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Immigrant Women's Experience of Childbirth and Implications for Midwifery Practice: A Literature Review

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The steady increase in international migration has brought about many challenges to those working in the field of healthcare. Providing care that takes into account a patient's ethnic background as well as their cultural beliefs, values and customs has become increasingly recognized as being an important aspect of caring for patients in a holistic manner. In this thesis we sought answers to two research questions: 1) What experiences do immigrant women report regarding childbirth in a new country? and 2) What implications do these findings have for nursing and midwifery practices and education?

The purpose of this project is to examine the reported healthcare experiences of one specific group of migrants: immigrant women giving birth in a new country and summarize this information. Our aim is to explore the implications that our findings will have on midwifery and nursing care.

Three electronic databases (Cinahl, PubMed and EBSCOhost) were searched for relevant literature, with a final result of seven research articles matching the criteria set by the authors. The findings of these articles were examined and the information synthesized using *inductive content analysis*.

After coding the findings of the literature, the following five themes emerged: communication difficulties; lack of cultural competence; lack of sensitivity and empathy; clinical expertise; settings and practice. These raised issues concerning whether or not the women participating in the studies felt that they were in control during childbirth; whether their emotional and physical needs were met; and whether their expectations of the childbirth experience were fulfilled. Additionally, concerns regarding violations of the participants' rights were noted.

Education and access to information are called for to ensure that patients receive care which is culturally appropriate and shows them due respect. Healthcare should take into account the patient's emotional as well as physical needs in order to provide a childbirth experience which is positive. This includes providing the necessary information to the patient required to ensure their ability to control their own care. More research is needed which exclusively targets the act of childbirth, as well as studies which would examine the experiences of specific groups of migrants.

Keywords	childbirth, childbirth experience, mother, immigrant, migrant, intercultural, transcultural, cultural competence

Tekijät(t) Otsikko Sivumäärä Aika	Veronika Eloranta, Christopher Friedmann, Ellie Parvi Maahanmuuttajanaisten synnytyskokemukset ja implikaatiot kätilötyön käytännöille: kirjallisuus katsaus 39 sivua + 1 liitte 06.04.2016
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Maahanmuuton kasvu on tuonut mukanaan paljon haasteita synnytyksen hoitoon. Synnyttäjän etnisen taustan, kulttuuristen uskomusten, arvojen sekä tapojen huomioiminen hoitotyössä korostuu yhä enemmän tärkeänä osana potilaan kokonaisvaltaista hoitoa. Opinnäytetyössä etsittiin vastausta kahteen kysymykseen: 1) Millaisia kokemuksia maahanmuuttajanaisilla on synnytyksestä? ja 2) Miten maahanmuuttajanaisten kokemukset voidaan ottaa huomioon hoidon kehittämisessä?

Opinnäytetyömme tarkoituksena oli selvittää maahanmuuttajanaisten synnytyskokemuksia sekä sitä, miten kyseiset kokemukset voidaan käyttää kehittääkseen hoitotyötä. Tarkastelimme hoitotyön implikaatioita sekä kätilöiden että sairaanhoitajien näkökulmasta.
Tietoa haettiin kolmesta sähköisestä tietokannasta: Cinahl, PubMed ja ESBCOhost. Aineistoksi valitsimme seitsemän tieteellistä artikkelia. Aineisto analysoitiin induktiivisella sisällönanalyysillä.

Aineistosta muodostui viisi teemaa: kommunikaatiovaikeudet; hoitohenkilökunnan kulttuurisen kompetenssin puute; hoitohenkilökunnan hienotunteisuuden ja empatian puute; hoitohenkilökunnan kliininen asiantuntijuus; laadukas hoitoympäristö ja erilaiset hoitokäytännöt. Näiden lisäksi tutkittiin synnyttäjien oikeuksien rikkomisen; hallinnan tunteen menettämisen synnytyksessä; emotionaalisten tunteiden sekä synnyttäjien odotusten huomiotta jättämisen.

Tulosten mukaan synnyttäjien tiedonsaanti ja opetus sekä kulttuurisesti kompetentti hoito, joka osoittaa potilaiden kunnioittamista tulee varmistaa. Terveydenhuollossa tulee huomioida synnyttäjien henkiset ja fyysiset tarpeet, vasta tällöin on mahdollista vaikuttaa positiivisen synnytyskokemuksen muodostumiseen. Myös tämä edellyttää tarpeiden mukaisen tiedon tarjoamista niin, että maahanmuuttajanaisten olisi mahdollisuus säilyttävää hallinnantunteen synnytyksen. Aiheesta tarvitaan lisää tutkimustietoa.

Avainsanat	Synnytys, synnytyskokemus, äiti, maahanmuuttaja, siirtolainen, interkulttuurinen, transkulttuurinen, kulttuurinen kompetenssi

Contents

1 Introduction

Finland, like most western countries, has experienced a change in the makeup of its population as increasing numbers of people from other parts of the world have immigrated to work, study, marry, or seek refuge and safety from conflict or oppression (Maahanmuuttovirasto 2014). Traditionally a fairly closed society, immigration to Finland began in earnest only in the early 1990s. Since then, however, it has increased steadily (Korkiasaari & Söderling 2003: 7.); the number of immigrants in Finland as a percentage of the population nearly doubled between the years 2006-2014, from 2,168% to 4,055% (Statistics Finland 2015) and in the Helsinki region at the end of 2012, 19% of families with children had at least one parent whose native language was not Finnish (Selander 2013: 15). The ongoing refugee crisis that gripped Europe last year has impacted Finland as well - the number of asylum seekers entering the country rose from 3651 in 2014 to 32 476 in 2015, an almost ten-fold increase (Maahanmuuttovirasto 2014 & 2015).

Upon their arrival, immigrants are often relatively healthy, sometimes more so than the average citizen of the host country - the so-called “healthy migrant effect”. Notwithstanding this phenomenon, immigrants often have unique health needs outside the experience of the healthcare system of their new home. (Rechel *et al*. 2011: 4.) The Finnish Health Care Act of 2010 guarantees access to medical care, including maternity and child health services, to all legal residents (Health Care Act 2010) and it is therefore extremely likely that anyone practicing as a healthcare professional in Finland will interact with immigrants in the course of their work. For these reasons there is a need to evaluate how well the healthcare needs of patients of varying ethnic and cultural backgrounds are being met.

