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EXPERIENCES OF MIDWIVES ON WORKING WITH IMMIGRANTS:

A literature review

Aira Muhiya

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JYVÄSKYLÄN AMMATTIKORKEAKOULU
JAMK UNIVERSITY OF APPLIED SCIENCES

JYVÄSKYLÄN AMMATTIKORKEAKOULU
JAMK UNIVERSITY OF APPLIED SCIENCES

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GARBRAH, William; SINIVUO, Riikka

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Abstract

The aim of the study was to find out what kinds of experiences midwives have on working with immigrants and their families The purpose of the study was to gain information on the midwives' encounters with multicultural families, in order to understand the challenges of transcultural nursing in midwifery. The study was also aiming to figure out how midwives feel about their clinical cultural competence.

The research method was literature review. The research data was obtained from different databases including CINAHL, Elsevier ScienceDirect, and through Google Scholar search engine. Manual data search also yielded one article for the study. Data search was limited to the years 2003-2013. Altogether eight studies were reviewed. Inductive content analysis was used to analyse the data.

The findings revealed that midwives perceive communication and language problems to be the most substantial barrier to providing quality care to immigrants and their families. Differences in cultural practices and beliefs cause difficulties when caring for immigrants. Midwives conveyed that they lack sufficient information on different cultural and religious practices and beliefs. Insufficient health knowledge and differing expectations of care of the immigrants were seen to add extra workload to the midwives' work. Midwives experienced the work with immigrants to be demanding, but also rewarding and satisfying. Midwives felt that they need to improve their clinical cultural competence.

Breaking down the barriers of communication requires good interpreter services and additional materials, such as brochures and leaflets, to be used when caring for immigrants. Education on the cultural practices and beliefs of at least the biggest immigrant groups is needed in order for the midwives to improve their cultural competence and give quality care to immigrants and their families.

Keywords
Midwives' experiences, immigrants, cultural competence

Miscellaneous

JYVÄSKYLÄN AMMATTIKORKEAKOULU
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Tiivistelmä

Opinnäytetyön tavoitteena oli selvittää millaisia kokemuksia kätilöillä on maahanmuuttajien ja heidän perheidensä kanssa työskentelystä. Tarkoituksena oli saada tietoa kätilöiden kohtaamisista monikulttuuristen perheiden kanssa, jotta voitaisiin ymmärtää transkulturaalisen kätilötyön haasteita. Tavoitteena oli myös saada selville kuinka kätilöt kokevat kliinisen kulttuurisen kompetenssinsa.

Tutkimusmenetelmänä oli kirjallisuuskatsaus. Alkuperäisaineisto saatiin CINAHL ja Elsevier ScienceDirect artikkelitietokannoista sekä Google Scholar hakupalvelun avulla. Myös manuaalinen tiedonhaku tuotti yhden artikkelin kirjallisuuskatsaukseen. Tiedonhaku rajattiin vuosiin 2003-2013. Yhteensä kahdeksan tutkimusta analysoitiin kirjallisuuskatsauksessa. Aineiston analysoinnissa käytettiin induktiivista sisällönanalyysia.

Tulosten perusteella kommunikaatio- ja kieliongelmat ovat huomattavin este laadukkaan hoidon tarjoamiselle maahanmuuttajille ja heidän perheilleen. Erot kulttuurisissa tavoissa ja uskomuksissa aiheuttavat vaikeuksia maahanmuuttajia hoidettaessa. Kätilöt totesivat, että heillä ei ole tarpeesi tietoa erilaisista kulttuurisista ja uskonnollisista tavoista ja uskomuksista. Maahanmuuttajien riittämättömän terveystiedon ja poikkeavien hoito-odotusten nähtiin lisäävän kätilöiden työtaakkaa. Kätilöt kokivat työskentelyn maahanmuuttajien kanssa olevan vaativaa, mutta myös palkitsevaa ja tyydyttävää. Kätilöt kokivat, että heidän täytyy parantaa kliinistä kulttuurista kompetenssiaan.

Kommunikaatiovaikeuksien ylittäminen vaatii hyviä tulkkipalveluita sekä lisämateriaaleja, kuten esitteitä ja lehtisiä, joita voidaan hyödyntää maahanmuuttajia hoidettaessa. Tarvitaan koulutusta kulttuurisista tavoista ja uskomuksista, ainakin suurimpien maahanmuuttajaryhmien osalta, jotta kätilö voivat parantaa kulttuurista kompetenssiaan ja tarjota laadukasta hoitoa maahanmuuttajille.

Avainsanat (asiasanat)
Kätilöiden kokemukset, maahanmuuttajat, kulttuurinen kompetenssi

Muut tiedot

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1. Introduction

Immigration has been a growing trend in Finland during the past two decades and the number of inhabitants with foreign origin has been increasing continuously (Statistics Finland 2012a; Tilastokeskus 2013). The growing rate of immigration can also be seen in the health care services as the clients and patients are coming from ever more several countries and are speaking increasingly many different languages. According to the ethical principles of health care, every individual should be treated and served fairly and equally as per the same principles. The good treatment and services include also taking into account the linguistic and religious or ethical backgrounds of the patients and clients. (ETENE 2012, 6.) These same commitments are provided for in the Act on the status and rights of patients (A 785/1992).

According to Statistics Finland (2012a) the share of people with foreign origin in Finland is highest among young adults of 25-34 year-olds. This is also the age group that has the highest fertility rate and thus is giving births the most (Statistic Finland 2012b). The immigrant women between 15-29 of age have more hospital treatment periods and policlinic admissions than the women of Finnish origin of the same age group. These treatment periods and policlinic admissions are related especially to pregnancy and giving birth. (Gissler, Malin & Matveinen 2006, 3.)

In Finland the overwhelming majority of children are born in hospital (THL 2011, 14). Thus maternity units of hospitals are places were the growing multiculturalism is encountered for sure (Seppänen 2008). Midwives and other nursing staff working in the maternity units are encountering and taking care of the emerging group of immigrant women and multicultural families. The aim of this study is to find out what kinds of experiences midwives have on working with immigrants and their families. The purpose is to gain information on the midwives' encounters with multicultural families in order to understand better the challenges of transcultural nursing in midwifery. The study is also aiming to figure out how midwives feel about their clinical cultural competence. The research method is literature review and research data consists of studies done between the years 2003 and 2013.

2. Immigrants in Finland

According to Statistics Finland (2012a) there were 257 248 persons of foreign origin living in Finland at the end of 2011, which represents 4.8 per cent of the population of Finland. In 2003 the corresponding figures were 137 674 persons of foreign origin representing 2,6 % of the population. The origin and background country are determined based on the country of birth data of the person's parents. 30 420 persons, out of which 22 750 were citizens of foreign countries, immigrated to Finland in 2012 and this is the highest number of immigrants during Finland’s independence (Tilastokeskus 2013).

