If there are several or major changes and exceptions in the growth chart, it is always time to intervene. (STM 2004:11.)

Full breastfeeding is recommended to be continued until the age of six months. At the age of four to six months the baby begins to be developmentally ready to eat solid food. Exercises with spoon and getting used to the mashed food can start by getting accustomed with small taste samples, according to individual needs. First tastings are usually vegetables as potatoes, carrots, cauliflower or sweet potato, fruits or berries in fine puree. Initially a teaspoon is enough and the dose may be increased gradually. Gruels that contain vegetables, rice and maize accustom the baby to new tastes. Different kinds of food are introduced one by one, and the diet is expanded slowly with one to two new foodstuffs in a week. (Valio Oy 2013.)

The protein quantity and quality of breast milk are ideal for the infant. Protein in breast milk covers the child's need for until the age of six months, as far as the amount of milk satisfies the need of energy. Porridge, gruel and meat purees increase protein intake at the age of six months. (STM 2004:11.)

Fat covers about half of the energy in breast milk. Therefore the child's high energy demand will be satisfied with a relatively small amount of food, because the energy content of fat is twice as high compared to other nutrients. The content of fat decreases in the diet of the child naturally when the child proceeds to additional foods and the same food that the family eats. The child receives essential fatty acids needed for growth and development of the nervous system from soft fat. Pre-school children can safely follow the same versatile, high in soft fat diet than the rest of the family. Low fat dairy products are important to use enough. Skimmed milk is a good choice for a child's first milk. A child under two years of age, using skimmed milk should receive approximately 2-3 teaspoons of rapeseed oil or margarine in addition in a day. (STM 2004:11.)

The recommended diet contains enough fibre. To ensure adequate fibre intake it is good to eat more brown bread, especially rye bread, whole grain, vegetables, berries and fruits. Otherwise they will improve the nutrient density of the food. During a baby's first six months the baby will receive from breast milk all the vitamins and minerals needed, with the exception of vitamin D. The new-born has excellent nutrient stocks in their body, which will help the baby during their first months. When the baby is six months old, complementary solid food is needed. A toddler's balanced and variable diet includes all minerals and vitamins needed, vitamin D has to be added to the diet. (STM 2004:11.)

6.7.1 Vitamin D

Additional vitamin D is an essential element in the baby's and child's nutrition, especially in Finland where the exposure to the sun is minimal. Vitamin D is required especially in the formation of bones and teeth, as well as calcium and phosphorus metabolism. Without vitamin D, calcium is not properly absorbed by the body and the normal development, growth and maintenance of bones are prevented. Vitamin D is the basic regulation mechanism of the body's every tissue. It affects the dynamism of the cell division and cell differentiation. Vitamin D contributes to the development of tissues to their own purpose. (Orion Oyj 2012.)

Vitamin D is recommended to be given from the age of two weeks 10µg (400IU) per day all around the year. It does not matter if the child is fed by breast milk, some processed milk for infants or vitamin enriched porridge. From the age of two, vitamin D should be used 7,5µg (300IU) per day throughout the year. The usage of products which have been enriched with vitamin D is safe to use while taking extra vitamin D, and there is no risk of excessive intake. (THL 2011.)

6.7.2 Breastfeeding

Healthy, full-term and normal weight new-borns, receive enough nutrition, even from a small amount of breast milk. Especially the first few days the milk consists of colostrum. Colostrum, which has also been called "super milk", includes a very high content of antibodies, which protects the baby from the pathogens surrounding the baby and his or her mother. It also helps the meconium to leave the baby's intestines. The composition of the colostrum is thick and sometimes slightly yellowish in colour. It includes a lot of protein, but less fat and lactose than normal skimmed milk. (Niemi 2006, 10.)

Approximately two weeks after birth mother's breast will begin to produce milk, which energy, protein, salt and mineral quantity are equalized. The baby receives enough fluids, because the water content of breast milk is approximately 87%. The carbohydrates of breast milk contribute to the infant's intestinal immune defence. The baby receives energy from the fats that breast milk includes; the fats are also involved in the central nervous system's normal growth and development. Breast milk proteins are in highly absorbed form, as well as the minerals and trace elements. For example the quantity of iron, zinc and copper decreases while the breastfeeding proceeds. (Deufel 2010, 33-36.)

Breast milk has a number of immunological functions, such as to protect the child's mucous membranes from microbes and therefore infections. Breast milk has, among others, type sIgA antibody, which is excreted in the breast milk from the mother's intestinal lymphocytes. Particularly the level of antibody is high in breast milk; however, it decreases rapidly when the quantity of milk increases. It does not mean that there would be any fewer antibodies; their ratio only dilutes when the amount of milk increases. Breast milk protein; lactoferrin, is able to kill bacteria, viruses and yeast. It also has the ability to bind the available iron in the intestines, and therefore prevent harmful bacterial growth. On the other hand it increases the development of the intestinal flora by supporting the growth of bifid bacteria. (Deufel 2010, 33-36.)

The carbohydrates, such as oligosaccharides, affect on the composition of the intestinal bacterial flora and prevent microbes binding to the mucous membranes by attaching to the receptors they are using. Proteins, such as lymphocytes, in breast milk, strengthen the effects of vaccinations. Breast milk also contains various growth factors, which supports the maturation of the child's body. Several hormones are excreted in the breast milk, which have various tasks. For instance, leptin may be involved in appetite regulation. (Deufel 2010, 33-36.)

6.7.3 Formulas

When breastfeeding is not possible or when breastfeeding is stopped before the age of one, the child is then given formula in place of breast milk. The mother is given support and guidance in the weaning on to bottle-feeding. Early weaning is often associated with internal and external pressures of the family, as well as feelings of guilt and failure. It is advisable to discuss these things with the family and support their decisions. (STM 2004:11.)

Formulas are prepared from cow’s milk and its various components to suit the infant. Lactose, vegetable oil and vitamins are added and the formula is completed with missing minerals and other necessary nutrients. Formulas, like breast milk, contain less protein compared to cow’s milk and therefore cow’s milk, organic non-homogenized milk included, is not recommended for infants. Soy-based infants’ products purchased from the pharmacy have nutritional traits of the same kind as formulas. All the formulas are quite similar to each other. The manufacturing and marketing of formulas is strictly regulated. (STM 2004:11.)

Like in breastfeeding, the proximity of the child and the feeder as well as eye and skin contact are also important when bottle-feeding. The right position when feeding reduces problems. The child must be in a semi-upright position, in the arms of the feeder. When the child’s auditory tube is above the stomach, milk does not flow into the auditory tube via the throat. It is also important that the holes of the pacifier are adequately small so the milk flows freely one drop at a time. Too swift flow of milk can easily cause intestinal gas and rumination. (STM 2004:11.)

Table 4. The indicative amounts of formula. (STM 2004:11.)

Age of the child (in months)	Quantity of formula (ml/day)
0-1	500-600
1-2	600-800
2-3	700-1000
3-5	700-1200
5-6	700-1000 (including gruels)
6-8	600-800 (including gruels)
8-10	600 (including gruels)
10-12	600 (including gruels)

The baby’s feeding equipment needs to be sterilized before each use. After the feeding, the child’s bottles and teats are rinsed immediately in cold water, washed with dishwashing liquids and rinsed well. Washed bottles are boiled in water for five minutes and teats are dipped into boiling water. (STM 2004:11.) The teats and bottles need to be checked regularly for any damage. If the bottles are not being used immediately, they should be put together with the teat and lid in place to prevent the inside of the sterilized bottle from being contaminated, along with the inside and outside of the teat. (NHS 2012.)

6.7.4 Introduction of solid foods

Weaning on to solid foods should start when the baby is around six months old. Six-month-old children often learn to feed themselves quickly and with less mess as they will be able to swallow properly. Introducing the baby to solid foods is a really important step in the baby's development and can be great fun to explore new flavour and textures together. In the beginning it's more important getting the child used to the idea of eating rather than how much the baby takes. At the age of six months the child is still getting most of their nutrition from breast milk or formula. Gradually the amount and variety of food the baby eats increases. Eventually the baby will eat the same food as the rest of the family but in smaller portions. The slow introduction to solid foods gives the baby's digestive system time to develop to cope with the solid foods. (NHS 2011.)