Our study will focus specifically on the experiences of immigrant women giving birth in a new country. As of 2013, 48% of immigrants globally were women (OECD 2013). In terms of such metrics as maternal mortality and availability of healthcare professionals during childbirth, there can be little doubt that Finland is a good place to have a child. In Save the Children’s *State of the World’s Mothers* report for 2015, Finland was ranked second in their assessment of which countries provided the best support and care for both mothers and children; aside from Australia, all of the countries in the ranking’s top ten places were European, with the Nordic countries making up the top five. Maternal healthcare is one of the criteria used for these rankings. (Save the Children 2015: 9.)

Likewise, the World Health Organization's 2015 *World Health Statistics* notes that virtually all births in Finland are carried out with the assistance of trained healthcare professionals (WHO 2015a: 30) and the World Bank's database ranks Finland as consistently having among the lowest maternal mortality rates in the world (World Bank 2015).

While state-of-the-art facilities and up-to-date medical training such as that found in most western countries certainly provide a solid basis for providing a safe and healthy childbirth environment, these factors alone do not guarantee a positive childbirth experience. This is especially true for immigrant mothers giving birth in surroundings which are much different than what they are used to while being attended to by professionals who may not understand or show respect for their patient's background. Some cultures do not necessarily share the West's enthusiasm for science and technology in the fields of medicine and childbirth, instead valuing spirituality or traditional methods (Elliot 2006: 12). Overly "clinical" delivery rooms can cause anxiety and language barriers can lead to the mother's wishes being ignored (Juslén 2012: 90). Because immigrants come from a wide variety of cultures, they naturally have a wide variety of expectations and may be surprised, for example, by the doctor's relatively minor role, or conversely, by the expectation of the father to have a larger role during childbirth in Finland than in their native country or culture. (Kuusisto 2011: 31.) Overall, reported experiences have both positive and negative aspects, and these subjective experiences form the basis of our work.

Discussion of nursing and midwifery involving immigrant patients will often involve the concepts of transcultural nursing and cultural competence. Transcultural nursing originated with the work of Madeleine Leininger and provides a framework for building a successful relationship between caregiver and patient which overcomes the barriers of cultural differences. (Sitzman & Eichelberger 2004: 93-97.) Cultural competence is the ability to put the principles of transcultural nursing into practice and is an indispensable skill for working in today's healthcare environment. It requires self-awareness and adaptability, as well as knowledge and acceptance of cultural differences (Fleming & Towey 2001: 14). Indeed, more than simply being a desirable trait in caregivers, respect for patients and their cultures is mandated in the respective codes of professional ethics for both nurses and midwives (ICN 2012: 2; ICM 2014).

Searching for data relevant to our review revealed that while numerous research exists regarding the maternal experiences of immigrants, the majority of them focus on either

pre- or postnatal experiences rather than the actual act of childbirth. This study will examine existing research relevant to our topic carried out both inside Finland and abroad. We will highlight any common themes arising from both positive and negative experiences specific to the act of childbirth reported in the available material with the aim of suggesting directions for further research in order to develop and advance evidence-based nursing practice, thus aiding healthcare professionals to provide better care to a vulnerable group of patients during one of the most important and emotional events of their lives. Although there is a certain emphasis placed on the implications for the Finnish healthcare system and those working within it, in our opinion the findings and conclusions drawn from this study are applicable outside of Finland as well.

This literature review has been conducted as part of the Immigrant and Ethnic Minority Women's Health Network, whose purpose is the development of cultural competence in midwifery and the improvement of maternal and family health care through education, research, development, and networking (Wikberg 2016: 31).

2 Background

In this section we will define the concepts and terms which are relevant to this literature review. This will serve to provide background and context for the findings, discussion and conclusions which follow.

2.1 Childbirth, Normal Childbirth and the Childbirth Experience

> For the mother particularly, childbirth exerts a profound physical, mental, emotional and social effect. No other event involves pain, emotional stress, vulnerability, possible physical injury or death, and permanent role change, and includes responsibility for a dependent, helpless human being. Moreover, it generally all takes place within a single day. (Simkin 1992: 64.)

The World Health Organization's definition of normal childbirth, which we have used in the selection of our source materials, is a birth that is:

> …spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition. (WHO 1996: 4.)

While this adequately describes the desirable outcome of labor from a clinical and physiological viewpoint, for the mother the experience of childbirth involves much more than

the physical act of delivering a child, as childbirth educator and doula Penny Simkin so vividly describes in the quote which begins this section. A positive childbirth experience varies based on each woman's perceptions, but commonly mentioned factors include having a healthy baby, having their emotional and physical needs taken care of, feeling that their expectations regarding care have been met (Hardin & Buckner 2004: 15), and feeling as if they are in control (Cook & Loomis 2012: 158). The experience can profoundly influence a woman's self-image and relationships (Ricci & Kyle 2009: 372) and a negative experience can result in depression, post-traumatic stress disorder, and avoidance behavior, with women reporting a negative birth experience being significantly less likely to have another baby within the next eight to ten years than women whose experiences were positive. (Waldenström, Hildingsson, Rubertsson and Rådestad 2004: 17.) A participant in Beck's (2004: 32) study describes her labor leaving her feeling as if she were "the victim of a violent crime or rape". The importance of striving to provide a positive childbirth experience is certainly clear.