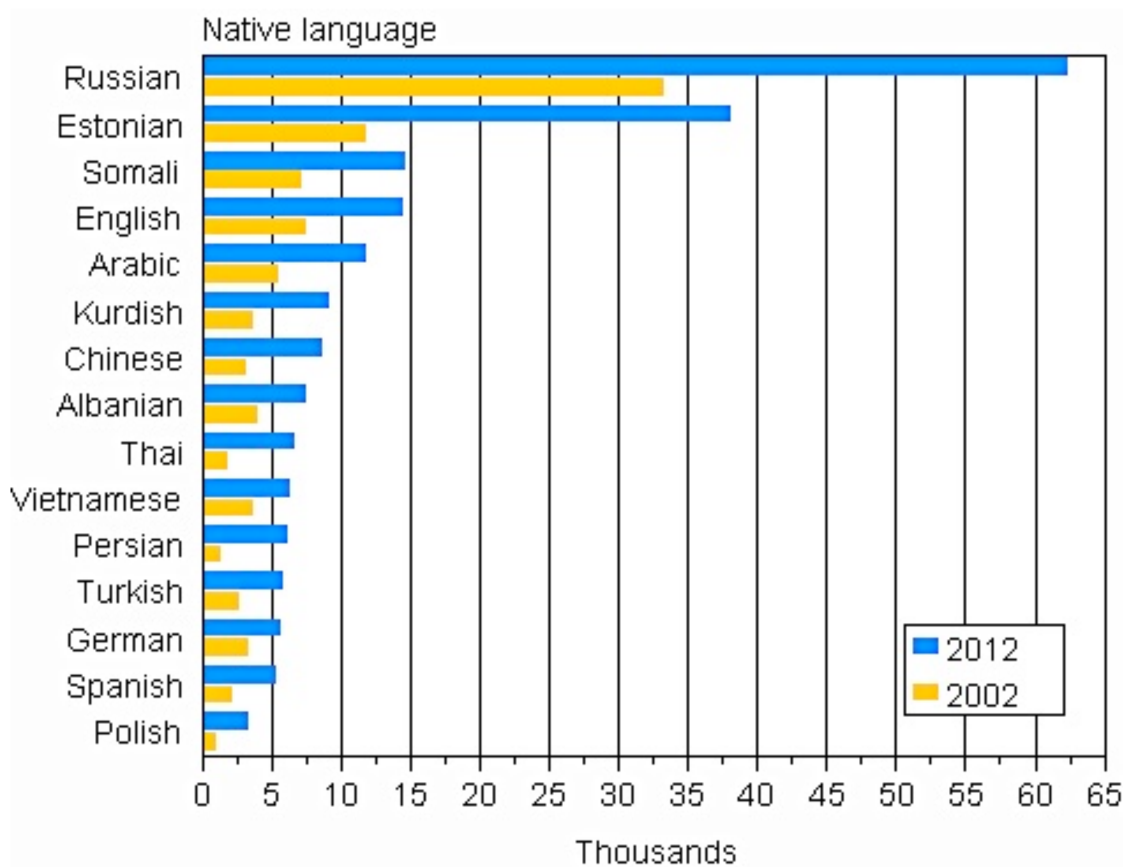

FIGURE 1. The largest groups by native language in 2002 and 2012 (Statistics Finland 2013).

At the end of 2012 there were 266 949 persons in Finland whose mother tongue was something else than Finnish or Swedish. This number represents 4,9 per cent of Finland’s population. The biggest language groups were

Russian, Estonian, Somali, English and Arabic (Figure 1). (Statistics Finland 2013.) Respectively in 2003 there were 124 817 people speaking something else than Finnish or Swedish as their mother tongue and this was 2,4 % of the whole population (Statistics Finland 2012a).

Most of the immigrants are coming to Finland from the neighbouring states. 59 per cent of all persons with foreign origin were of European origin. The second largest group were people of Asian origin, whose share was 23 per cent, and the third largest were people of African origin, 12 per cent. The figure 2 represents the largest groups of foreign origin among the Finnish population by the background country. (Statistics Finland 2012a).

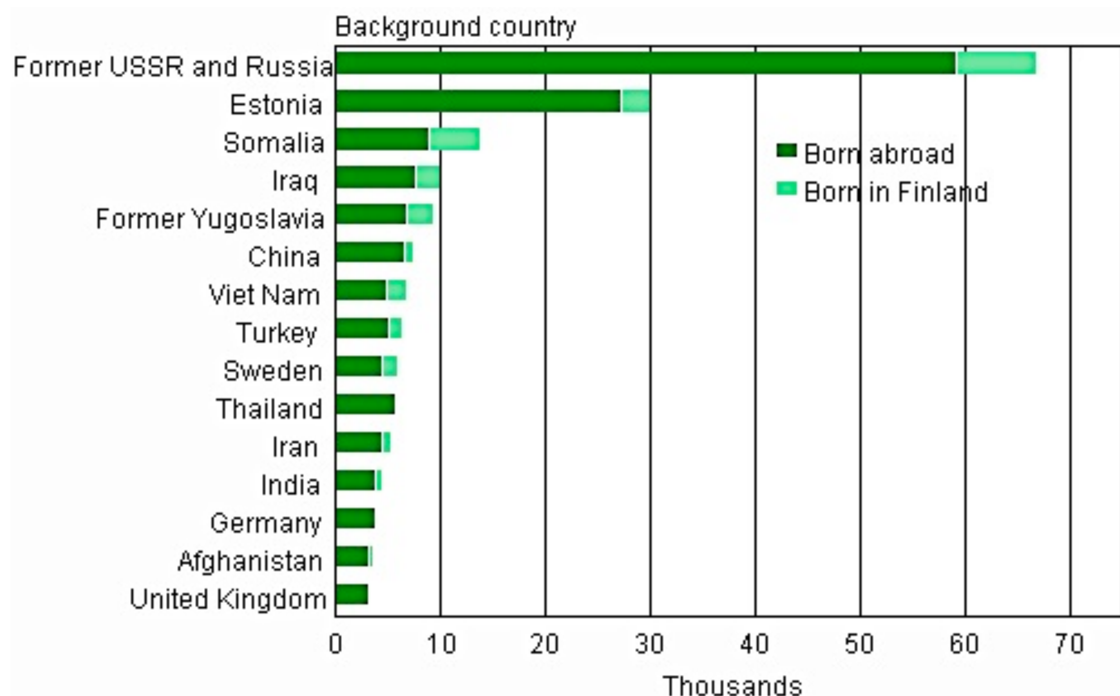

FIGURE 2. Largest groups of foreign origin among the Finnish population at the end of year 2011 (Statistics Finland 2012).

According to Statistics Finland (2012a) people of foreign origin are notably younger than the rest of the population. The effect of immigration on the age structure of Finland can be seen among young adults. At the end of 2011, the share of people with foreign origin among 25-34 year-olds was 8.7 per cent, young adults being the age group having the highest share of people with

foreign origin. Above-mentioned figures indicate that there are more and more people of foreign origin who are in fertile age and possibly becoming clients and patients of midwives.

People are migrating to Finland for various reasons, for example as refugees, as asylum seekers, as returnees, after work and for family reasons (ETENE 2004, 27). The Finnish immigration service (2013) defines immigrant as a person moving from one country to another and it applies to all migrants with different reasons for moving. This study employs the same broad definition of the concept of immigrant. The term immigrant family is often used in literature to describe a family wherein one parent or both parents, and none, one or more of the children have immigrated to Finland. In this study the concept of multicultural family is used to describe such families. The term immigrant family assumes that all the family members have migrated to Finland, but as noted before in reality only one family member could be immigrant to the letter and others were born in Finland. The concept of multicultural family is used as another research subject because in many cultures the whole family or even the whole community is taking part in the decision making concerning the patient (ETENE 2004, 10). Family is an important part of midwives' work since giving birth naturally concerns the whole family, and father or another support person is often there for the mother during the birth.

3. Culture and health

3.1. Definition of culture

The definitions of culture have been varying over the time and from science to another. Either way, people have always tried to understand how culture is arising and developing, how cultures differ from each other and what culture means to its members. (Abdelhamid, Juntunen & Koskinen 2010, 16) According to Giger (2013, 2) culture is a permanent behaviour, a state of mind that is founded as a result of ambient social relations, religion and intellectual and artistic outputs. A distinctive feature of culture is that people belonging to

the same culture share the values, beliefs, norms and courses of action. Culture guides thinking, working, decision making, subsistence and being of its members. Culture enables self-respect of a person and gives the basis for self-esteem.

Dreachslin, Gilbert and Malone (2012, 129) state that culture is pervasive and affects every aspect of life. They also remind that major cultures almost always contain subcultures. Such things as social class, gender, age, race, religion, occupation, region, generation, and sexual orientation form subcultures. A subculture shares much of the overarching culture of the larger group within which it occurs, but also has characteristics that are unique and identifiable. Subcultures are a very important source of diversity within a cultural group. (op. cit. p. 137.)

Helman (1995, 2) says that culture is a set of guidelines, both explicit and implicit, which individuals inherit as members of a particular society. Culture also provides its members with a way of transmitting these guidelines to the next generation by the use of symbols, language, art and ritual. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the guidelines of that society. Without such a shared perception of the world, both the cohesion and continuity of any human group would be impossible. Cultural background therefore has an important influence on many aspects of people's lives, including their beliefs, behaviours, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, concepts of space and time and attitudes to illness, pain and other forms of misfortune. All of these factors may have significant implications for health and health care.

Helman (1995, 4) also stresses that cultures are never homogenous and that's why one should always avoid using generalisations in explaining people's beliefs and behaviours. Broad generalisations about the members of any human group cannot be made without taking into account that differences among the group's members may be just as obvious as those between the members of different cultural groups. Helman underlines that cultures are never static. They are usually influenced by other human groups around them,

and in most parts of the world cultures are in a constant process of adaptation and change. Cultures must always be seen in its particular context. This means that the culture of any group of people, at any particular point in time, is always influenced by many other factors. Leininger and McFarland (2002, 49) also point out that all human cultures have some intercultural variations between and within cultures. Cultural variation is an important concept to keep in mind when studying individuals and different cultures. Multiculturalism refers to a perspective and reality that there are many different cultures and sub-cultures in the world that need to be recognised, valued and understood for their differences and similarities.