There are three signs to indicate that your baby is ready for solid foods alongside breast milk or formula. It is very rare for these signs to appear together before the child is six months old but all children are individuals. First of the signs is that the child can stay in a sitting position and hold their head steady. The second sign is that the child can co-ordinate their eyes, hands and mouth so that they can look at the food, pick it up and put it in their mouth all by themselves. The third sign is that the child is able to swallow food. Babies who are not ready will most likely push their food back out. Chewing fists, waking up in the night when they have previously slept through and wanting extra milk feeds are normal behaviour and not necessarily a sign of hunger or a sign for a baby to be ready for solid foods. (NHS 2011.)

It is important that someone stays with the baby when they are eating in case they start to choke. The baby should be allowed to enjoy touching and holding the food. The child shouldn't be forced. The transition can start with just a few pieces or teaspoons of food a day. Hot foods need to be cooled and tested before given to the baby. No additional salt, sugar or stock cubes are needed to the baby's food or cooking water. (NHS 2011.) The public health nurse will give instructions with what kinds of food the baby should start.

7 KELA BENEFITS

Families are entitled to various benefits from Finnish social insurance institution, Kela. The parents must have lived in Finland for at least 180 days immediately before the baby's expected date of delivery to qualify for parental allowances. The parents must also be covered by the Finnish social security system. The insurance period can also include insurance period from another EU or EEA country, Israel or Switzerland. (Kela 2013.)

When the pregnancy has lasted at least 154 days (about 5 months), the mother will receive a pregnancy certificate during her visit at the maternity clinic. The mother has to find out whether her employer will pay wages during her leave. The payment of wages is often based on the collective agreement. The mother will need this information when applying for allowances from Kela. After receiving the pregnancy certificate she can apply for maternity allowance, maternity grant, parental allowance and child benefit from Kela. (Kela 2012.)

Table 5. Benefits which Kela grants. (Kela 2013.)

Benefit	
Maternity grant	Maternity package or cash benefit.
Maternity allowance and special maternity allowance	Until the child is about 3 months old.
Paternity allowance	After the child is born.
Parental allowance	For the mother or the father. When the child is about 3 to 9 months old.
Child benefit	For a child under 17 years of age.
Child home care allowance	For a child under 3 years of age and not in municipal day care.
Private day care allowance	For a child under school age and not in municipal day care.
Child maintenance allowance	For a child under 18 years of age.
Various benefits	When the child becomes ill.

The mother notifies her employer of the forthcoming family leave when applying for allowances from Kela or at least 2 months before starting the leave. She needs to find out whether she can give the notification informally or if it needs to be in writing. (Kela 2012.)

Mothers can decide whether they want to start their maternity leave 50 working days before the estimated day of delivery or at a later date. The maternity leave must start at least 30 working days before the estimated date of delivery. If the mother's work is potentially dangerous to her or the baby's health, she may be able to start her maternity leave earlier and receive special maternity allowance. (Kela 2012.)

In the case of a multiple pregnancy, the parental allowance period will be longer than normal. The maternity grant will also be multiplied. If the older child is under 3 years old on the day of the baby's estimated date of delivery, the mother may qualify for parental allowance on the basis of the same income as her older child. (Kela 2012.)

Paternity leave will not begin until after the baby is born but the father has to notify his employer of the leave at least 2 months in advance. If the father takes his leave in shorter periods and the total leave is 12 days or less, it is sufficient to give a month's notice. Fathers need to negotiate with their employers when they will take their paternity leave and whether they will take it in shorter periods or all at once. It should also be agreed with the employer on what to do in case of premature or overdue birth. The easiest way to apply for the paternity leave allowances is after the baby is born. (Kela 2012.)

8 THE FOLDER

The theory of the thesis was used as a basis for the support material folder. The theory was collected mostly from Finnish sources due to the fact that Finnish maternity and child welfare clinic system is unique. Also the Finnish health recommendations are specifically made for Finland.

There was an endless list of possible topics to be used in the folder but only the seemingly more important ones were chosen. Also the requests from the public health nurse, who had provided the idea for the thesis, influenced the decisions. These topics were the maternity and child welfare clinic system in Finland, planned visits at the clinics, vaccination programme, nutrition and Kela benefits. The folder also contains useful web-sites as well as pictures to be used as examples.

The aim was to make the folder readable and look sophisticated. The layout of the folder was finished after the theoretical part was ready. Pictures were requested to be added into the folder so the topics would be easier to visualize. To make the folder more personalized and interesting, hand-made pictures were chosen to be used. Subheadings and graphs were used so it would be quicker to find the needed information in the folder.

In the future the folder can be used as one of the tools to improve the interaction between the public health nurse and their English-speaking clients in maternity and child welfare clinics. The folder can be modified, updated and expanded freely but on a condition that the original writers are mentioned.

9 CONCLUSION

The process of this thesis began in September 2012 when the idea came to us from a public health nurse working in a maternity and child welfare clinic in Hämeenlinna. The interesting idea motivated us to finish the thesis quickly. During the writing process we learnt a lot about the rules and means of writing a thesis. It also challenged us to choose the topics we wanted from a vast selection.

The purpose of the thesis was to provide English support material to the maternity and child welfare clinics in Hämeenlinna. Because of the uniqueness of Finnish recommendations and the maternity and child welfare clinic system, most of the material was translated from Finnish. The English material is beneficial to both the public health nurses and their English-speaking clients. The theory provides the public health nurses with useful phrases and vocabulary. The folder is a more compact information tool to be used in the interaction between the public health nurses and the clients.

During the thesis process we learnt a lot of useful professional terminology and also gained a more detailed view of Finnish maternity and child welfare clinic system. We also expanded our knowledge of culture as well as of immigrants in Finland and them as clients of public health nurses. This will be useful if we ever decide to apply for jobs overseas or even in Finland in maternity and child welfare clinics with clients from different cultural backgrounds. We feel like we have grown professionally.

When planning the thesis, topics were asked from the public health nurse, who had provided us with the original idea for the thesis. From those topics we chose the ones we thought would be the most useful for the clients when maintaining the children's wellbeing. Children are the most vulnerable in the society so their health and wellbeing must be treasured. Children from different ethnic backgrounds may have additional challenges but also special resources when growing up in Finland. (THL 2013.)

At the end of the thesis we asked for opinions from the public health nurses but currently we have not had any specific replies considering the content of the folder. We did, however, get an approval. We were also given permission to post our thesis in Theseus, the open repository of the Finnish Universities of Applied Sciences. The thesis will be handed in an electronic form to the public health nurses in their weekly meeting.

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[FI/hyvakaytanto/kuvaus/?PracticeId=9c177920-d814-4244-ae4c-9196b93cc7f5](http://www.sosiaaliportti.fi/fi-FI/hyvakaytanto/kuvaus/?PracticeId=9c177920-d814-4244-ae4c-9196b93cc7f5)

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MATERNITY AND CHILD WELFARE CLINICS IN HÄMEENLINNA

Support material for English-speaking clients



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1 GREETINGS FROM THE WRITERS

This folder is part of a thesis written as a part of public health nurse studies in HAMK University of Applied Sciences in spring 2013. The writers of this folder are public health nurse students Iina Oras and Maria Raunio. The illustrations were done by Maria Valo.

We hope that this folder helps English-speaking clients in maternity and child welfare clinics in Hämeenlinna to receive information concerning their and their children's health in a more understanding way. The folder contains facts about how maternity and child welfare clinics are organised in Finland and general view on how the planned visits should be carried out. The nutritional advice is according to Finnish recommendations.