Traditionally the domain of midwives, over the past two centuries childbirth has become increasingly medicalized, particularly in the west (Johanson, Newburn & MacFarlane 2002: 892). This medical model of childbirth attempts to impose order and structure onto what is, in its natural state, a very individual and organic experience (Walsh & Downe 2010: 3). The end result is that even in places where the role of the midwife was not taken over by (usually male) obstetricians, midwives were often nevertheless swept along in the tide of perceived progress, coming to place more trust in a one-size-fits-all approach than in their own experience and intuition, or in what the women in labor were experiencing and reporting (Downe 2004: 122-123). The World Health Organization similarly describes an institutional culture in which, due to the tendency to treat all births as potentially complicated, labor wards throughout the world have become overcrowded with women engaged in routine, uncomplicated childbirths receiving unnecessary interventions while possibly depriving those who require extra care of needed time and resources (WHO 1996: 2).

In recent decades, a shift back to more traditional views and practices of childbirth has begun to take place as research has largely vindicated the belief that proper setting and individualized, continuous support for the woman during labor can help bring about the conditions which promote a normal childbirth. This support does not necessarily need to come from trained professionals; studies have indicated, in fact, that the most effective care is often provided by untrained lay women with whom the laboring woman is familiar

(Rosen 2004: 25) and who, if the birth takes place in an institutional setting, are not employed by the facility or institution where the labor occurs (Hodnett, Gates, Hofmeyr & Sakala 2007: 16). Hodnett *et al* (2007: 15) also found that women receiving continuous support during labor were more likely to have a spontaneous vaginal birth with a shorter duration of labor and were less likely to need intrapartum analgesia. Fewer cesarean sections, instrument births and low Apgar scores were reported. (Hodnett *et al*. 2007: 15.) Likewise, the assumption that a hospital is the best setting for all births regardless of risk is also being challenged. In the United Kingdom, for example, the NICE guideline *Intrapartum care for healthy women and babies* (2014) advises that for women with low risk of complications during labor, home births and births in midwifery-based units are considered very safe and in fact may result in better outcomes than births occurring in an obstetric labor ward. This change in position at such a high level is noteworthy, even if the reported number of home births has thus far increased only slightly (Zielinski, Ackerson & Low 2015: 361).

For the purpose of this study, we are considering only the portion of the childbirth experience which takes place within the hospital setting, beginning upon admission to the labor ward and ending with the expulsion of the fetus and placenta.

2.2 Midwifery

The World Health Organization describes midwifery as the profession tasked with providing care to women during the various stages of pregnancy, childbirth and the postpartum period, as well as caring for the newborn child (WHO n.d.). Although related to and requiring many of the same skills and competencies as nursing, midwifery is a distinct profession (NHS Health Careers n.d.).

The role, if not profession, of midwife is ancient, being mentioned in the Bible and in the histories of the Greek and Roman empires. In the western world, the history of midwifery is largely a history of marginalization. With the rise to power of the Catholic Church midwives commonly faced accusations of witchcraft and even as midwifery became more recognized as a profession, the requirements for becoming licensed generally were more concerned with the applicant’s character and piety than their actual competence in aiding in the safe delivery of a child. (Donnison 1988: 11-13, 15-19.)

The medicalization of childbirth as mentioned in the previous section of this review has been characterized as being motivated at least partially by the desire of the patriarchal medical establishment to usurp power and knowledge traditionally held by the female profession of midwifery (Clews 2013). Regardless of the motivation, it had the effect of largely placing midwives into a role where they were subordinate to obstetricians (Mander & Fleming 2002: 44).

Literature has acknowledged a need for midwives to re-create themselves. As the healthcare field evolves and become more focused on technology, midwives face the threat of their profession being depreciated and perceived as old-fashioned. In consideration of societal changes, especially increased support for feminist ideas, midwifery may benefit from embracing the public image of the occupation that is woman-centered and based on the midwife's traditional role. (Marland & Rafferty 2002: 249-253.)

2.3 Terms Related to Immigration and the Legal Rights and Status of Immigrants

In our text the words *immigrant* and *international migrant*, or simply *migrant*, have been used interchangeably. The United Nations' *Convention on Migrants' Rights* defines an international migrant simply as a person who lives in a country of which they are not a citizen, either temporarily or permanently, and who has taken the decision to migrate freely and of their own will (UNESCO 2003: 25).

In contrast to those who have migrated voluntarily for reasons of opportunity or family, *refugees* and *asylum seekers* are persons who have left their home country due to persecution based on race, nationality, religion, political affiliation, or other reasons. (CPRSR 1967: 14). An asylum seeker is a person who has requested refugee status in a host country and is awaiting an official decision (UNHCR n.d.). Policies regarding granting refugee status vary between nations, but the guiding principles for United Nations member states are derived from the *Convention and Protocol Relating to the Status of Refugees* of 1967 (UNHCR 2011: 8).

Naturalization is the granting of citizenship by the state to a foreign national, generally via a formal process of application (Perruchoud & Redpath-Cross 2011: 44). Naturalization processes vary by country and tend to be more restrictive in developing regions than in developed regions (UNDESA 2013: 55). A *residence permit* may be granted to non-citizens of a host nation. This grants the foreign national the right to live and possibly to

work in the host country on either a temporary or permanent basis (Perruchoud & Redpath-Cross 211: 47, 56).

International declarations and treaties recognize health as a basic human right; in particular, the United Nations' *International Covenant on Economic, Social and Cultural Rights* and *Convention on the Elimination of All Forms of Discrimination against Women*, both of which Finland is signatory to (United Nations Treaty Collection 2016a & United Nations Treaty Collection 2016b), contain language related to obligating signatory countries to assure access to basic medical care (ICESCR: art. 12), with specific obligations related to pregnancy and postnatal care (ICESCR 1966: art. 10 & 12; CEAFDAW: art. 12).

Despite the obligations laid out in various treaties in regards to human rights and the right to adequate healthcare, in practice an immigrant's legal status in large part determines the amount of access they have to the healthcare system of their host country (IOM, WHO & UNOHCHR 2013: 19). This is the case in Finland. Immigrants who are legally resident in Finland are entitled to the same health care services as Finnish citizens, as are refugees (Kela 2015a: 16,31). Citizens of other EU countries who have a European Health Insurance Card are also eligible for necessary treatment while staying temporarily in Finland (Kela 2015b). Adult asylum seekers are eligible for essential or emergency health care, while children are entitled to full healthcare benefits (Kela 2015a: 31). Undocumented immigrants are entitled only to essential care (Kela 2015a: 30). Care related to pregnancy and childbirth is always considered essential and is therefore always provided, regardless of a person's citizenship status (Kela 2015a: 19).