3.2. Transcultural nursing

Transcultural nursing refers to nursing among different cultures or to nursing communities whose workers and clients are coming from different cultures and ethnic groups. In transcultural therapeutic relationships and nursing communities, the cultural premises of people are taken into account and respect for difference, equality and parity are characterising the contacts. (Abdelhamid et al. 2010, 28.) The founder of transcultural nursing discipline is Professor Madeline Leininger, who started studying and developing transcultural nursing in the 1950s. She characterises it as a “substantive area of study and practice focused on comparative cultural care values, beliefs, practices of individuals or groups of similar or different cultures. Transcultural nursing’s goal is to provide culture specific and universal nursing care practices for the health and well-being of people or to help them face unfavourable human conditions, illness or death in culturally meaningful ways”. (Leininger & McFarland 2002, 46)

Leininger’s theory of “The culture care diversity and universality” is represented as the sunrise enabler to discover culture care, symbolic of the hope to generate new knowledge for nursing. Leininger has refined her theory for six decades and it is still used in nursing as well as in other health-related disciplines. The model shows factors such as technological, religious and philosophical, kinship and social, cultural values and life ways, political and legal, economic, and educational, forming sunrays that influence individuals,

families, and groups in health and illness. Leininger places great emphasis on the role of appropriate *culturalogical* assessment when working with individuals, families, groups, and institutions to provide culturally congruent care. (Sagar 2012, 1-3.)

The development of traditional models of transcultural nursing welled from the need to produce frameworks to structure nursing, when clients are having diverse cultural backgrounds. The models offer frames to help health care providers to piece together the extent and diversity of transcultural nursing and to take culturally specific needs of the clients into account in order to enable good nursing care. Later the traditional models have been criticised for example for that using them can lead to overemphasising the cultural difference of the clients and to stereotyped nursing, which at the worst only increase the clients' detachment and marginalisation in the society and nursing care. It is also not possible for a single health care provider to master a large amount of detailed information related to different cultures. It is more important that the nurse has politico social knowledge, self-reflection and empathy skills. (Abdelhamid et al. 2010, 29.)

Today in transcultural nursing universal cultural knowledge is rather underlined instead of culture specific knowledge. Dialogic therapeutic relationship, wherein client's social reality, life history and resources are looked into, is emphasised in place of client-oriented relationship. (Abdelhamid et al. 2010, 29.) One of the later models of transcultural nursing is "The process of cultural competence in the delivery of healthcare services" by Campinha-Bacote. This is culturally consciously model of care that defines cultural competence as a process. It is a process of becoming culturally competent, not being culturally competent. This model views cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire as the five constructs of cultural competence. (Campinha-Bacote 2012.)

According to Camponha-Bacote's (2012) model "*cultural awareness* is defined as the process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional

background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in healthcare delivery. *Cultural knowledge* is defined as the process in which the healthcare professional seeks and obtains a sound educational base about culturally diverse groups. *Cultural skill* is the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment. *Cultural encounters* is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping. *Cultural desire* is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters; "not the "have to." Cultural encounter are the pivotal construct of cultural competence that provide the energy source and foundation for one's journey towards cultural competence."

3.2. Cultural competence in health care

Cultural competence indicates the cultural know-how of a person and the skills to act in multicultural environments, and it presents itself primarily in interpersonal interactions as taking account of difference and accepting it (Abdelhamid et al. 2010, 32). In health care cultural competence is the sensitivity of the health care provider to see the cultural dimension of the client, and the skills to have a dialogic therapeutic relationship with a client representing foreign culture by utilising cultural knowledge. Cultural competence of a health care provider enables ethical therapeutic relationship and empowers the client. (Ikonen 2007, 140.)

Cultural competence is commonly considered to be a lifelong and gradual process of human progress that comprehensively affects the values, attitudes and actions of a person (Abdelhamid et al. 2010, 33). Campinha-Bacote (2002, 181) states, "Cultural competence is an on-going process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client."

According to Tuokko (2007) successful encounters with immigrants can be educational and interesting and they can grow health care providers' self-esteem and courage to confront clients and patients coming from different cultures. Transcultural work is often described to be challenging and demanding but meaningful. However, many studies show that health care providers feel that they need more information and education on transcultural nursing (Hultsjö & Hjelm 2005; Tuokko 2007; Høye & Severinsson 2008; Kurth, Jaeger, Zemp, Tschudin & Bischoff 2010; Bennet & Burton 2012, 15).

In this study the concept of clinical cultural competence refers to health care provider's cultural ability and will in the encounters with clients and patients coming from different cultural backgrounds. The concept is leaning on Campinha-Bacote's model of cultural competence (Campinha-Bacote 2012). The study is aiming to look into midwives' own views and feelings about their clinical cultural competence.

3.3. Cultural issues in care given during pregnancy and childbirth

The care given during pregnancy and labour is of great significance in every culture and childbirth is a very sensitive moment in life. Lauderdale (2008, 85) state that childbearing is a time of transition and social celebration of central importance in any society and it signals a realignment of existing cultural roles and responsibilities, psychological and biological states, and social relationships. The different ways in which a particular society views this transitional period and manages childbirth depend on the culture's consensus about health, medical care, reproduction and the role and status of women. Each culture has its own values, beliefs and practices concerning pregnancy and childbirth, and these should be discussed with the mother and the family in order to be able to give culturally sensitive care (Abdelhamid et al. 2010, 232).

In contemporary Western societies pregnancy and childbirth are often seen as medical conditions that can be pathological, medically diagnosed and treated with medical methods (Abdelhamid et al. 2010, 232). Medical care focuses on

the pregnant woman and foetus, and the father and other family members or significant others, if they are included at all, are relegated to be observers rather than participants. People of foreign origin or otherwise having divergent cultural backgrounds can have very different practices, values and beliefs about pregnancy and childbirth, the roles of women and men, social support networks and health care providers. (Lauderdale 2008, 86)

In developing countries pregnancy is generally not seen as medical condition, which can explain the possible suspicions of immigrants towards frequent health checks, screenings and procedure –centred practice. Some people may preserve and protect their fertility and pregnancy from outsiders, because having a child is personally and communally so important. Some of the multiparous immigrant women may feel that the care provider is criticising their number of children, circumcision or frequent birth intervals. Some people may be afraid of being sterilized in pursuance of Caesarean section against their own will. Confidential relationship between the caregiver and the patient requires that the patient feels accepted. (Malin 2011, 3312)

Giger (2013, 5) stresses that every individual is culturally unique and nurses are no exception to this premise. Health care providers must thus carefully discern personal cultural beliefs and values to separate them from the patients' and clients' beliefs and values. Transcultural knowledge needs to be used in a skilful and artful manner to provide culturally appropriate and competent care to rapidly changing, heterogeneous client population.

Encounters between midwives, as well as other health care providers, and immigrants have been studied especially in countries where multiculturalism has been a noticeable part of communities for a long time. In Finland this subject has been studied to some extent more recently. In many studies language and communication have been noticed to be a substantial barrier to care. Other factors that have found to cause difficulties when caring for immigrants are differences in culture and religion, lack of interpretation services, shortage of time, social deprivation and traumatic experiences, lack of familiarity with the health care system, negative attitudes among staff and patients, lack of access to medical history and differences in conception of

time. (Hultsjö & Hjelm 2005; Høye & Severinsson 2008; Nielsen & Birkelund 2009; Kurt et al. 2010; Priebe, Sandhu, Dias, Gaddini, Greacen, Ioannidis, Kluge, Krasnik, Lamkaddem, Lorant, Puigpinósi Riera, Sarvary, Soares, Stankunas, Straßmayr, Wahlbeck, Welbel & Bogic 2011)

This study applies the definition of Finnish confederation of midwives (2013):

> *A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.*
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units.*

The international confederation of midwives has approved this definition and although the job descriptions and tasks are varying from country to another, the midwives work is rather similar in all the western countries.

4. Aim and purpose

Aim of this study is to find out what kinds of experiences midwives have on working with immigrants and their families and to figure out how midwives feel about their clinical cultural competence. The purpose of the study is to gain information on the midwives' encounters with multicultural families, in order to understand the challenges of transcultural nursing in midwifery.

Research questions:

1. What kind of experiences midwives have on caring immigrants and their families?
2. How do midwives feel about their clinical cultural competence?