Finns are proud of their unique maternity and child welfare clinic system. Public health nurses are professionals and we encourage you to contact them if you have any questions relating to your or your family's health. Likewise we hope that you are willing to share the knowledge of your own culture with your public health nurse and thus develop the Finnish multicultural maternity and child welfare clinic system.

2 MATERNITY AND CHILD WELFARE CLINICS IN FINLAND

<p>Health promotion is the foundation of maternity and child welfare clinics. It includes preventing illnesses by improving health of individuals and their communities. The aim is to increase people's activity to influence their own and their environmental health. The work at the maternity and child welfare clinics is based on population responsibility. This leads to the idea that when promoting health, it has long term effects on the whole community's health.</p>
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The unique maternity and child welfare clinics are part of the Finnish preventive public health work. Maternity clinics' services are used by approximately 56 000 pregnant women and their partners in a year. The number is more or less 97-99% of all pregnant women. Child welfare clinics are used by approximately 278 000 families with children aged 0 to 6. Maternity and child welfare clinics are used by almost all families in Finland, however visiting these clinics is voluntary. This is mainly due to the fact that it is free of charge and families consider visiting easy. Finnish maternity and child welfare clinic system is provided across the country. The services are designed for the citizens. By law and national guidelines quality and quantity of the services are controlled.

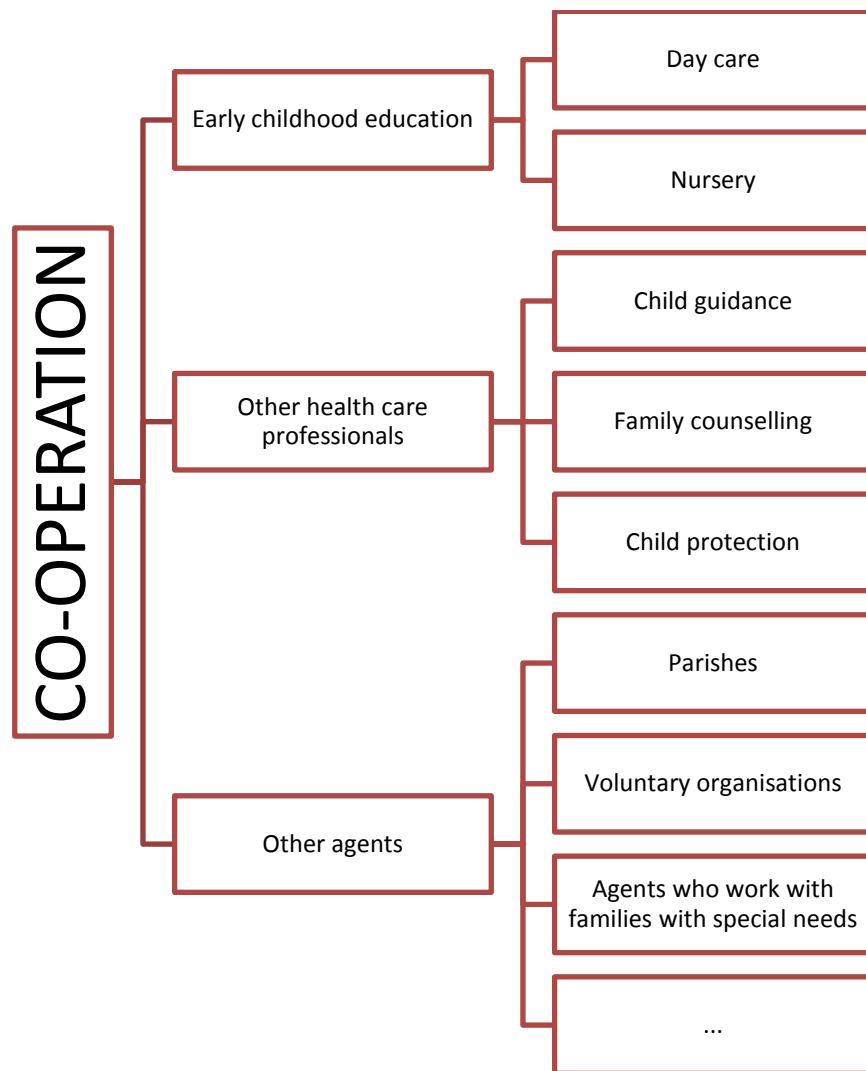
Legislation

Ministry of Social Affairs and Health directs legislation and provides recommendations for maternity and child welfare clinics. The social and health care authorization and supervision offices' (VALVIRA) aim is to improve the quality of legal protection and services in maternity and child welfare clinics. Regional Agency for the Management directs and supervises the municipal and private health care. Health and Welfare Department (THL) is part of The Research and Development Department which operates under the Finnish Ministry of Social Affairs and Health (STM). It controls municipalities and researches and develops maternity and child welfare clinics.



Picture 1. Coat of Arms of Finland. (Source: www.finland.fi.)

It is said in the law of health care that municipalities have to organize maternity and child welfare services for the residents. While arranging the services, the municipality should co-operate with early childhood education, child protection, social services and other required parties. The law requires that the following services should be included to the visits at maternity or child welfare clinic. In maternity clinic the most important things are monitoring and promoting foetal healthy growth, development and well-being as well as supporting and observing pregnant women and women having given birth. In child welfare clinics the focus is on child's healthy growth, development and well-being. The law includes also children's oral health inspection every two years. It is also important to support parenthood and the whole family welfare. It is necessary to evolve healthy living environments and families' healthy lifestyles. The health care professionals should discover those children and families who are in need of special support and to guide them to further examination.



3 VISITS AT A MATERNITY CLINICS

The latest recommendations for screenings and prenatal care are from 1999 (Stakes). Maternity clinics have recently confronted major structural and contentual changes. Relevant is the increase of the average age of parturients, morbidity, substance abuse and mental health problems, and multiculturalism. Inconsistencies in organizing services put customers in unequal positions. There is a new expert group set up by the Health and Welfare department, which aim is that the new recommendations for maternity care will be completed and established in 2013.

Contents

Health inspection at maternity clinic includes maternal and fetal health examination. In an extensive health inspection more attention is paid to the well being of the whole family. Families which are expecting their first baby will receive an oral health status canvas. The extensive health inspection also includes discussion about the upcoming baby, the expectations and possible fears for the changing family structure as well as family's social relationships and resources. Clarifying the family's well being is based on parents description of the family situation, their needs, resources and concerns. To sort out the family's living conditions, parents' health and well being, relationship and parenting, there are nationally recommended structured questionnaires. For example the role map of relationship and parenting, family's resources and early interaction forms. The aim of the interview is to support parents' interaction and early interaction.

Table 6. Hämeenlinna's plan for the content of the maternity clinic visits.

Visit	Examinations	Content of the visit
The first contact	The client makes an appointment	Public health nurse asks for client's diseases, medications, previous pregnancies and deliveries and use of intoxicants. The mother to be is reminded of the importance of additional folic acid.
PHN 8-10 weeks	Samples taken in early pregnancy. Measuring the weight, blood pressure, hemoglobin, external examination and glucose tolerance test.	Discussion about lifestyle; smoking, substance abuse screening for the parents, nutrition, exercise, dental care, drugs, vitamin D, Fathers role during the pregnancy and attendance to the visits, sexual health, and prenatal screenings.
12-13 weeks	Early pregnancy screenings at hospital's maternity clinic.	
Doctor 11-12 weeks	Gynecological examination and foetus heart rates.	Doctor will discuss about basic illnesses, medication and the laboratory results.
PHN 16 weeks	Examining the proteins and glucose of the urine. Measuring weight and blood pressure. External examination and foetus heart rate.	Discussion about family, relatives, friends and support. Sexuality during pregnancy. Understanding of the pregnancy and commitment to it. Foetal movements. Relationship.
20-21 weeks	Physical structures of the foetus by ultrasound et the hospital's maternity clinic.	