For the purposes of this study we have not made a distinction between migrants and refugees. We have also made the decision to include naturalized citizens along with immigrants, as we feel that a person's cultural and ethnic background plays a larger role in establishing personal identity than does a legal designation of status.

2.4 Culture, Transcultural Care and Cultural Competence

Edward Burnett Tylor (1871:1.) described *culture* as being the characteristics of a society, and, through socialization, of its members. It includes, but is not limited to, beliefs, morals, laws, and customs. This shared understanding serves to create a common identity which both bonds the group internally and distinguishes it from other groups of people

(CARLA 2014). Cultures also developed in part as a survival mechanism in response to the physical environments groups of people found themselves living in (Henrich 2011).

Because the process of socialization and acquisition of culture begins literally at birth, it becomes such an integral part of one's personal and identity that it is sometimes difficult for the individual to even conceptualize how they are influenced and shaped by it; Erickson makes the comparison to a tool which is used so often that its characteristics are not considered or questioned - it simply works for the purpose it was designed for. (Erickson 2010: 35.) Naturally, the contents of a person's "cultural toolbox" will differ from those of a member of a different society. These differences are addressed in the concept of *cultural relativism*, which acknowledges this variety of worldviews while granting them equal validity (Howson 2009: 1).

In response to increased exposure of healthcare workers to different cultures due to the rise in international migration and travel, as well as a growing level of assertiveness from minority cultures in demanding their beliefs and values be respected by healthcare providers, nursing theorist Dr. Madeleine Leininger developed the concept of *transcultural nursing*. Her work, begun in the 1950s and continued by others after her death in 2012, seeks to develop a knowledge base which can be drawn from to provide both culture-specific and culture-universal models of care in order to best serve patients and clients in a manner which acknowledges and respects their backgrounds. (Andrews & Boyle 2012: 3-5.)

Transcultural nursing is not without its criticisms (Andrews & Boyle 2012: 10), the major of these being a tendency to stereotype members of certain cultures due to an incomplete or overly simplified knowledge of these cultures (Juntunen 2011: 24) and a failure to account for imbalances of power at both a societal (Gustafson 1999: 469) and institutional level (Culley 1996: 566). These criticisms, however, point out theoretical and practical limitations rather than fundamental flaws in underlying principles of transcultural nursing (Andrews & Boyle 2012: 11), and the need for further research regarding these issues has been acknowledged by those who have taken on the responsibility for the continued development of transcultural care as a unique specialty within the healthcare field (TCNS 2010: 22).

Cultural competence can be described as the ability to use the skills required for the successful implementation of transcultural nursing in one's everyday practice as a

healthcare provider (Papadopoulos 2006: 11). Purnell (2005: 8) describes characteristics of cultural competence at both an individual and organizational level. For the individual caregiver, it is important to possess knowledge of one's culture as well as that of the patient, especially as it regards health and illness; open-mindedness and an ability to regard cultural differences without passing judgement are likewise essential for the professional to provide care congruent with a patient's values and beliefs. The organization, on the other hand, should strive to assemble a diverse workforce representative of the community it serves, and this workforce should be provided with the training, resources, and motivation necessary to provide culturally congruent care. Clients and their families should be cared for in accordance with their cultural needs, including provision of interpretation services, special dietary considerations, and an environment which acknowledges the community it serves. (Purnell 2005: 8.)

Similar in principle to the Purnell model, the Papadopoulos, Tilki and Taylor model proposes a four stage cyclical framework for attaining cultural competence. The first stage, *cultural awareness*, requires an examination of one's own background to achieve sufficient insight to recognize how one's own experiences and interactions are influenced by their culture. *Cultural knowledge*, the second stage, is exactly that - knowledge of the characteristics of a given culture, particularly the ways in which different societies view health and illness. Also of interest are issues of power and inequality, again with an emphasis on health and access to healthcare. The third stage, *cultural sensitivity*, refers to the development of the skills necessary to establish relationships with patients which overcome cultural differences by building upon the awareness and knowledge acquired in the first two stages; these relationships should be based on mutual respect and trust, and require that the professional be able to communicate appropriately and effectively. *Cultural competence*, the fourth stage, requires the synthesis of the skills gained throughout the whole of the process along with the development of assessment and diagnostic skills, as well as the ability to recognize and address any forms of discrimination encountered in practice. Rather than being an endpoint, this stage acts as a springboard to continue one's development, as cultural competence is a process of lifelong learning and professional growth. (Papadopoulos 2006: 9-18.)

2.5 Female Genital Mutilation

Female genital mutilation (FGM), or *female circumcision*, is a common practice in parts of Africa, the Middle East and Asia which consists of partially or totally removing the external female genitalia without medical cause. The reasons for the practice of FGM are strictly cultural, and it continues to be carried out due to tradition and religious beliefs, with a strong element of conformity and social pressure along with the belief that it prepares one for adulthood and marriage. Deinfibulation, the surgical opening of the sealed vagina, is sometimes required to open the vaginal opening to facilitate childbirth. Risks associated with FGM from the point of view of childbirth include increased risk for caesarean sections, hemorrhage, obstetric tears, and the need for episiotomies. (WHO 2016.)

3 Statement of Purpose and Research Questions

3.1 Purpose

The purpose of this study is to describe the experiences of immigrant women during childbirth in a hospital in their host country. Any emerging patterns or recurring themes stemming from either positive or negative experiences will be noted, as will inconsistencies or gaps in knowledge, with the aim of suggesting directions for further research in order to advance evidence-based nursing and midwifery practice.