5. Research methodology

5.1. Literature review

Literature reviews structure the existing research information and enable the conceptualisation of the entirety of existent research (Johansson 2007, 3). Systematic literature review indicates a research method that locates, appraises, analyses and synthesises evidence from scientific studies comprehensively. Systematic literature review follows the principles of scientific research; it is based on a research plan, has repeatability and is striving to deduct systematic bias and other lapses during the research. (Kääriäinen & Lahtinen 2006, 37; Webb & Roe 2008, 3.) Summarising, analysing and evaluating current knowledge in the form of a systematic literature review provides valuable information on a given topics (Clamp, Gough & Land 2005, 54).

Systematic literature review is a process that proceeds from planning to reporting through certain, beforehand planned phases. The phases are making the research plan, defining the research question, systematic and comprehensive data search, data selection with clear inclusion criteria, critical appraisal of relevant literature, data analyses and synthesis and reporting the results. The research plan guides the progress of the entire research process and is consequently the most important phase of a systematic literature review. The research questions, method for data collection and clear inclusion criteria for data selection are defined in the research plan. In addition to these the quality criteria for the original research data and methods for data analyse are described in the research plan. The research questions delineate the aim and purpose of the systematic literature review. The research data is selected with inclusion criteria that are based on the research questions. The inclusion criteria can focus on the participants, intervention, outcomes or design of the research. The purpose of the data analyses is to respond to the research questions as comprehensively, objectively and intelligibly as possible. (Kääriäinen & Lahtinen 2006, 38-41; Johansson 2007, 5; Webb & Roe 2008, 4.)

The research method applied in this study is literature review. This review is following the general principles and guidelines of systematic literature review and proceeds systematically through before hand planned research phases.

5.2. Literature search

The data for this literature review was collected from the article databases of CINAHL and Elsevier ScienceDirect, and from GoogleScholar. Manual search in the school library and in the publication lists of departments of nursing science of Finnish universities were also implemented in order to obtain all the relevant data. Different combinations of pertinent key words were tested in the beginning of the data search. The best results were obtained with the combination of the words midwife or nurse midwife and immigrant. The table 1 is demonstrating the searched databases, used key words and the results of the search. The search results were quite broad, but that was due to an intentional choice to try to ensure all the relevant data. The obtained data were glanced through and the abstracts were read. 12 articles were chosen on the basis of the abstracts. After reading through the studies the final selection was done basing on the predetermined inclusion criteria.

The inclusion criteria for this literature review data were:

- Study in English or Finnish
- Scientific publication, doctoral and master’s thesis included
- Peer-reviewed studies
- Published between years 2003 and 2013
- Full text access
- Responds to the research questions (one or both)
- Studies the experiences of midwives working with immigrants in any health care unit

All the other literature reviews were excluded from the data for this study.

TABLE 1. Results of the literature search

Database	Key terms	Results	Chosen on the basis of title and abstract	Relevant studies
CINAHL	midwives OR nurse midwives AND immigrants	246	4	3
BioMed Central	midwi* AND immigrant*	161	2	0
Google Scholar	nurse midwives AND immigrants AND midwives' experiences	151	3	2
Science Direct	midwife AND immigrant	111	3	2

The database searches yielded seven relevant scientific articles. One master's thesis was found when carrying out the manual searches in the publication lists of the departments of nursing science of the Finnish universities. Altogether eight studies were chosen for this literature review: from Australia, Canada, Ireland, The Netherlands, Norway and USA one from each country, and two from Finland. The Appendix 1 represents the authors, titles, publishing times, aims, participants, data collection and analysis methods and key results of the reviewed studies in a table.

One of the inclusion criteria for the relevant studies was that the study should be surveying the experiences of midwives on working with immigrants. Three of the included studies were studying only midwives. Other studies searched the experience and perceptions of all maternal care providers, but they were included in this study because in the participant group were also midwives. In some studies the views of midwives and other providers were also reported separately.

5.3. Data analyses

The selected and appraised data was analysed by using content analysis. Content analysis is a conventional method of analysis. With content analysis it is possible to analyse different kinds of data and at the same time describe them. (Kankkunen & Vehviläinen-Julkunen 2009, 133.) Content analysis offers a means of synthesising study reports by allowing a systematic way of categorising and counting themes (Dixon-Woods, Agarwal, Jones, Young, Sutton & Noyes 2008, 94).

Content analysis can be inductive, originating from the data, or deductive, originating from a theory (Kankkunen & Vehviläinen-Julkunen 2009, 135). The categories are derived from the data in inductive content analysis. An approach based on inductive data moves from the specific to the general, so that particular instances are observed and then combined into a larger whole or general statement (Elo & Kyngäs 2008, 109.) In this study the inductive content analysis was used to analyse the data.

According to Elo and Kyngäs (2008, 109) inductive analysis processes is consisting of three main phases: preparation, organizing and reporting. Despite this, there are no systematic rules for analysing data; the key feature of all content analysis is that the many words of the text are classified into much smaller content categories. Tuomi & Sarajärvi (2009, 108) state that inductive content analysis includes three steps. In the first step the data is reduced into smaller units. The second phase consists of clustering the data, which means separating it into groups and subcategories. The third step is abstraction in which subcategories with similarities in their contents are connected and general categories are formed. (Kankkunen & Vehviläinen-Julkunen 2009, 135.)

The data analysis began with reading carefully through all the chosen studies, testing the data on the research questions of this literature review. The answers to the questions were marked to the studies using words as similar as possible to the original text. Single word or combinations of few words were used as analytical units in this reducing phase. When all the articles were

carefully read and reduction done, the reduced expressions were gathered into lists according to the research questions. The similarities and distinctions between reduced expressions were searched for in the clustering phase of the data analysis. Clustering yielded 15 subcategories that were given names that represented the contents of them. In the last phase of the analysis the subcategories with similarities in their contents were connected under six main categories. The figure 3 is demonstrating an example of how the data analysis was proceeding through reduction phase to main category.

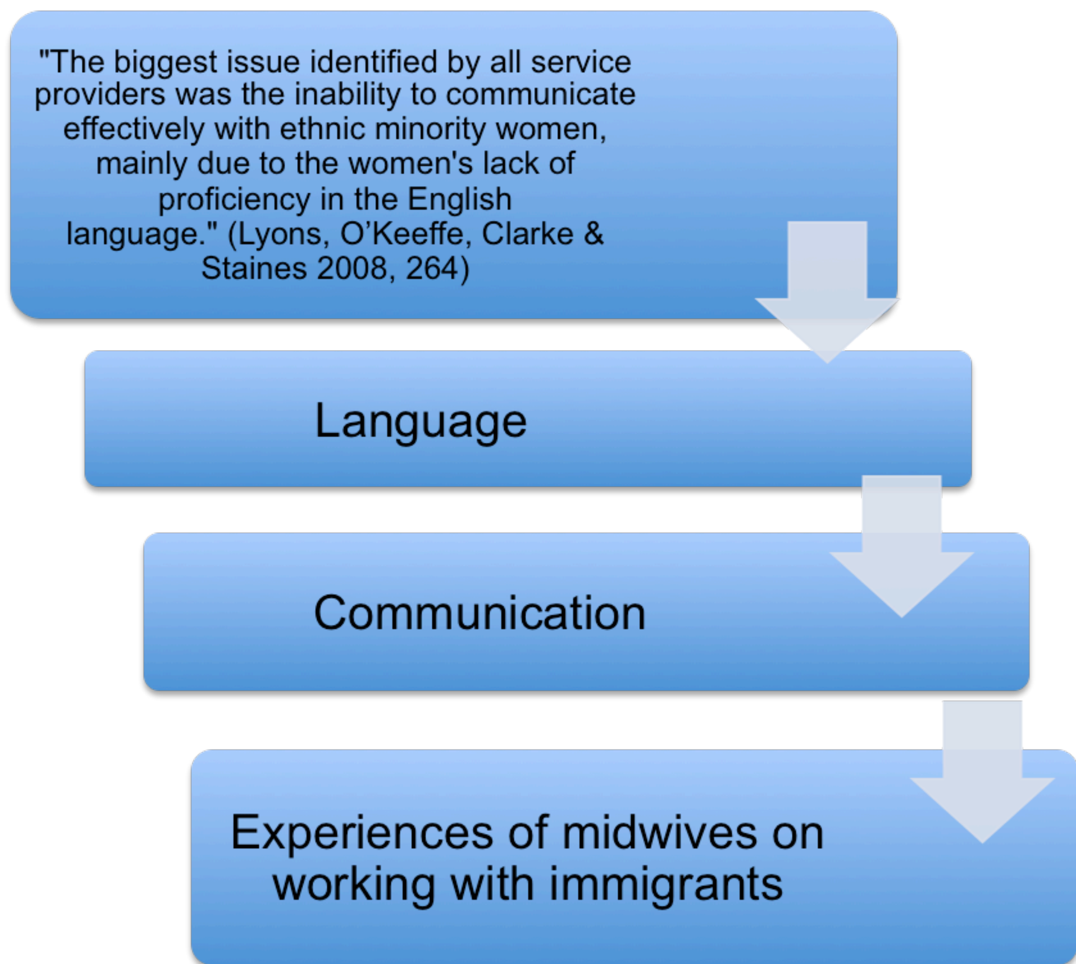

FIGURE 3. An example of the progress of data analysis.