Visit	Examinations	Content of the visit
PHN 22-23 weeks (extensive health inspection)	Hemoglobin, protein and glucose of the urine. Measuring the weight and the blood pressure. External examination. Symphysis Fundus-measure (SF). Foetal movements and heart rates. Glucose tolerance test, if necessary.	Attention is paid to the whole family wellbeing. The family who is expecting their first baby, will receive an examination of dental care. The parents will be directed to dental care, if it is necessary. Discussion about foetal movements and the signs of a premature labor.
PHN Doctor 27 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and hemoglobin. Rh-control.	Instructions to count the foetal movements for the risk group. Gynecological examination by doctor.
PHN 30 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Foetal movements and heart rates.	Discussion about itching and hepatogestose. Fear for the delivery and referral to the hospital's maternity clinic, if necessary.
PHN 32-34 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Foetal movements and heart rates.	Discussion about breast and breastfeeding, sleep, delivery, upcoming baby and new situation in family. Counting the movements of the foetus.
PHN Doctor 35-36 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. Foetal movements and heart rates.	
PHN 37-39 weeks (once week) a	Protein and glucose of the urine. Measuring weight, blood pressure and SF. External examination. Swelling. Foetal movements, presentation and heart rates.	Discussion about mood and fatigue. Family situation. Smoking, use of intoxicants and their affect on the baby. Beginning of the delivery and going to the hospital.
PHN 40-41 weeks	Protein and glucose of the urine. Measuring weight, blood pressure and SF. Hemoglobin if necessary. External examination. Foetal movements, presentation and heart rates. Swelling.	Overtime and making the appointment to the hospitals maternity clinic weeks 41+5.
PHN	Overall checkout of the	Discussion about delivery,

Home visit after delivery	baby; skin, bellybutton, mouth, eyes, color, fontanelles, reflexes. Mother's examination; general welfare, breasts, breastfeeding, episiotomy, womb, bleeding, early interaction with the baby.	mood, nutrition and rest. Possible concerns or troubles in breastfeeding, taking care of the breasts, going outdoors, family situation and childcare.
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4 VISITS AT A CHILD WELFARE CLINICS

Periodic inspections relate to the basic function of child welfare clinics. Monitoring and supporting the child's physical, mental and social growth and development allows recognizing any abnormalities as early as possible in these inspections. Reasonably the whole family should be taken into account during the health inspection. Supporting parenting and early interaction becomes possible within regular contacts. Child welfare clinics are given recommended implementations about periodic inspections, but the execution should be customer-oriented.

Health inspections

Within health inspection it is essential to strengthen child and family welfare, their recourses and parent ability to function for the family. With all families their situation in life and habits concerning health, for example diet, exercise, substance abuse, time spend together and shared joy producing things should be discussed. It is important to discuss any problems related to the situation in life, for example partner and immediate family violence, substance abuse and mental health problems, housing and livelihood problems. Children and their guardians are given feedback about their skills and resources in the particular situation in life, special attention is paid to resources of parenting and supporting parents in their educational tasks. Parents should be clearly informed what a child needs from her or his parents to develop and feel well.

Table 7. Hämeenlinna's plan for the content of the child welfare clinic visits.

Age	Nutrition	Examinations	Content of the visit
1-4 weeks PHN	Vitamin D drops. Breast milk or formula.	General impression. Weight. Head. Senses. Skin, navel. Reflexes. Atmosphere.	Early interaction Family's resources Social relations Breastfeeding Skin care Outdoor activities Home environment Safety Smoking and drugs in the family. (BCG reaction)
6-8 weeks	Breast milk or	The baby's	Psycho-social resources of

Age	Nutrition	Examinations	Content of the visit
PHN Doctor	formula	growth, general impression and medical examination. The mother's haemoglobin, urinary protein and glucose, blood pressure, weight and gynaecological examination.	the family, monitoring and support. The vaccination program Mood. Contraception. Baby care and mother's ability to cope. Breastfeeding. Intoxicants.
3 months PHN	Breast milk or formula	Growth. Development. General impression. Interaction.	Family's resources. Nutrition, breast-feeding. Introducing infants on formula to solid foods
4 months PHN Doctor	Breast milk or formula	Growth. Neurological general impression. Interaction. Medical examination.	Family's resources and concerns. Nutritional information. Wellbeing assessment of the whole family.
5 months PHN	Breast milk or formula Fruit, berry and vegetable purees (if necessary)	Growth. Development. General impression. Interaction.	Stimuli for the baby's psycho-social and motor development. The atmosphere of the family. Nutritional information. Baby's sleep. Applying for day-care.
6 months PHN	Breast milk or formula Solid food + meat, chicken, fish, porridge, gruel. Finger food. Mug.	Growth. Development (movement, reflexes) General impression. Interaction. Vision. Hearing.	The atmosphere of the family. Smoking and the use of intoxicants in the family. Safety Nutritional information.
8 months PHN Doctor	Breast milk or formula. Coarseness and amount of solid food is increased. Two meat meals a day.	Growth. General impression. Hearing. Medical examination.	Stimuli and support of the baby's psycho-social and motor development. Family's resources and atmosphere. If necessary, the child's day-care arrangements and what happens if the child becomes ill. Reminder of vitamin D drops.

Age	Nutrition	Examinations	Content of the visit
10 months PHN	Encouragement to independent initiative. Tasting of low-fat, sour milk products.	Growth. Development. General impression. Interaction.	Supporting the psychosocial development. Books. Toys. Songs. Games. Shoes. Nutritional information.

Age	Nutrition	Examinations	Content of the visit
1 year PHN	Feeding of a toddler (salt, sugar, fat). Breastfeeding. Low fat milk products.	Growth. Development. Hearing. Development of speech. Interaction. Hemoglobine.	Supporting psycho-social and motor development. Independent initiative. Outdoor activities. Family's atmosphere. Nutritional information. Toilet training. The word "no", boundaries.
1 year 3 months PHN		Growth. Development. Speaking.	Assessing the family's wellbeing. Audit. Violence.
1 year 6 months PHN Doctor	Feeding of a toddler. Bottles. Dummies.	Growth. Development. General impression. Interaction. Medical examination.	Family's resources and concerns. Encouragement to independent initiative. Assessing the whole family's wellbeing.
2 years PHN	Independent initiative. Bottles and dummies away.	Growth. Development. Speaking. Interaction. Appointment for dental care.	Supporting psycho-social and motor development. The daily rhythm. Obstinate age and boundaries. Toilet training. Family's atmosphere. Time spent with entertainment media.
3 years PHN	Nutritional habits of the family.	Growth. Development. Feedback from day-care.	Family's atmosphere and resources. Independence. Day-care. Obstinate age. Smoking and the use of intoxicants in the family. Safe environment.
4 years PHN Doctor	Nutritional habits of the family.	Growth. Development. Feedback from day-care. Blood pressure. Vision. Hearing. Medical examination.	Assessing the whole family's well-being. Child's health. Family's healthy habits. Obstinate age Family's atmosphere. Club activities. Playmates. Safe environment. Time spent with entertainment media.

Age	Nutrition	Examinations	Content of the visit
5 years PHN	Nutritional habits of the family.	Growth. Development.	Psycho-social development and support. Family's atmosphere. Importance of friends. Games, play. Independence. Pre-school. Safe environment. Nutritional information. Bed-wetting. Time spent with entertainment media.
6 years PHN	Nutritional habits of the family.	Growth. Development.	Independence. Pre-school. Smoking and substance abuse in the family. Readiness for school. Safe environment. Nutritional information. Time spent with entertainment media.

4.1 Vaccination program

In Finland children and young people have a good opportunity to receive vaccinations against eleven different disease, their complications and long-term problems. The vaccination program is presented in the subsequent table. The coverage of the vaccination in the program is excellent in Finland. Families who refuse to take vaccinations are very rare.

Vaccination is one of the most important, cheapest and most successful tools for health promotion. For instance Smallpox has been eradicated worldwide by vaccination. In Finland diseases such as measles, mumps and rubella have been eliminated by vaccinations. Nevertheless the vaccinations should be continued according to the recommendations, because it is possible for non-vaccinated person to catch the diseases from abroad.