3.2 Research Questions

1. What experiences do immigrant women report regarding childbirth in a new country?

2. What implications do these findings have for nursing and midwifery practices and education?

4 Methodology

4.1 Literature Review

The amount of knowledge and research available to the healthcare professional is breathtaking; online databases have made enormous volumes of specialized literature available at the push of a button. This ease of access, however, highlights the importance of critically analyzing and judging literature in regards to quality and consistency. (Coughlan, Cronin & Ryan. 2013: 2, 9.) *Literature review* is an effective technique for comparing findings from numerous sources and creating an overview of the current knowledge available on a given topic (Green, Johnson & Adams 2006: 102).

A literature review is an analysis and synthesis of previously conducted research, generally conducted for the purpose of condensing a large body of studies into a relatively compact and succinct format. More than simply compiling and summarizing the features and results of the reviewed literature, an effective literature review will examine the materials in question critically, noting patterns as well as inconsistencies between them and discussing the relevance of this synthesized data to practice in the field in question. Gaps in knowledge can also be identified, providing motivation and direction for further research without needing to "reinvent the wheel". (Coughlan *et al*. 2013: 2-4; McNabb 2009: 120.)

There are numerous methods available for conducting literature reviews. This review is a *narrative review*, which we feel well suits our topic due to the variance in the types of source literature available to us as well as the subjective nature of the experiences being studied. Compared to, for example, a *systematic review*, a descriptive review is less rigorous and restrictive in terms of criteria for selecting materials, meaning that a broader range of sources can be utilized. This does not imply, however, that a descriptive review cannot or should not be carried out methodically. (Coughlan *et al*. 2013: 14-15, 29.)

4.2 Selection and Description of Source Materials

This section will describe the criteria used in selecting the research articles used in conducting our literature review. We will also give a brief overview of the methodologies

these studies used, the settings in which they were conducted and the women who participated in them.

4.2.1 Criteria for Inclusion

One of the more striking features of the experiences reported by immigrant women giving birth in their host countries is the amount of similarity between them, despite obvious differences in customs, beliefs and expectations between people migrating from different parts of the world. Thus, we have not felt it necessary nor beneficial to limit our source materials to research carried out within any particular geographical region.

When selecting materials for review, we have limited them to studies involving vaginal deliveries, resulting in live birth and conducted in a hospital setting, which conform to the World Health Organization's definition of a normal birth as mentioned earlier. Births involving routine episiotomy or minor tearing have been included, but those involving major tears or other events requiring reparative surgery or other major interventions during or after delivery, such as caesarean section, have not.

This study is concerned with the intrapartum phase of childbirth, and more specifically, that portion of the intrapartum phase which occurs within the labor ward. Although childbirth usually begins some time before the mother's arrival on the ward and that period is certainly an important part of the mother's experience as well, our work is nevertheless focused on that portion of the experience in which the patient is in the care of professionals.

In addition to the criteria regarding childbirth, we limited our source materials to those with the full text written in English no earlier than 2000 and which include adequate descriptions and justifications of their ethical safeguards, as well as their research and analytical methodologies.

To locate source literature for this review, the authors conducted keyword searches from three online databases, resulting in 136 hits. The majority of these we were able to immediately discard as inappropriate or irrelevant based on our selection criteria, leaving 32 studies to scrutinize further. After additional screening, we were left with seven research articles from which to conduct our final review (see Appendix 1). Details of our searches can be seen in Table 1.

Table 1. Database searches.

Database	Language	Search date	Search terms	Number of hits	Number reviewed (title + abstract)	Number reviewed full-text	Number chosen
Cinahl (EBSCO)	English	6.10.2015	birthing OR childbirth AND experience AND immigrant	86	14	3	3
PubMed	English	6.10.2015	birthing OR childbirth AND experience AND immigrant	33	8	5	1
EBSCO host	English	1.11.2015	immigrant AND Finland	17	10	2	3

4.2.2 Description of the Studies Used

Methods of data collection and analysis in each of the studies used in this review tended to be quite similar. All seven used semi-structured interviews, mostly individual and conducted face-to-face, although telephone interviews were also used in some cases, and one study conducted focus group interviews due to its large sample size. A follow-up questionnaire was also used in one study.

Most of the researchers analyzed their data using some form of phenomenological methodology. Phenomenological analysis is inductive in approach and emphasizes the participant's experiences of the phenomenon being described (Reid, Flowers & Larkin 2005: 20). It can be combined with other analytical methods (Jyväskylän yliopisto 2010); no less than four different variants were employed among the studies used in this review. One of the studies used ethnographic techniques, in which the researcher focuses on the participant's cultural background to interpret the reported experiences (Trochim 2006).

Except for one study conducted in South Africa, all of the research used in this review were carried out in Western countries. This was not intentional, but rather a reflection of the limited amount of literature available to use. Of the other studies, two were conducted in Finland, three in the United States, and one in Australia.

The total number of women participating in the seven studies was 157, although almost half of those - 70 participants - were included in one study. The remaining studies included between nine and twenty-seven participants. Several of the studies investigated the experiences of discrete ethnic groups: two focused on Somali women and one each on Japanese and Korean mothers. Another had participants from several different African nations, including Somalia, Sudan, Liberia and Ethiopia; yet another study featured women from no less than twelve different countries: Australia, Bosnia, Burma, Colombia, Estonia, Hungary, India, Iraq, Russia, Thailand, Uganda, and Vietnam. One did not specify the origins of its participants.

See Appendix 1: *Table of Selected Articles* for additional information regarding the studies used in this review.

4.3 Data Analysis

In analyzing the findings of the studies used in this literature review, we have employed an inductive form of *thematic analysis*. Thematic analysis (or *theme analysis*) is the most commonly used method for analyzing qualitative data in a narrative review and is an appropriate tool for summarizing information obtained from a wide variety of research techniques (Coughlan *et al*. 2013: 96; Onwuegbuzie, Leech & Collins. 2012: 22).

Thematic analysis involves carefully reading the literature and identifying words, groups of words, or phrases significant to the questions being studied; these small pieces of information are known as *codes*. Once this has been done for every article or study being used in the review, these codes are then compared and grouped into sub-categories or *themes* based on their similarities in the context of the topic at hand. These can then similarly be grouped into broader categories. These themes form the basis of the findings of the literature review and, by extension, the discussion and conclusions derived from these findings. (Coughlan *et al*. 2013: 97.)