6. Results

TABLE 2. The results grouped according to the research questions.

<table>
<tr><th>Subcategory</th><th>Main category</th><th>Research question</th></tr>
<tr><td>Language</td><td>Communication</td><td rowspan="15">Experiences of midwives on working with immigrants</td></tr>
<tr><td>Interpreter use</td><td></td></tr>
<tr><td>Alternative ways of communication</td><td></td></tr>
<tr><td>Expression of pain</td><td>Cultural practices and beliefs</td></tr>
<tr><td>Conception of time</td><td></td></tr>
<tr><td>Preference for female attendants</td><td></td></tr>
<tr><td>Family, friends and community</td><td></td></tr>
<tr><td>Breastfeeding</td><td></td></tr>
<tr><td>Female genital mutilation</td><td></td></tr>
<tr><td></td><td>Health knowledge of immigrants</td></tr>
<tr><td>Expectations of immigrants</td><td>Expectations of care</td></tr>
<tr><td>Expectations of midwives</td><td></td></tr>
<tr><td>Role of the midwives</td><td></td></tr>
<tr><td>Workload</td><td>Demanding but rewarding work</td></tr>
<tr><td>Negative and positive feelings</td><td></td></tr>
<tr><td></td><td>Cultural competence of midwives</td><td>Clinical cultural competence of midwives</td></tr>
</table>

The results of this literature review are presented according to the research questions. Table 2 demonstrates how the subcategories and main categories are organized under the research questions. The first five main categories of the results are describing the experiences of midwives on working with immigrants. The sixth main category portrays how the midwives feel about their clinical cultural competence

6.1. Communication

Language

Communication and language problems were coming up in seven of the eight reviewed studies. Only the study of Cioffi and Grad (2004) did not bring out communication issues. Lack of common language and other problems in client-midwife communication appear to be the most substantial barrier to provision of quality care to immigrants and their families. Lyberg, Viken, Haruna and Severinsson (2012, 292) state that linguistic barriers can complicate consultations and midwives are often uncertain whether the migrant woman had understood their message and if they themselves had understood what she related. Language barriers were also seen to be reason for possible confusions, for example a patient being sent home from the admissions instead of being admitted to the labour ward (Juslén 2012, 71).

According to Lyons, O'Keeffe, Clarke and Staines (2008, 264) maternity service providers felt they were unable to get accurate obstetric and medical histories due to lack of common language. They also felt worried that they were missing important medical information and therefore may not be providing appropriate care. Poor communication and language difficulties impacted greatly on their workload, as working with immigrants who did not speak at all or spoke very little their language, required much more time than others. Ng and Newbold (2011, 564) noted that when patient and provider do not understand each other, patient may have limited or no access to appropriate and complete health care because they cannot communicate and understand their care provider.

Interpreter use

Interpreters were brought up in all of the reviewed studies; expect the one of Cioffi and Grad (2004). The use of professional interpreters was described to be helpful, useful and important. The use of interpretation services varies a lot from country to country and region to region depending on different regulations and economic restrictions. Telephone interpreting was mentioned in several studies. Boerleider, Francke, Manniën, Wiegers and Devillé (2013) state that telephone interpretation is preferred when discussing sensitive issues. Telephone interpretation assures confidentiality and privacy. The quality and availability of professional interpreting services was also criticised. According to Lyons et al. (2008, 265) professional interpreter services are not without limitations or difficulties, because the nature of obstetrics means that interpreters are often needed out of hours or urgently to deal with emergencies and it is not possible to wait for these services. Concerns about objectivity and quality of interpretation services were arising from the midwives and other maternity care providers. Also male interpreters were seen problematic when acting between care providers and immigrant women. (Lyons et al. 2008, 265; Lyberg et al. 2012, 292; Lazar, Johnson-Agbakwu, Davis & Shipp 2013, 3.)

The use of informal interpreters was highlighted in several studies (Lyons et al. 2008, 265; Degni, Suominen, Essén, El Ansari & Vehviläinen-Julkunen 2011, 336; Ng and Newbold 2011, 565; Juslén 2012, 69). This means the situations were spouses, friends, children or other family members are acting as interpreters. The use of informal interpreters was generally seen difficult and avoided whenever possible, but sometimes it was necessary. Ng and Newbold (2011, 565) say that using informal interpreters can compromise health care. Issues of confidentiality and accuracy of interpretation arise when using family or friends as translators. Particularly using children and teenagers as interpreters was perceived to be difficult.

Alternative ways of communicating

The midwives used non-verbal communication, such as gestures, facial expressions and touch in addition to trying to speak very slowly using only few words, when there were language problems (Juslén 2012, 69). Also leaflets and brochures with important information translated into variety of languages, DVD's, pictures and drawings were used to help the communication, alongside web pages. (Juslén 2012, 68; Boerleider et al. 2013.)

6.2. Cultural practices and beliefs

Immigrants having diverse cultural backgrounds naturally have different and varied beliefs and practices related to pregnancy and giving birth. Midwives are not expected to master a large amount of information related to different cultures, but they are anticipated to show awareness of and interest in different cultural practices and beliefs. Ng and Newbold (2011, 566) state that immigrant women may feel that they are not receiving appropriate care when their cultural needs are not being met. Patients and clients may not always express clearly their traditions and practices to the providers, but when prompted they will convey their beliefs and practices. That is why immigrants should be encouraged to ask questions and tell their opinions (Juslén 2012, 72). Maternity care providers conveyed that they tried to respect different cultural practices and beliefs even though they did not always understand them (Lazar et al. 2013, 5).

Different gender roles in multicultural families were speaking to the midwives and other maternity care providers participating in the reviewed studies. Lazar et al. (2013, 4) stress that providers had strong responses when their patients abdicated communication to their male partners and suggested that the male dominance of the communication deprived the patient of the autonomy they felt she should have in decision making around her care. Providers felt that the woman was not communicating her own wishes and the male dictates exactly what happens to the woman. Lyberg et al. (2012, 292) refer in their

study to the power of the community over women; the family clans often had a chief who was in control and made the decisions.

In the two Finnish studies reviewed the naturally arising tendency for immigrant women to often touch, hug or hold on to the midwife during labour or consultations was conveyed. Some midwives indicated acceptance and regarded its supportive function to be a natural part of their job. However some found it to be an invasion to their physical autonomy and therefore could not allow it. (Degni et al. 2012, 336; Juslén 2012, 71.)

Expression of pain

Expression of labour pain and preference for pain relief reported to be different depending on the cultural background of the women. Lyons et al. (2008, 267) state that some women were thought to be louder, more dramatic and consequently more difficult to deal with in labour, while others wanted to be left alone and not speak. For example the women from Chinese background tended to be quiet and suppress expressions of pain and feelings (Cioffi and Grad 2004, 440). Midwives described their response as being mindful to monitor quite women more closely (Cioffi and grad 2004, 440; Juslén 2012, 73).

Many immigrant women prefer not to have pain relief during labour (Lyons et al. 2008, 267; Juslén 2012, 78) This was not always seen as a good thing and was reported to add the workload of the midwives. According to Juslén (2012, 78) the immigrant women may be more open to receiving a wider variety of supportive aides for managing pain. The choice of requiring less or no pain medication was seen to be due conscious choice but also resulting from a lack of understanding.

Conception of time

Three of the studies reviewed suggested that the concept of time of the immigrants is differing from that of the midwives and other care providers.

Lyberg et al. (2012, 290) reveal that there is often a problem with continuity in the case of care of migrant women. The migrant women can show up for every second appointment and are often coming at a different time. They can appear suddenly and think that they can just drop in to the office of a midwife. According to Boerleider et al. (2013) notifying the midwife in the event of delayed or missed appointment, attending appointment outside the midwifery practice, attending group meetings and applying for postnatal care do not always go smoothly in the case of immigrants. Degni et al. (2012, 338) reported the same kind of experiences in their study of providing reproductive health care to Somali women living in Finland.