Finnish well-functioning child welfare clinic system and its employees, especially public health nurses and child welfare clinic doctors, have by their professional work together with citizens contributed to the vaccination coverage to remain high. It is a great privilege that the society offers the vaccinations at the local child welfare clinics. The vaccinations included in the general vaccination program are voluntary and free of charge.

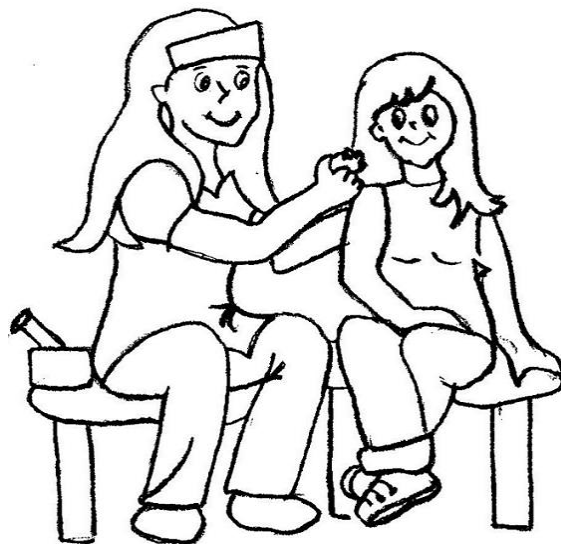
Finnish vaccination program offers vaccination protection for the following immigrants; asylum-seeking children and pregnant women, the quota

refugees, asylum-received, adopted children and other people who have moved permanently to Finland. If the information about the vaccinations given in the previous home country is missing, the immunization should be built from the beginning as if the person has not received any vaccinations. An unvaccinated child should be vaccinated with an accelerated schedule.

A baby's parents will receive a child welfare clinic card, which contains information on given vaccinations. The card is brought to the child welfare clinic with the child. The card will be completed after the vaccination. The child welfare clinic card is replaced with a health card, which contains all the received vaccinations.

Vaccinating

Vaccinating means administering a pathogenic microorganism or part of it in to the body in such a form that it provides a protection to the body. The



question is about the active immunity that arises against the disease. The protection is achieved without the dangerous or harmful symptoms of the disease. Infants will receive the vaccination injection usually on the outer side of the thigh. To a preschooler the vaccination is injected in to the arm. The needle is injected subcutaneously or intramuscularly after which the vaccine is injected slowly. Some vaccinations are taken orally.

Contraindications and side effects

The general rule is that the vaccination should be postponed if the child has a fever. If the child has a cold but no fever, a child can be vaccinated. In special cases, such as the child having previously had some side effects from vaccinations, it should be discussed with the doctor.

Some children may receive some kind of side effects from the vaccinations. For example local reaction occurs at the injection site as swelling, warmth, erythema and tenderness. The reaction disappears within two to three days. When vaccinating with the live diluted virus, for instance measles, mumps or rubella, the child can get a mild form of the disease, which he or she has been vaccinated against. However, much more moderate than if the child would have the disease in its natural form.

A child may get an allergic reaction after vaccination, for example nettle rash. Nettle rash is an intensively itchy rash that spreads throughout the

body and disappears again in a short time. Nettle rash occurs immediately after the vaccination. All vaccinations can cause a fever.

At-risk groups

In addition, children who belong to the risk-group are entitled to receive additional vaccinations. Vaccination against tuberculosis should be offered only to those children who have the increased risk for tuberculosis. Children whose health is under substantial threat by influenza, are given each year before the beginning of the epidemic season, seasonal influenza vaccination. Children under 5 years of age who belong to certain medical risk groups can receive pneumococcal vaccines. Pneumococcal vaccine has been part of the vaccination program since 2010. Every child from Åland and over three years old has the right to receive the tick-born encephalitis vaccination. The child who has an increased risk of acquiring hepatitis A or hepatitis B infection, because of living conditions, will be given hepatitis vaccinations according to the National Institute for Health and Welfare modifier. (THL 2013.)

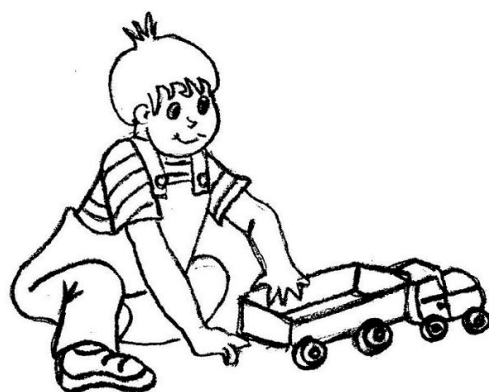
Table 8. THL, 2013. Vaccination of children and young people.

Age	The disease which the vaccine protects	Vaccine
2 months	Diarrhea by Rotavirus	Rotavirus RV (Oral)
3 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
3 months	Diarrhea by Rotavirus	Rotavirus RV (Oral)
3 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib
5 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
5 months	Diarrhea by Rotavirus	Rotavirus RV (Oral)
5 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib
12 months	Meningitis, pneumonia, sepsis and ear infection	Pneumococcal conjugate PCV
12 months	Diphtheria, tetanus, pertussis, polio and haemophilus influenza diseases, such as meningitis, inflammation of the epiglottis and sepsis.	Combination vaccine DTaP-IPV-Hib
12	Measles, mumps and rubella.	MPR

months		
6-35 months	Seasonal influenza (annual)	Seasonal influenza
4 years	Diphtheria, tetanus, pertussis and polio.	DTaP-IPV
6 years	Measles, mumps and rubella.	MPR
14-15 years	Diphtheria, tetanus and pertussis.	dtap

5 NUTRITION

Children and their families' eating habits are observed and estimated at the child welfare clinic. Especially it is important to clarify eating habits during the changing stages of life. Infant and toddlers nutritional education depends on the age and phase of development. A child's eating habits and



needs for food evolve step by step with age and accumulating skills. Children have different kinds of temperaments and developing paces, this can be seen in differences in the eating process. The positive interaction between the child and their parents makes the eating situation pleasant and enables the support for the child according to the development pace he or she is in.

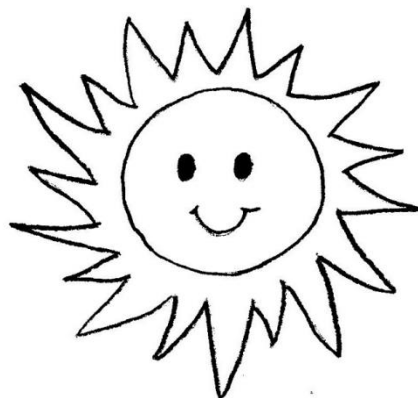
Active basic metabolism and rapid growth affects a child's nutritional needs. The growth is most intense during the child's first year and then decelerates. Children's need for all nutrients related to body weight is high in comparison with adults. The assessment of an infant's nutritional needs is based on the composition of the breast milk. It has the best contents to satisfy the child's need for energy and various nutrients. Breastfed babies' growth and development is considered optimal. Children's need of energy varies. There are factors that affect the need of energy, for example the child's gender, height, weight, growth rate and physical activity. A child's energy requirements can vary between the days.

A healthy, regular and balanced diet is important for the growing child. Nutritional habits are learned at an early age. Parent's and the whole family's food choices and eating habits affect the small child. In addition to what the child eats, it is also important to pay attention to the way he or she eats. Healthy habits and lifestyle are also the foundation of the adult's health and wellness.



Full breastfeeding is recommended to be continued until the age of six months. At the age of four to six months the baby begins to be developmentally ready to eat solid food. Exercises with spoon and getting used to the mashed food can start by getting accustomed with small taste samples, according to individual needs. First tastings are usually vegetables as potatoes, carrots, cauliflower or sweet potato, fruits or berries in fine puree. Initially a teaspoon is enough and the dose may be increased gradually. Gruels that contain vegetables, rice and maize accustom the baby to new tastes. Different kinds of food are introduced one by one, and the diet is expanded slowly with one to two new foodstuffs in a week.