Inductive analysis refers to the nature of the approach to the coding, theming and hence formation of the findings of a literature review. Specifically, it indicates that the findings have been arrived at from the data, rather than the data being used to support or refute an already existing theory or viewpoint, which is known as deductive analysis. (University of Auckland School of Psychology n.d..)

5 Validity, Limitations and Ethical Considerations

5.1 Validity

Cronin, Ryan and Coughlan (2008: 42) describe the validity of a literature review as on the one hand being an extension of the validity of the literature being studied, and on the other hand a measure of the ability of the author's ability to effectively and concisely analyze and synthesize what they have found.

All of the studies used in this review were selected from databases which are recognized as being reliable. They have all been peer-reviewed and published in professional healthcare, nursing and midwifery journals.

In synthesizing our findings we have attempted to place them into the context of already existing concepts concerning what constitutes the childbirth experience. This gave us a useful framework within which to structure our discussion of the findings founded on a legitimate, recognized knowledge base.

5.2 Limitations

Certain limitations affected the process of conducting this literature review. These can be divided into the following three categories: *availability of literature for review*; *potential limitations of the reviewed literature*; and *inexperience of the authors*.

Due to the very specific topic being considered in the review, the authors faced challenges in locating relevant literature to use. Many of the studies purporting to investigate issues surrounding childbirth actually focused more on antenatal or postnatal experiences, resulting in a very time-consuming screening process which, in the end, yielded

a somewhat smaller sample size of literature than we would have liked to have had to work with. Additionally, all but one of the studies used in this review were conducted in developed, Western countries, limiting the perspectives available for this study.

As mentioned earlier, much time was spent screening literature for relevance to our topic. Due to the limited amount of studies we had to work with it was necessary to use some research which was not necessarily specific to the perinatal phase of childbirth, and in some cases it was not always clear if specific passages or accounts were referring to the act of childbirth itself or another stage of pregnancy. If the nature or timing of the account could not be verified, that data was not used in our review; nonetheless, it must be acknowledged that these were matters of judgement and the possibility of error cannot be ruled out.

Due to the nature of the research being examined, a significant portion of it was carried out with the aid of interpreters and community liaisons. While the methodologies of data collection and analysis in the studies were in all cases well-documented, the potential for misunderstanding due to language, cultural differences or potential bias leading to misrepresentation of the participants' experiences must be acknowledged.

Finally, while this literature review was conducted in good faith according to the research guidelines of Metropolia University of Applied Sciences and with guidance and input from supervisors and others, the authors are nonetheless inexperienced in the implementation of such a project, and the quality of the product may reflect this.

5.3 Ethical Considerations

Ethical considerations are a significant concern in all research, and literature reviews are no exception (Coughlan *et al*. 2013: 77). One of the criteria applied when selecting literature for this review was a clearly stated explanation of the methods used by the authors of the studies to ensure that participants were treated in a manner that ensured their autonomy, confidentiality, dignity, and privacy. Every study used had received approval from a relevant ethics board or committee prior to the authors carrying out their research.

The inductive content analysis methods used in this review allow for rigorous and thorough collection and analysis of data, and every effort was made to interpret that data accurately, objectively, and without personal bias. Our conclusions were arrived at

through consideration of all the available data, and information was not “cherry-picked” to influence the findings.

In writing this literature review, the authors have made every attempt to accurately cite and credit all sources of information used throughout the work using Metropolia University of Applied Sciences’ citation guidelines. It was screened for plagiarism using the *Turnitin* online software.

6 Findings

While finding data relevant to our research questions was a relatively straightforward task, it proved to be significantly more of a challenge to separate these findings into two distinct subtopics. The reported experiences of the participants in the various studies reflected, in the majority of cases, either their interactions with midwives and other healthcare staff or differences between the practices and environments surrounding the childbirth experience; the findings thus tend to apply to both research questions simultaneously. Listing these findings separately would have led to a good deal of repetition and redundancy and for this reason we have chosen to note them together throughout the following subsection.

6.1 Communication Difficulties

Perhaps unsurprisingly, one of the most consistent themes that arose from the selected research was that of difficulties in communicating. In addition to obvious issues of language, participants also at times reported more general lapses in communication, as well as having information regarding their care being withheld. Information given to patients was sometimes reported as being insufficient, incorrect, or simply not understood.

In one Finnish study, lack of communication was sometimes perceived as preventing effective relationships between nurses and patients from developing, causing frustration for all involved (Wikberg, Eriksson & Bondas 2012: 642). In another study also conducted in Finland by Degni, Suominen, El Ansari Vehviläinen-Julkunen and Essen (2014: 358.), Somali mothers reported feeling that their lack of Finnish language skills caused misunderstandings, which gave them negative impressions of staff. It was felt that staff listen and speak more to Finnish-speaking patients.

All the participants in the study conducted in Brisbane, Australia agreed that events occurring during childbirth were not sufficiently explained. They reported not being given staff introductions, information on medication, and neither reasons for procedures nor opportunities to properly consent to them. This caused fear, distress and distrust. (Murray, Windsor, Parker & Tewfik 2010: 463.)

Similar experiences were expressed by both Somali (Wojnar 2015: 364, 367) and Korean immigrant women in the United States. Feelings of fear and lack of control were increased if it was a woman's first birth. (Seo, Kim & Dickerson 2014: 309.) Some participants in Wojnar's (2015: 363) study also reported that they simply had to hope that healthcare workers would know when to provide information, which sometimes led to the new parents missing chances to perform cultural rituals and blessings for the newborn.

Language barriers caused stress and loneliness as well as a fear of being misunderstood (Taniguchi & Magnussen 2009: 273). Along with familiarity with the healthcare system, proficiency in the local language was considered empowering, allowing for ease of communication. This provided women with a feeling of awareness and control going into the birth (Murray *et al*. 2010: 464; Wikberg *et al*. 2012: 642; Wojnar 2015: 365). Despite this, a lack of health literacy sometimes hindered understanding, as staff often used medical terms or jargon. This limited mothers' ability to comprehend information and make decisions. Some mothers reported that they blindly followed healthcare staff's instructions as they did not feel they knew any better and no opportunities for decision making were presented (Seo *et al*. 2014: 309, 311-312).