Preference of female attendants

The immigrant women and families were often expressing preference for female doctors and other attendants, especially the ones from Islamic background. Lyons et al. (2008, 267) state that in general health service providers showed an acceptance and understanding for this preference and willingness to accommodate the request. However, if there were no female on duty out of hours, this request becomes harder to facilitate and could cause difficulties for both woman immigrant and staff. Negotiating this preference for female attendants was often presented as a challenge (Cioffi and Grad 2004, 440). Ng and Newbold (2011, 566) stress that the difficulty in providing a female care provider during routine prenatal examination and during delivery complicates the process or may jeopardise care and health of the patient. If the patient cannot be guaranteed a female care provider, some Muslim women will refuse care, and will not have her pregnancy monitored.

Family, friends and community

The immigrants were noted to have many visitors in the hospital after giving birth and these visitors were not always going along with the visiting protocols of the hospitals. According to Juslén (2012, 76) the significance of visiting of family and friends was clearly noted by midwives. The visitors were generally many and they were often coming in big groups. Several midwives had

observed the supportive function of relatives to immigrant women and conveyed such support was clearly significant to these women. Cioffi and Grad (2004, 441) underlined that visiting by family, neighbours and friends was understood to be a traditional practice of social obligation. Managing visitors could however be an issue. The patient rooms were not big enough for large groups of visitors. The privacy can be also an issue when there is more than one bed in the room. Visiting hours were not always respected. Cioffi and Grad (2004,441) mentioned specifically Ramadan, because during this period of time family and friends usually delayed visiting after dark.

Sometimes problems and difficulties arose when family and relatives were involved and giving immigrant women advice that contradicted midwives' instructions. The immigrant women could also experience pressure from their community in remaining and cherishing the cultural beliefs and rituals. Boerleider et al. (2013) state that immigrant women are being confronted with different cultural values and can be pressured by their families. This is especially apparent during the postnatal period, when family members come to stay with the new mother and take over the domestic chores. As well as taking over domestic chores, the family also gives a lot of advice and information to the new mother. Most of this advice is culturally based and innocent, but sometimes it can contradict the advice of health care professionals.

Breastfeeding

According to Juslén (2012, 79) the midwives indicate that the immigrant women in general have no need to breastfeed their babies in the initial stage and are perfectly willing to wait for milk to arise before any attempt to feed their baby with breast milk. Breastfeeding appeared to come naturally to the majority of immigrant women and complications were less often encountered. Immigrant women had the tendency to require for baby formula. Donated breast milk was recognised to be a less favourable option to immigrant women. The midwives who participated in the studies of Lyons et al. (2008, 267) and Cioffi and Grad (2004, 439) shared the same views.

Female genital mutilation

Female genital cutting (FGC) was coming up in two of the reviewed studies. Lyberg et al. (2012, 291) state that circumcision was common health challenge among migrant women. Accroding to Lazar et al. (2013) many health care providers possessed discomfort communicating with their patients about circumcision. Also providers' suboptimal training in the care and management of women with FGC was mentioned. Some providers indicated that they would have appreciated more formal training while others felt it was unnecessary because they had become competent without training.

6.3. Health knowledge of immigrants

The midwives brought up the fact that many immigrant women had limited knowledge of health issues. Boerleider et al. (2013) state that, besides communication problems, midwives are also confronted with health literacy problems. The impact of a limited ability to read, understand and use health information was clear in the utilisation of maternity care of some clients. Lyberg et al. (2012, 291) note that many migrant women lacked basic body knowledge and had different educational needs in relation to their own and baby's health. The midwives indicated that many migrant women were not very concerned about and paid little attention to their own health during the prenatal and postnatal period. Inconsistence in contraceptive use was regarded by the midwives as a result of lack of knowledge of birth control methods among some Somali women (Degni 2012, 338). The level of knowledge was seen to be commensurate with the educational level of the immigrant and also the length of stay in the target country.

Midwives had also noticed that many immigrants, especially the recently immigrated ones, did not have sufficient knowledge of the health care and maternity care systems of their new home countries. Lyons et al. (2008, 266) say that many minority women were unfamiliar with the health care system

and how to use it or even what to expect from it. This was seen as adding extra workload to the service providers and that women were not using the services properly. Ng and Newbold (2011, 569) stress that there is the expectation that patients are able to navigate the system. Yet, navigation a complex system is particularly difficult for new arrivals.

6.4. Expectations of care

Expectations of the immigrants

Midwives participating in the reviewed studies had noticed differing expectations of maternal care among the immigrants, which are naturally welling from the previous experiences of the immigrants. Juslén (2012, 72) states that the midwives indicated a tendency for viewing care giving as a more non-reciprocal task. Caring for the baby was perceived to be of secondary importance while at the maternity ward. Midwives conveyed that immigrant women viewed it to be midwives' duty to take charge of caring for the baby in order for them to have the opportunity for enough rest and personal recovery. (op. cit. p. 79.)

The medicalised nature of maternal care, for example the big number of prenatal testing, in Western countries can be overwhelming to many immigrants. Ng and Newbold (2011, 568) stress that the patients who find the medicalised model of maternal care overwhelming, believe standard prenatal testing and screening are unnecessary. The number of prenatal visits and diagnostic and screening tests can be an additional stress factor that immigrant women need to overcome and can result in a negative birth outcome. While patients have their own preconceived notions of health care, providers also have their own expectations. The differences in expectations can create friction and disconnect between the two groups. Prenatal visits seemed to generate the most friction between the immigrants and providers. If patients do not see prenatal visits as necessary, they may not show up to appointments. Maternity care providers have noticed that immigrant women

tend to seek care later on in their pregnancies (Lyons et al. 2008, 266; Ng & Newbold 2011, 569; Boerleider et al. 2013).

According to Lazar et al. (2013, 3) Somali women have lower expectations in terms of success with a pregnancy. Many providers stated that they perceived a sense of mistrust from their Somali patients and their spouses and families and they felt this impacted their care. They felt this mistrust was much greater barrier to providing quality care to Somali women than their circumcision status or other cultural factors. Providers also conveyed frustration with Somali women 's resistance to obstetric interventions. Somali immigrants were noticed to have strong resistance for caesarean delivery. Quite the contrary, Lyberg et al. (2012, 291) state that the midwives have noticed the increasing tendency of East European women to request a caesarean section.

Expectations of the midwives

Care providers have their own expectations of maternal care that are based upon a Western medical model. These expectations include the timing of the first prenatal visit and number and frequency of subsequent visits. The conflict between patient and provider expectations of care can be problematic and act as a barrier preventing immigrant women from accessing and receiving maternal care. (Ng & Newbold 2011, 568.) Lyberg et al. (2012, 292) state that the midwives emphasised that they concerned the diversity among the migrant women as a huge challenge. Although they originated from the same country, some migrant women were highly educated, while others were illiterate and could also represent different cultures and clans. Midwives also considered that migrant women's pregnancies need special attention. Juslén (2012, 85) note that not all staff members experienced caring for immigrant women as favourable.

Role of the midwives

According to Juslén (2012, 77) several midwives interviewed indicated often coming across requests and expectations for doctor’s consultations, especially by spouses of immigrant women. Ng and Newbold (2011, 567) state that while some immigrants preferred to be seen and cared for by midwives, many are also reluctant to have midwives oversee their pregnancy, delivery and postpartum care. In some countries midwives do not have formal training. That is why some immigrants not only see midwifery as substandard care, but also associate the use of midwives to lower socio-economic status. Midwives often find themselves in a position where they need to explain their role to their patients. Some immigrants seem to believe that being able to see a medically trained doctor is a symbol of status and that the obstetrician gynecologist will give them the best possible care and therefore the best birth outcome.

6.5. Demanding but rewarding work

Workload

Many midwives in the reviewed studies indicated that working with immigrants is generally adding to their workload. Juslén (2012, 85) states that immigrant women in general were considered to require a great deal more of time and effort in terms of care giving. Some midwives were also concerned about the quality of care their were giving to immigrants, because the limited time resources combined with increasing workload did not always enable meeting all the expectations of the immigrants. Lyons et al. (2008, 265) stress that the service providers felt that poor communication and language difficulties impacted greatly on their workload, as they perceived that ethnic minority women with limited or no English required much more time than others. When talking about the workload associated with non-western clients, Boerleider et al. (2013) noticed a clear difference between practices with many non-western

clients and those with just a few. Midwives working in urban practices with a lot of non-western clients indicated clearly that caring for some of these clients was very demanding. Midwives working in rural areas with few non-westerns said the same, but reckoned it was manageable.