5.1 Vitamin D



Additional vitamin D is essential element in the baby's and child's nutrition, especially in Finnish low-sunny climate. Vitamin D is required especially in the formation of bones and teeth, as well as calcium and phosphorus metabolism. Without vitamin D, calcium is not properly absorbed by the body and the normal development, growth and maintenance of bones are prevented. Vitamin D is the basic regulation mechanism of the body's every tissue. It affects on the dynamism of the cell division and cell differentiation. Vitamin D contributes to the development of tissues to their own purpose.

Recommendations

Age	Daily intake throughout the year
From 2 weeks to 2 years	10 µg (400 IU)
From the age of 2 years	7,5 µg (300 IU)

5.2 Breast feeding

Healthy, full-term and normal weight newborns, receive enough nutrition, even from a small amount of breast milk. Especially the first few days the milk consists of colostrum. Colostrum, which has also been called “super milk”, includes a very high content of antibodies, which protects the baby from the pathogens surrounding the baby and his or her mother. It also helps the meconium to leave the baby’s intestines. The composition of the colostrum is thick and sometimes slightly yellowish in color. It includes a lot of protein, but less fat and lactose than normal skimmed milk.

Approximately two weeks after birth mothers breast will begin to produce milk, which energy, protein, salt and mineral quantity are equalized. The baby receives enough fluids, because the water content of breast milk is approximately 87%. The carbohydrates of breast milk contribute to the infant's intestinal immune defense. Baby receives energy from the fats the breast milk includes; they are also involved in the central nervous systems normal growth and development. Breast milk proteins are in highly absorbed form, as well as the minerals and trace elements.

Breast milk has a number of immunological functions, such as to protect the child's mucous membranes from microbes and therefore infections. Particularly the level of antibody is high in breast milk. Breast milk protein is able to kill bacteria, viruses and yeast. It also has the ability to bind the available iron in the intestines, and therefore prevent harmful bacterial growth. The carbohydrates affect on the composition of the intestinal bacterial flora and prevent microbes binding to the mucous membranes by attaching to the receptors they are using. Proteins in breast milk strengthen the effects of vaccinations. Breast milk also contains various growth factors, which supports the maturation of the child's body.



A breastfed baby controls their energy intake via physiological sensations. During infancy, the child searches for their own way to grow. Individual growth monitoring, parent's observations and child's satisfaction as well as wellbeing helps with the assessment of the situation. If there are several or major changes and exceptions in the growth chart, it is always time to intervene.

5.3 Formulas

Formulas are prepared from cow's milk and its various components to suit the infant. Lactose, vegetable oil and vitamins are added and the formula is completed with missing minerals and other necessary nutrients. Formulas, like breast milk, contain less protein compared to cow's milk and therefore cow's milk, organic non-homogenized milk included, is not recommended for infants. Soy-based infants' products purchased from the pharmacy have nutritional traits of the same kind as formulas. All the formulas are quite similar to each other. The manufacturing and marketing of formulas is strictly regulated.

Like in breastfeeding, the proximity of the child and the feeder as well as eye and skin contact are equally important when bottle-feeding. Right position when feeding reduces problems. The child must be in a semi-upright position, in the arms of the feeder. When the child's auditory tube is above the stomach, milk does not flow into the auditory tube via the throat. It is also important that the holes of the pacifier are adequately small so the milk flows freely one drop at a time. Too swift flow of milk can easily cause intestinal gas and rumination.



Picture 2. Example of a formula. (www.valio.fi)

Bottle-feeding is recommended to follow the child's desired feeding rhythm. Feeding stops when the child stops sucking. The prepared formula is to be used immediately and not stored or reheated later. If the child has digestive problems, it is advisable to check suitability of the formula, hygiene and also the preparation of the formula and the way of feeding.



Picture 3. Example of a formula. (www.nestlebaby.com)

Table 9. The indicative amounts of formula.

Age of the child (in months)	Quantity of formula (ml/day)
0-1	500-600
1-2	600-800
2-3	700-1000
3-5	700-1200
5-6	700-1000 (including gruels)
6-8	600-800 (including gruels)
8-10	600 (including gruels)
10-12	600 (including gruels)

The baby's feeding equipment needs to be sterilized before each use. After the feeding, the child's bottles and teats are rinsed immediately in cold water, washed with dishwashing liquids and rinsed well. Washed bottles are boiled in water for five minutes and teats are dipped into boiling water. The teats and bottles need to be checked regularly for any damage. If the bottles are not being used immediately, they should be put together with the teat and lid in place to prevent the inside of the sterilized bottle from being contaminated, along with the inside and outside of the teat.

5.4 Solid foods

Weaning on to solid foods should start when the baby is around six months old. Six-month-old children often learn to feed themselves quickly and with less mess as they will be able to swallow properly. Introducing the baby to solid foods is a really important step in the baby's development and can be great fun to explore new flavour and textures together. In the beginning it's more important getting the child used to the idea of eating rather than how much the baby takes.

At the age of six months the child is still getting most of their nutrition from breast milk or formula. Gradually the amount and variety of food the baby eats increases. Eventually the baby will eat the same as the rest of the family but in smaller portions. The slow introduction to solid foods gives the baby's digestive system time to develop to cope with the solid foods.



Picture 4. Example of a fruit puree for babies above the age of 8 months. (www.nestlebaby.com)

There are three signs to indicate that your baby is ready for solid foods alongside breast milk or formula.

1. The child can stay in a sitting position and hold their head steady.
2. The child can co-ordinate their eyes, hands and mouth so that they can look at the food, pick it up and put it in their mouth all by themselves.
3. The child is able to swallow food. Babies who are not ready will most likely push their food back out.



Chewing fists, waking up in the night when they have previously slept through and wanting extra milk feeds are normal behaviour and not necessarily a sign of hunger or a sign for a baby to be ready for solid foods. It is very rare for these three signs to appear together before the child is six months old but all children are individuals.

Picture 5. Example of gruel. (www.valio.fi)

It is important that someone stays with the baby when they are eating in case they start to choke. The baby should be allowed to enjoy touching and holding the food. The child shouldn't be forced. The transition can start with just a few pieces or teaspoons of food a day. Hot foods need to be cooled and tested before given to the baby. No additional salt, sugar or stock cubes are needed to the baby's food or cooking water. The public health nurse will give instructions with what types of food the baby should begin.



Picture 6. Examples of baby food purees. (piltpiiri.fi)

6 KELA BENEFITS

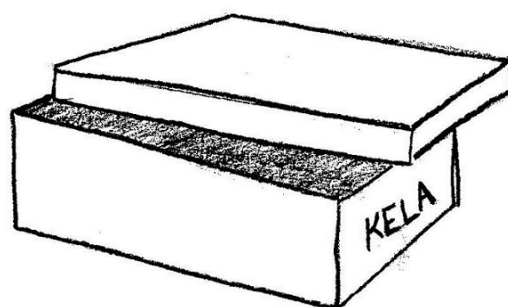
Families are entitled to various benefits from Finnish social insurance institution, Kela. The parents must have lived in Finland for at least 180 days immediately before the baby's expected date of delivery to qualify for parental allowances. The parents must also be covered by the Finnish social security system. The insurance period can also include insurance period from another EU or EEA country, Israel or Switzerland.

When the pregnancy has lasted at least 154 days (about 5 months), the mother will receive a pregnancy certificate during her visit at the maternity clinic. The mother has to find out whether her employer will pay wages during her leave. The payment of wages is often based on the collective agreement. The mother will need this information when applying for allowances from Kela. After receiving the pregnancy certificate she can apply for maternity allowance, maternity grant, parental allowance and child benefit from Kela.