Not all of the African women in the study from Australia were aware of the availability of interpretation services and in some cases used unofficial interpreters (Murray *et al*. 2010: 463). Even with a professional interpreter in use, these were not always available when needed suddenly, as described, for example, by the Korean women giving birth in the United States (Seo *et al*. 2014: 309-311). Participants in the South African study conducted by Tebid, Du Plessis, Beukes, Van Niekerk & Jooste (2011: 970-972) described caregivers who were too impatient to provide mothers with information or gave them information which was inconsistent; one woman even describes having an episiotomy performed on her without being informed of or consenting to the procedure, which is a clear violation of medical ethics.

6.2 Cultural Competence of Healthcare Staff

None of the studies used in this review reported unanimously positive descriptions by immigrant mothers of healthcare workers' cultural awareness or sensitivity. At what can be considered the positive end of the spectrum, participants described nurses and midwives as being culturally incompetent but, at least in some cases, well-intentioned and willing to learn (Wikberg *et al*. 2012: 642), whereas at the other end, attitudes and behaviors were explicitly discriminatory, abusive, and unprofessional (Tebid *et al*. 2011: 971).

In general women did not necessarily expect healthcare providers to be deeply familiar of their cultures or languages. On the other hand, those nurses who were aware of cultural differences made a good impression on their patients by, for example, providing the correct diet for Muslim women; options in choosing the gender of their health care providers were also appreciated (Wikberg *et al*. 2012: 644). Any knowledge that staff had and used during care was appreciated by mothers; participants sometime felt, however, that they knew more about the differences between their own culture and that of their host country than staff did and that they would have wanted staff to be better educated on foreign customs. (Wojnar 2015: 366-367.) Some reported that while they were comfortable giving information about their own culture, they felt that only part of the staff showed any interest in learning (Wikberg *et al*. 2012: 642).

Some participants reported that staff assumed women from the same cultures shared the same background - despite them having a wide range of past histories in regard to for example female genital mutilation or experiences of war - and that women with previous childbirth experience would be competent to give birth in a new country. On the contrary, many mothers felt that their new environment was so different that their past experiences did not prepare them for birth. (Murray *et al*. 2010: 466.)

Degni *et al*'*s* (2014: 359-360.) interviews conducted in Finland report varied feedback from participants. Some of the women who didn't speak Finnish nevertheless described having positive experiences with healthcare staff; they felt they were treated on equal basis with Finnish mothers and that they were listened to and supported. Other participants, however, disagreed, reporting that they felt the workers were uninterested and uncaring, and that they did not listen to the participants. One woman felt that staff require

more education on cultural differences to prevent them from assuming that people of different cultures are inferior to Finns.

One aspect of childbirth that highlights the differences between different cultures is that of the presence of the father during the delivery. One participant of Japanese origin in Taniguchi and Magnussen's (2009: 274) study in the United States felt that the shared experience of childbirth strengthened the bond between the parents. Some of the Somali women interviewed in Wojnar's (2015: 365) study, however, would have rather had other women supporting them during labor, in line with their cultural traditions. The African women participating in Murray *et al*'s (2010: 466) study mentioned having the support of family members, in the plural, during childbirth.

Wikberg *et al*. (2012: 643.) noted that some women felt that they faced prejudice as staff made inappropriate and stereotyping comments about their culture, such as a nurse commenting that people of a certain mother's culture are less able to endure pain. They felt that their experiences were not taken seriously enough due to the way they expressed them, such as a woman who expressed pain more quietly and was denied analgesia when it was requested.

The most extreme descriptions of cultural insensitivity were reported in Tebid *et al*'s (2011: 971.) study. The majority of participants described behavior by healthcare professionals which they felt was discriminatory, disrespectful, and insensitive. They felt that this was a direct result of their ethnic and cultural backgrounds.

6.3 Sensitivity and Empathy of Healthcare Staff

In addition to issues regarding cultural sensitivity, participants in the various studies presented a wide range of positive and negative experiences in regards to the levels of general sensitivity and empathy they perceived that they had received from healthcare staff.

There were mixed experiences of interaction with individual staff members in many of the studies. Murray *et al*'s (2010: 465) study is typical of this, with participants reporting that while midwives and nurses were obliging, comforting, caring and calming, they also sometimes gave the impression of being too busy to give patients their full attention.

Some mothers in Wikberg *et al*'s (2012: 642-645.) study conducted in Finland had experiences which left them feeling disregarded. One, for example, recalled being laughed at by a nurse when she asked a question, which caused her to become embarrassed and upset. On the other hand, participants also praised nurses for apologizing for and making an effort to discuss negative experiences with them in order to resolve conflicts and avoid lasting distrust or bad feelings. It was also noted that many participants found staff to be accommodating with requests, such as for treatment by female doctors.

Some of the participants in Wojnar's (2015: 364.) study of Somali immigrants in America reported interactions with caregivers as being supportive, informative and allowing for their own participation in care. Others, however, felt that promises were sometimes broken or that their requests were ignored, which they described as causing them to feel disregarded and lonely.

The most extreme accounts of negative experiences of mothers' interactions with healthcare providers were once again reported in Tebid *et al*'s (2011: 970-971.) study conducted in South Africa. Participants were called names, shouted at, and even threatened with acts of violence. Pain medication and basic care were withheld. Staff were described as rude, cruel, indifferent and tactless. Some women were left alone in the delivery room and had to call the midwife for a checkup; some were too intimidated to even ask for help due to the hostile responses they received. In general, the insensitive treatment they were given left them feeling unwelcome, resentful, and traumatized.