Negative and positive feelings

The midwives participating to the reviewed studies brought up many negatives feelings related to their work with immigrants. According to Lyons et al. (2008, 268) feelings such as stress, worry and difficult recurred throughout their data. The other negative words related to caring for ethnic minority women appearing were frustration, tired and exhausted. Some participants were worried that they could be seen to be racist by their words or actions in the normal course of their work. Work with immigrants was also described to be demanding (Boerleider et al. 2013). Juslén (2012, 88) says that midwives may find themselves balancing amidst feelings of frustration when they become aware of all they can do to alleviate delivery yet finding the woman not being in position to respond to alternate suggestions. Lazar et al. (2013, 1) state that health care providers expressed frustration with what they perceived as Somali patients' resistance to obstetrical interventions and disappointment with a perception of mistrust from patients and their families.

The feelings arising from working with immigrants were no only negative. Boerleider et al. (2013) underline that although midwives experience caring for immigrants as demanding on the other hand, they also experience caring for them as rewarding on the other. Several midwives said that satisfaction after caring for non-western clients was high. Lyons et al. (2008, 269) state that some maternity service providers felt that minority women had made their work interesting and challenging.

6.6. Cultural competence of midwives

Some midwives participating the reviewed studies highlighted the importance of having cultural knowledge, and indicated that they were lacking sufficient information on different practices and beliefs related to different cultures which affected their ability to give care to patients with diverse cultural backgrounds. Lazar et al. (2013, 8) underline that health care providers understanding of patients culture needs to be enhanced.

Some midwives were presenting cultural awareness and desire in their striving for acquiring more cultural knowledge, exploring their own cultural beliefs and becoming skillful in cultural encounters. Degni et al. (2012, 335) state that some midwives describe the visits to their clients' homes as opportunities to build up personal relationship with women and to understand their culture. It is important to understand immigrant women's history, culture, religion and the changes in their lives in the new country. According to Lyons et al. (2008, 269) some midwives had seen interactions that they felt to be racist from both other staff and patients in the hospital and found it unacceptable. It was also highlighted that some midwives did not have cultural desire for encounters with immigrants.

When referring to cultural skill the interaction between health care providers and immigrants was coming up. Being alert and proactive in therapeutic relationships was conveyed in many studies. Boerleider et al. (2013) state that one of the ways some midwives tried to achieve optimal care for non-western clients was by being alert. They did this by asking clients to recite the information given to them, checking whether they have the necessities for childbirth and the baby, keeping un updated overview of clients who have missed appointment and checking clients' knowledge of the maternity care system. Some midwives also try to be proactive by for example calling to clients who do not show up for appointments. Juslén (2012, 74) brought out a way of one midwife: she had found the key to successful interaction with immigrant women through being genuinely present in the situation, having regular eye contact and demonstrating empathy through each and every one of her actions. Ng and Newbold (2011, 566) noted that some providers lack of

insight and understanding that they need to be proactive in the consultations. Some practitioners expect their patients to bring up cultural practices that need to be respected and followed, but patients may not be able to communicate their need or may not be forthcoming. Also Juslén (2012, 84) highlights a significant assumption of the majority of midwives involved relying on arising questions being asked. There was a clear indication of not being as familiar with the needs of immigrant women. The idea was to wait for the immigrant woman to inquire and follow such a lead in evaluating the care she would be likely to require.

Juslén (2012, 85) states that sharing of observations and findings among all midwives caring for a particular woman was viewed as a valuable contributor to caring for her during the stay. Midwives were sharing their experiences in order to develop their cultural skills. Cioffi and Grad (2004. 442) stressed that the interface between the midwife, the client, and their family can be considered critical, for it can be the first experience the culturally diverse family has of the health care services.

7. Discussion

7.1. Discussion of the findings

The aim of this literature review was to find out what kinds of experiences midwives have on working with immigrants and their families. This aim was achieved well and various experiences were covered. The reviewed studies were carried out in seven countries around the world. The scarcity of studies focusing on the perceptions of midwives was taking the author by surprise. Only three of the reviewed studies were surveying exclusively the experiences and perceptions of midwives. Other five studies were exploring the experiences of all the maternal care providers. This could have affected the results, because the aim was to look solely into midwives experiences. On the other hand, the maternal care providers also work in close multiprofessional groups, and the views of different professional groups are likely to reflect each other's. This study was aiming to review the experiences of midwives working with both the immigrant women and their families. Six of the eight studies were focusing merely on caring for immigrant women, however. Although all of the studies were discussing the families as well, the immigrant women were on focal point. The conception of immigrant was also changing from one study to another. Two of the studies were focusing on Somali women, whereas one study used the concept of non-western clients. The concepts of women from culturally diverse backgrounds and ethnic minority women were used in two other studies. This variety of the concepts could have also affected the results of this literature review.

Communication problems between midwives, as well as other maternal care providers, and immigrants were highlighted in all except one of the reviewed studies. Communication and language problems and barriers were perceived to be the most substantial barrier to providing quality care to immigrants and their families. Similar results have been attained in many studies searching the relations between the health care providers and immigrants (Hultsjö & Hjelm 2005; Høye & Severinsson 2008; Jirwe 2008; Nielsen & Birkelund 2009; Kurth et al. 2010). Priebe et al. (2011, 4) state that language and communication problems were most commonly reported, with frequent

references made to a ‘language barrier’ between practitioners and patients. Much effort should be made to overcome this huge problem that inconveniences and also prevents quality health care to immigrants around the world. The interpreting services were also discussed and many midwives viewed professional interpreters helpful and useful. However, the availability and quality of these services was questioned by some and informal interpreters seen mainly difficult and even dangerous. One answer to communication problems is the leaflets and brochures containing important information that are translated into different languages. Since the biggest groups of immigrants in each country or area are known, the availability of the written materials should be ensured at least for the languages of these immigrant groups. Similarly the interpretation services at least for the biggest immigrant groups should be ensured. The availability of interpreters for the most common languages is also better than for the smaller and unusual ones. Priebe et al. (2011, 8) also suggest the good interpreting services to be a component of good practice in health care for migrants. The governments and municipalities should not cut down these services when looking for savings.

Different cultural practices and beliefs of the immigrants were coming up and causing difficulties to midwives when caring for immigrants and their families. Many midwives conveyed that they are lacking sufficient information related to different cultural and religious practices and beliefs and this hinders giving quality care to the immigrants and their families and affects the way they feel about their clinical cultural competence. Difficulties related to different cultural practices and beliefs are common findings when studying transcultural nursing (Hutsjö & Hjelm 2005; Berlin, Johansson & Törnkvist 2006, 162; Høye & Severinsson 2008; Priebe et al. 2011, 6). The cultural knowledge of the midwives could be improved by providing education on different cultural and religious groups and their practices and beliefs. Again, at least the biggest immigrant groups in a particular area should be covered. Nowadays in many institutions and wards, there are many workers having culturally diverse backgrounds. The language skills and cultural knowledge of these workers should be used in caring for immigrants, and could be also used in educating the other health care providers. The education enhancing cultural knowledge and skills could be organized in co-operation with other institutes, for example

immigrant services, schools and immigrant associations. Priebe et al. (2011, 8) stressed the importance of this kind of education for good practice, too.

The midwives in reviewed studies brought out the limited health knowledge of the immigrants. The immigrants lacked sufficient knowledge of the health care system and this was seen to add extra workload to the service providers and to reduce immigrants' ability to use the services properly. The immigrants need education and tailored information packages on health care and maternity care services as well. Although working with immigrants is often found to add extra to the workload of care providers and to be demanding and even difficult, it is also experienced as interesting, rewarding and satisfying. These views are shared at least in the study of Bennet and Burton (2012, 14). Midwives in the studies reviewed for this iterature review and in many other studies feel that their cultural competence is inadequate and that they need formal training in it (Hultsjö & Hjelm 2005; Tuokko 2007; Høye & Severinsson 2008; Meddings & Haith-Cooper 2008; Kurth et al. 2010; Bennet & Burton 2012). Different ways of coping in difficult situations and breaking down barriers have been developed by midwives around the world and sharing these experiences and perceptions could be very beneficial in order to improve the cultural competence of midwives.