Table 10. Benefits which Kela grants.

Benefit	
Maternity grant	Maternity package or cash benefit.
Maternity allowance and special maternity allowance.	Until the child is about 3 months old.
Paternity allowance	After the child is born.
Parental allowance	For the mother or the father. When the child is about 3 to 9 months old.
Child benefit	
Child home care allowance	For a child under 3 years of age and not in municipal day care.
Private day care allowance	For a child under school age and not in municipal day care.
Child maintenance allowance	For a child under 18 years of age.
Various benefits	When the child becomes ill.

The mother notifies her employer of the forthcoming family leave when applying for allowances from Kela or at least 2 months before starting the leave. She needs to find out whether she can give the notification informally or if it needs to be in writing.



Mothers can decide whether they want to start their maternity leave 50 working days before the estimated day of delivery or at a later date. The maternity leave must start at least 30 working days before the estimated date of delivery. If the mother's work is potentially dangerous to her or the baby's health, she may be able to start her maternity leave earlier and receive special maternity allowance.

In the case of a multiple pregnancy, the parental allowance period will be longer than normal. The maternity grant will also be multiplied. If the older child is under 3 years old on the day of the baby's estimated date of delivery, the mother may qualify for parental allowance on the basis of the same income as her older child.

Paternity leave will not begin until after the baby is born but the father has to notify his employer of the leave at least 2 months in advance. If the father takes his leave in shorter period and the total leave is 12 days or less, it is sufficient to give 1 month's notice. Fathers need to negotiate with their employers when they will take their paternity leave and whether they will take it in shorter periods or all at once. It should also be agreed with the employer on what to do in case of premature or overdue birth. The easiest way to apply for the paternity leave allowances is after the baby is born.

7 USEFUL WEBSITES

Hämeenlinna's website of the city's health care services:
<http://www.hameenlinna.fi/english/Services/Health-care/>

The website of Finnish immigration service:
<http://www.migri.fi>

The pages of Infopankki contain a variety of information for immigrants in multiple languages on the functioning society:
http://www.infopankki.fi/en-GB/When_You_Are_Pregnant/

Suomi.fi's portal containing e-services, forms, information links and packages, legislation and news from public administration:
<http://www.suomi.fi/suomifi/english/>

Finnish social insurance institution, Kela's website for benefits for families with children:
<http://www.kela.fi/web/en/families>

The website of Ministry of Social Affairs and Health on primary health care in Finland:
http://www.stm.fi/en/social_and_health_services/health_services/primary_healthcare

National Institute for Health and Welfare: Prenatal screening – A guide for expectant parents:
<http://www.thl.fi/thl-client/pdfs/09e1e398-a191-49fe-aa9e-e85eb01b0bc5>

**MATERNITY AND CHILD WELFARE CLINICS IN
HÄMEENLINNA**

Presenting the support material



University of Applied Sciences Development Project

Degree Programme in Nursing

HAMK, Lahdensivu

Spring 2013

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Maria Raunio

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Appendix 1 PowerPoint presentation

1 INTRODUCTION

The thesis process involves the actual thesis in addition to the public health nursing development project. There are several ways to implement the development project. The thesis is meant to develop and benefit the practical working life. Development project is intended to expand the thesis topic in terms of health promotion and development of the health care profession. (Hämeen Ammattikorkeakoulu 2012.)

The Finnish law states in the act on the status and right of patients (1992/785) that a patient has the right to receive information on their state of health in a language they can understand. If there is no mutual language, the health care professional has to try to organise an interpreting service. The patient must be fully aware of their health, treatment and the effects.

The public health nurses in maternity and child welfare clinics in Hämeenlinna area have a large variety of guidance material in Finnish. To make using those materials with English-speaking clients simpler, the material should be in English. The clients don't necessarily always speak Finnish or English as their mother tongue that is why this folder can also be used as tool to communicate through the interpreter. It is essential nowadays that public health nurses have skills and knowledge to face clients from different kinds of cultural background. (Oras, I. & Raunio, M. 2013.)

The aim of this development project was to present the folder created as a part of our thesis "Maternity and child welfare clinics in Hämeenlinna – Support material for English-speaking clients" (Oras & Raunio, 2013) to the local public health nurses. The presentation took place in a public health nurses' weekly meeting. The public health nurses present all worked in maternity and child welfare clinics in Hämeenlinna area. The aim was to present the folder with the help of a PowerPoint presentation and to provoke conversation on the position of foreign clients in maternity and child welfare clinics.

Ideas for the folder's content came from a local public health nurse working in a maternity and child welfare clinic. The folder includes Hämeenlinna's plan of visits at the maternity and child welfare clinics, Finnish vaccination programme, nutritional advice for children and Finnish Social Insurance Institution's (Kela) benefits for families. The folder is necessary in the modern Finnish society as the numbers of foreign people moving to Finland will increase. It is essential that the public health nurse has the appropriate tools to work with the foreign clients. (Oras & Raunio, 2013.)

When compiling the folder, practicality was taken into account. Since this type of folder was first of its kind in Hämeenlinna, a wide variety of topics were covered but not so much in depth. Many of the things mentioned in the support material could be discussed more thoroughly. In future, it is therefore possible to make more detailed, support materials in English. (Oras & Raunio, 2013.)

2 MULTICULTURAL PUBLIC HEALTH NURSING

Public health nurse should be able to work in a changing society and different kind of cultural environments, such as ethnical groups, youth cultures and immigrants. In this work public health nurse should use area and population orientated working methods. The public health nurse has the abilities to implement multicultural health care and she or he is to become familiar with international work of public health nurses. (Suomen terveydenhoitajaliitto 2008.)

Public health nurse should know the essential multicultural and international things of health promotion. Public health nurse should also understand the meaning of internationality in health promotion and maintenance. She or he is able to put different kind of health care actions and working methods in to practice in multicultural situations. Public health nurse analyzes the effects of multicultural factories into the public health nursing. She or he is able to develop the work of public health nursing as multiculturally required. (Suomen terveydenhoitajaliitto 2008.)

Different models try to explain the development of cultural competence. The models also direct the implementation of multicultural nursing. (Wellman 2009.) One of these models is Campinha-Bacote's process of cultural competence which has five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire (Transcultural C.A.R.E. 2012).

One of the best-known multicultural nursing models is Josepha Campinha Bacote's model of cultural competence which reflects the nurses' cultural knowledge of the acquisition process and the actual use of the knowledge gained. Campinha-Bacote (2012) urges nursing professionals to ask themselves the following five questions to make contact with multicultural nursing:

- Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other "isms" in healthcare?
- Do I have the skill of conducting a cultural assessment in a sensitive manner?
- Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of biocultural ecology?
- Do I seek out face-to-face and other types of interactions with individuals who are different from myself?
- Do I really "want to" become culturally competent?

The model has been modified several times since its initial development in 1991. The previous version was described in 2002 as a volcano where the starting point was the health care professional's desire to achieve cultural competence. In that version of the model the desire began the process of cultural competence, which eventually leads to the possibility of using the acquired information in planning the customer care, implementation and evaluation. Campinha-Bacote's model changed in 2010 so that all begins and ends with the seeking and experiencing of many cultural encounters. Only through continuous cultural encounters a health care professional acquires cultural awareness, cultural knowledge, cultural skill and cultural desire. From this perspective, cultural competence can be viewed as an on-going journey of un-remitting cultural encounters. (Campinha-Bacote 2012.)

The model, though originally made for nurses, is comparable to the field of public health as well. Public health nurses in Hämeenlinna nowadays frequently have multicultural encounters. The theory is a base for the cultural competence of the public health nurses. Each professional can use the model their own way. The five questions listed above are examples how to assess personal attitude towards the multicultural side of the work.

3 A GOOD PRESENTATION

A good presentation begins with good planning. PowerPoint can help making the presentation clearer but it needs to be clarified beforehand what kind of facilities are available. It is also important to know in time what is required of the presentation. Time limits need to be obeyed and the key message has to be clear. Thorough preparation helps the presenter feel more confident and thus the presentation sound more reliable. (Darlington 2012.)

During the presentation the presenter must avoid looking at the screen behind them but face the audience at all times. The presenter can use a computer screen in front of them or printed notes to keep track with what the viewers are seeing on the screen. It is a common mistake to prepare too much material and then run out of time. Short presentation allows more time for questions. (Darlington 2012.)

Event organiser should get the presentation beforehand. The organisers can give their own opinion on the presentation, if it looks fine and if the slideshow runs smoothly. That way the presenter doesn't need to worry about technological failures. It also enables the event's organiser to copy the slides if necessary so that they are available to the audience in good time. The copies can be handed out at the beginning or at the end of the presentation. In a case of a large crowd, the ones in the back might not be able to see the screen clearly and would probably appreciate having copies of the slides. The presenter can plan beforehand what kind of copies they want to give to the audience. (Darlington 2012.)

3.1 A good PowerPoint presentation

Firstly it is very important to grab the viewers' attention. This is done by not fitting as much as possible on the screen. The presenter should use the space on the slides effectively. Only elements that contribute to the wanted points should be included in the presentation. A well-chosen chart or diagram, even simple graphics which serve the purpose and benefit the idea make a much stronger point than plain text. (Krieger 2012.)

Themes in Microsoft Office PowerPoint 2007 or 2010 help to create a right look for the presentation. When choosing a theme in Microsoft Office PowerPoint, a coordinated set of fonts, colours and graphic effects is applied to all slides of the presentation. The use of video or audio may convey the message more effectively. Dynamic content, such as a brief video illustrating an important point, is a great way to engage the audience. Audio effects, like a recorded narration, can also help keep the slides cleaner and more approachable. (Krieger 2012.)

Animations and transitions are to be used wisely. Text and graphics appearing on the screen could be a nice touch but overdone animations can detract the viewers from the presentations content. It is advisable to limit the animations to key points and use consistent animation choices throughout the presentation. Consistent transitions can also provide a professional touch and help prevent distractions. (Krieger 2012.)

Secondly it is of uttermost importance to communicate the information clearly. PowerPoint only provides a host of tools for keeping the slides consistent, precise, professional and clear. Outlining the presentation before creating the slides can save time and help give a more clear and effective presentation. (Krieger 2012.) A certain phrase or a sentence could be used in the first slide or the last or even both, to support the key message (Darlington 2012).

If the presentation has been designed to be viewed on screen it doesn't necessarily work well on printed documents. For example, dark backgrounds look good on slides but rarely print well. Also, footer content which might be needed in print is likely to be a distraction on screen. Using notes pane below the slide in PowerPoint's normal view is an efficient way to make notes which the audience won't see. Printed notes for the viewers can help avoid overfilling the slides with text. (Krieger 2012.)

Thirdly and lastly the presenter must stay in control of the presentation at all times. A misaligned flowchart or a slideshow which crashes in the middle of the presentation will not make a good impression. One way to avoid this is to keep the file sizes manageable. The file easily becomes too large to edit or for the presentation to run smoothly. This problem can be solved by compressing the media in the files and by using PowerPoint's own features whenever possible instead of importing and embedding objects from other programs. The presenter must know exactly what the viewers will see. The slideshow therefore needs to be previewed before showing it to the targeted audience. (Krieger 2012.)

3.2 Our own presentation

The PowerPoint presentation was created following the guidelines above. We kept the slides as simple as possible. We picked out a theme and a font for the presentation which seemed clear and pleasant to both of us. Outside the slide show, we showed examples of the folder straight from the Word document. We did not use any pictures to make sure that the presentation would run smoothly even if the computer did not.

The presentation began by introducing ourselves. We aimed to make the folder more known among the public health nurses in Hämeenlinna area. We explained the reasons behind the folder, the criteria when choosing the topics and the ways how to use the folder. We sent the slides to the organiser beforehand just to make sure that they were acceptable. We didn't get any feedback. During the presentation we didn't give the public health nurses any hand-outs because they will have access to the entire thesis and the folder in electronic form right after the meeting.

The meeting was held at Hämeenlinna's Keskusneuvola, the central maternity and child welfare clinic. Eight participants were present. We were given 20 minutes for the presentation. We did not want the presentation itself to be too long and rather have time at the end to talk about the folder and the questions our work provoked. The feedback was asked through conversation and by using few key questions we had prepared beforehand. These questions were:

- Do you consider the folder's layout pleasant and the text readable?
- How do you reckon the folder will help your work when interacting with English-speaking clients?
- Is the content satisfactory?
- What would you have done differently?
- What are your own experiences when interacting with clients with whom you don't share a mutual language?

4 IMMIGRANT FAMILIES IN MATERNITY AND CHILD WELFARE CLINICS

The immigrant family experiences a big change in their lives. Families might be in a very different position for integration in to the society. In a great risk of social exclusion are families where parents have low education and language skills. They can easily be left unemployed or without other opportunities for participation in society. It is very important that the public health nurses and other professionals working with the immigrant family have familiarized themselves with the culture, so that they are able to provide appropriate support and assistance to the family. It is essential to discuss with the family about the things how immigration affects to the family life. It is also important to discuss about the family's culture and ask how things are done in their culture. The immigrant family is an expert in their own culture. (STM 2004:14.)

The language barrier should be taken into account when the public health nurse and the family don't have a mutual language. It is important to book an interpreter and enough time for the appointment. Even if the family's child spoke better Finnish or English, she or he should not be used as an interpreter. In some situations it might be advisable to book a female interpreter to a female client. For a woman it might be hard to talk about her gynaecological problems or tough situation in their family through male interpreter. The client has to be informed that the professional secrecy applies also to the interpreter. Appointments might take longer than normally and the family usually needs more information about several things, so additional visits to the maternity and child welfare clinic might be useful. (STM 2004:14.)

Many immigrant families come from countries which have different kind of attitude towards health care professionals. The trust between the client and the public health nurse builds up slowly. Home visits might help developing the trust. It is important to clarify how things are done in Finland and how Finnish maternity and child welfare clinics function. For example following the appointment times and cancelling the appointments in a case of obstacles can be strange for people coming from different kind of cultural background. They also should be explained why the preventive health care is free of charge in Finland. All in all there are several things that might be totally different in the immigrant family's culture, those things should be taken into consideration and should be discussed. (STM 2004:14.)

The folder is meant to function as a tool to help the public health nurse interact with their clients who understand English better than Finnish. As mentioned above, the public health nurse should be aware of cultural differences. She or he should be capable to explain the Finnish maternity and child welfare clinics as well as the Finnish health recommendation, because they are unique. The clients from different cultures may not be familiar with them. Pictures of the folder help to understand the matter under discussion easier. By using the folder the public health nurse can minimize the possibility of misunderstandings. (Oras & Raunio, 2013.)

5 CONCLUSIONS

The thesis and the folder were saved in an electronic format in the Intranet of the public health nurses of the maternity and child welfare clinics in Hämeenlinna area. The public health nurses have the right to modify, update and expand the folder freely but on a condition that the original writers are mentioned. We hope that the public health nurses find the folder beneficial and that the folder will be used.


So that the folder will be beneficial it should be introduced to the practical work at the maternity and child welfare clinic. This requires the activity from the public health nurses. Part of our presentation was to courage the public health nurses to use the folder bravely and without prejudice.

Writing the development project was both interesting and challenging. The most rewarding in the process has been noticing how our English nursing vocabulary has expanded. We have gathered extended knowledge about the unique Finnish maternity and child welfare system as well as meeting the clients from different cultures. It was important to improve our performing skills, which are essential in the profession of public health nurse. It has also been nice to cooperate with the local public health nurses. We have gained professional contacts we hope will be useful to us in the near future.

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Tarkoitus ja tavoite

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- Kansiota voidaan käyttää asiakastilanteissa

Tarkoitus ja tavoite

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