The data obtained in this literature review can be utilized in planning the education of midwives and midwifery students. The job descriptions and tasks of the midwives are varying from country to another and some of the midwives participating in the reviewed studies had fairly different roles comparing to the midwives in Finland. In some countries and regions the midwives can perform the tasks that in Finland belongs to the public health nurses in maternity and child health clinics. This is why the findings of this study could be applied and utilized there as well.

7.2. Discussion of the method and ethics

Tuomi and Sarajärvi (2009, 132) state that researcher's adhesion to good scientific practice will maintain the credibility of the research. Good scientific

practice includes integrity, reliability and accuracy in conducting research, recording and presenting results, and in judging research and its results. Researchers ought to apply ethically sustainable data collection, research and evaluation methods. Researchers should also take account of other researchers' work and achievements, respecting their work and giving due credit and weight to their achievements in carrying out their own research and publishing its results. (Academy of Finland 2003, 21.)

During this study the process of data collection and evaluation was recorded meticulously and described accurately in the final report. The whole research process was represented precisely and thoroughly in this final report in order the study to attain reliability, transparency and repeatability. The work and achievements of other researchers were taken into account and references to those reported according to instructions.

The research method of this study was literature review, that was following the general principles of a systematic literature review. According to Kääriäinen and Lahtinen (2006, 43) systematic literature review is a laborious and demanding research method. The errors can occur at any phase of the process and especially when resources of the researchers are limited. Finding relevant studies to be reviewed can be difficult and the changes in the quality of reviewed studies can undercut the reliability of the systematic literature review. In addition to these, the inclusion criteria for relevant studies can direct the results to a certain way. The studies included in this literature review were peer-reviewed in order to achieve reliability. One of the studies was a master's thesis from a Finnish university and it was included because the aim of the study was matching perfectly the inclusion criteria. When referring and interpreting the reviewed studies accuracy, integrity and impartiality were aimed at.

Both of the research questions were answered in the reviewed studies. This denotes that the data searching process was successful. The data was searched from three article databases, CINAHL, BioMed Central and ScienceDirect. Also GoogleScholar was used for data search since it is possible to find scientifi publications from there. Manual searches were carried

out as well. Reliability and accuracy of the chosen studies was evaluated carefully. All the included studies were in English which could generate bias of the language. This means that if the data search is limiting to a certain language, relevant studies can be excluded. Nonetheless, it is important to notice that studies with significant results are commonly published in English. (Kääriänen & Lahtinen 2006, 40.) There were few studies in Spanish and Swedish that were excluded from this study because of the language. Also few studies were excluded because full text access was not possible through the library of the school. Additional effort was made to get access to two of the studies even though it was not possible to have full-text access through school library. All in all, taking the limited time into account, the process of the data search was successful and sufficient for this literature review. The fact that this literature review has only one author can affect the reliability of the study.

7.3. Proposal for further studies

There are not many experimantal studies of midwives' or other maternity care providers' experiences on working with immigrants conducted in Finland. Nevertheless, there is a real need for this kind of information in order to be able to develop transcultural nursing in midwifery. The immigrant population is growing constantly and the effect of immigration on the age structure of Finland can be seen among young adults. There is an increasing group of people with foreign origin giving births and encountering midwives. This study was revealing that midwives are not feeling confident about their clinical cultural competence and that they need education to improve it. The situation is the same both in the countries with long history of immigration and in the countries with more recent history of immigration, as Finland. Research is needed to find out the contents for such education. Research is also needed on the experiences of immigrants using the maternity health services and giving birth in Finland. This information combined with the experiences of maternal care providers will help to outline the education needed to improve the cultural competence of midwives and increase the immigrants' knowledge of maternity care services in Finland.

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APPENDIX 1

No.	Authors, time and country	Title	Aim	Participants, sample	Data collection and analysis	Key results
1	Boerleider, A. W., Francke, A. L., Manniën, J., Wiegers, T.A. & DevilléW.L.J.M. 2013 The Netherlands	"A mixture of positive and negative feeling": A qualitative study of primary care midwives' experiences with non-western clients living in the Netherlands.	To explore Dutch primary care midwives' experiences with non-western clients.	13 midwives in individual interviews and eight midwives in focus group	Semi-structured interviews and a focus group guided by a semi-structured topic list. Thematic content analysis with the help of the software program MAXQDA.	Midwives perceived ethnic diversity as both difficult and interesting. Caring for non-western women was perceived as demanding but also rewarding. Midwives experienced a variety of difficulties: Communication problems, suboptimal health literacy, socio-economic problems, lack of knowledge of the maternity care system, pressure from the family and strong preference for physicians.
2	Cioffi, J. & Grad, D.E. 2004 Australia	Caring for women from culturally diverse backgrounds: midwives' experiences	To show how midwives cared for women from culturally diverse background.	12 experienced midwives	In-depth interviews. Interpretive-descriptive approach.	Midwives negotiated care that was culturally comfortable for women and their families. The study concentrated on women from Chinese and Islamic backgrounds.
3	Degni, F., Suominen, S., Essén, B., El Ansari, W. & Vehviläinen-Julkunen, K. 2012 Finland	Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland	To explore physicians-nurses/ mid-wives' com-munication when providing reproductive and maternity health care to Somali women	10 gynecologist/ obstetricians and 15 nurses/ midwives	Four individual and three focus group interviews. Analyzed using content analysis.	The health care providers considered communication, cultural traditions and religious beliefs to be problems when working with Somali women. Despite the problems, there was a tentative mutual understanding between the care providers and Somali women.

No.	Authors, time and country	Title	Aim	Participants, sample	Data collection and analysis	Key results
4	Juslén, S. 2012. Finland	Immigrant women giving birth in maternity hospital. Experience and expectations of immigrant women and perceptions of health care personnel in TAYS.	To convey experiences and expectations of immigrant women regarding the care they received while giving birth. Perceptions of midwives involving distinct needs of immigrant women are conveyed.	Eight immigrant women and 10 midwives	Thematic interviews. Theory driven content analysis.	Results revealed a genuine need for individual health care professional to begin developing one's capacity for culturally competent care. Culturally competent communication and interaction skills to be a major determinant in the manner care is received and perceived.
5	Lazar, J. N., Johnson-Agbakwu, C. E., Davis, O. I. & Shipp, M. P.-L. 2013 USA	Providers' perceptions of challenges in obstetrical care for Somali women.	To explore health care providers' perceptions of barriers to providing health care services to Somali refugee women.	14 obstetrician gynecologist and midwives	Individual semi-structured interviews. Content analysis.	Considerable challenges in communication with Somali patients and the lack of formal training or protocol guiding the management of FGC were noted. Providers expressed frustration with what they perceived as Somali patients' resistance to obstetrical interventions and disappointment with e perception of mistrust from patients and their families.
6	Lyberg, A., Viken, B., Haruna, M. & Severinsson, E. 2012 Norway	Diversity and challenges in the management of maternity care for migrant women	To illuminate midwives' and public health nurses' perceptions of managing and supporting prenatal and postnatal migrant women in Norway.	Five midwives and one public health nurse	Multistage focus group interviews. Analysed with conventional interpretative content analysis	Two major themes were coming up: "Health challenges" and "Cultural challenges". Norwegian maternity care is not adjusted to migrant women's needs.

No.	Authors, time and	Title	Aim	Participants, sample	Data collection and analysis	Key results
7	Lyons, S. M., O'Keeffe, F. M., Clarke, A. T. & Staines, A. 2008. Ireland	Cultural diversity in the Dublin Maternity services: the experiences of maternity service providers when caring for ethnic minority women	To explore the experiences, understanding and perceptions of maternity service providers when working with ethnic minority women in Dublin maternity services.	15 obstetricians and 27 midwives and auxiliary nurses	Semi -structured interviews and focus group interviews. Data was coded with a software package, QRS N6. Codes were clustered into categories and then themes	Four themes emerged from the study: communication difficulties, knowledge and use of services, cultural difference and "Them and Us". Ethnic minority women are expected to adapt to the system rather than the maternity services being responsive or adapting to the multicultural population.
8	Ng, C. & Newbold, K. B. 2011. Canada	Health care provider's perspectives on the provision of prenatal care to immigrants.	To gain a better understanding of the difficulties faced by health professionals and how the difficulties affected the delivery of care to immigrant women..	Three midwives, five nurse practitioners, two obstetricians gynecologist and a social worker.	Semi-structured interviews. Content analysis.	Results reveal the complexity of delivering care to immigrants, particularly with respect to expectations surrounding language, culture and type and professionalism of care.