6.4 Perceptions of Professional Expertise

The theme of healthcare staff being knowledgeable and capable appeared repeatedly in immigrant mothers' narratives, and mostly favorable experiences were reported. Healthcare workers were perceived as calm (Wikberg *et al*. 2012: 643) and as professionals with broad clinical knowledge (Murray *et al*. 2010: 465-466). In some cases, however, the amount of knowledge staff had intimidated mothers and made them hesitant to question care decisions, even when they disagreed with the course of action being taken.

Studies conducted in Finland state that immigrant mothers were pleased with the care they received, which was depicted as humane, of excellent quality, and provided in calm and unhurried surroundings. Likewise, the majority of nurses received positive feedback, listing qualities such as happy, cheerful, amiable, obliging, well informed, and profes-

sional. Midwives were described as being calm and efficient. They made informed decisions and did not use medical interventions unless absolutely necessary. Mothers felt that expert care was always accessible when they needed it. This appreciation deepened once the mothers gained a better understanding of maternity care organization in the new country. (Wikberg *et al*. 2012: 642-644.) Childbirth in Finland was found to be uncomplicated and secure (Degni *et al*. 2014: 355).

Gaps in professionals' knowledge linked to cultural differences, while uncommon, were nevertheless sometimes reported. A participant in one study, for example, noted being surprised by healthcare providers' lack of experience with female genital mutilation. (Murray *et al*. 2010: 465-466.) This was echoed by a woman in Wojnar's (2015: 364) study, who expressed fear concerning the doctor's ability to perform the correct type of episiotomy required to open the birth canal due to her circumcision.

6.5 Settings and Practices

Certain issues were raised in some of the studies used regarding the difference in settings and childbirth practices the participants were accustomed to. As with the other themes described, a variety of views and experiences were reported.

In some cases, the clinical surroundings and medical nature of childbirth in a Western country were found to be jarring. The African women in Murray *et al*'s (2010: 466-467.) study reported previous births occurring in a variety of settings, but most thought of childbirth as above all a natural process which does not need to be helped along. Thus, they sometimes felt uncomfortable with such measures as analgesia and practices designed to accelerate the birthing process, as well as by such things as lying in a bed when giving birth as opposed to squatting. Many of the women also reported that they waited as long as possible before coming to the hospital in the belief that this would decrease the chance of requiring a caesarean section; interestingly, this same practice was noted in Wojnar's study of Somali women in the United States (Wojnar 2015: 363).

Another example of cultural practices affecting one's expectations and perceptions of childbirth occurred in Seo *et al*'s (2014: 312) study of Korean women giving birth in the United States. A participant complained that the delivery room was too cold; this was due to the traditional Korean practice of Sanhujori which requires mothers to keep their bodies warm immediately following childbirth to avoid damage to their bones and joints.

This is an important tradition for many Korean women, but they report that it is largely unavailable to them outside of their home country.

7 Discussion

When reviewing the findings of the literature used in our review, two major areas of discussion emerged. The first is the birth experience itself. As mentioned earlier in the background information regarding childbirth, there are a number of factors which contribute to the overall childbirth experience, with the following contributing to what is generally considered a positive experience: a feeling of being in control; of having one's emotional and physical needs met; and of having one's expectations met. Discussing how our findings fit within the context of these factors provides a sound basis for answering, to the extent possible, our first research question, "what experiences do immigrant women report regarding childbirth in a new country?", while also providing an opportunity to address our second question, "what implications do these findings have for nursing and midwifery practice and education?".

In the second section of our discussion we address what we feel to be ethical violations regarding a patient's rights to autonomy and dignity which occur throughout the literature we have examined. Nurses and midwives, as part of their roles as healthcare providers, are responsible for advocating for those in their care. Unfortunately, we found that there is much need for improvement in this area, with even the most well-intentioned healthcare workers often falling short of providing care which meets the standards their professional obligations demand. Clearly, this results in implications for practice in caring for these patients.

7.1 The Childbirth Experience

When preparing the background for this thesis, a number of factors were commonly cited as combining to make up a positive childbirth experience. In this portion of the discussion we examine whether or not the experiences described in the findings have met these criteria. Specifically noted were participants' feelings during childbirth of being in control of themselves and the situation, of having their emotional and physical needs met, and of having their expectations of the childbirth experience fulfilled.

7.1.1 Feeling in Control During Childbirth

In the academic literature regarding the childbirth experience mentioned in the background section of this thesis, a central theme is the woman's perception of being in control of the situation (Cook & Loomis 2012: 158; Hardin & Buckner 2004: 14). Of the literature we have studied in our review, only Murray *et al*'s (2010: 463-464) study specifically notes a definitively positive factor contributing to control during childbirth, which reports that their participants reported feeling more in control of the situation when they were kept informed by healthcare workers.

On the other hand, while not a true measure of the effect of feeling in control during birth, it can be noted that several of the studies mentioned factors which had the opposing effect of causing participants to feel that they were less in control of themselves and the situation. This led to stress and anxiety among the women interviewed. Chief among these was lack of information, with every single study in this review mentioning communication between caregivers and patients being a problem. The majority of them also reported scenarios in which a lack of communication, either due to language issues or staff simply not providing information, specifically caused their participants to feel as if they were not in control during their childbirth experience. (Murray *et al*. 2010: 463; Seo *et al*. 2014: 309-310; Tebid *et al*. 2011: 971; Taniguchi & Magnussen 2009: 273; Wojnar 2015: 363.)

This clearly illustrates the importance of keeping patients informed and aware of developments concerning their care. It should not be taken for granted that a patient will assume that "no news is good news", and even the most routine situations can be intimidating for someone who is in new surroundings, especially when those surroundings consist of a tile room filled with machines and strange sounds. Likewise, the patient should be kept abreast of the situation in the event that things do not go as planned; they have a right to be informed and to make decisions regarding their care. If an interpreter is being used, it is important to ensure to the extent possible that they are healthcare literate and convey information that is accurate.

7.1.2 Emotional and Physical Needs During Childbirth

Hardin and Buckner (2004: 15) mention that having the mother's emotional and physical needs met are also factors contributing to a positive childbirth experience. As with the

issue of control, it is easier to find examples from the literature of these needs not being met.

Tebid *et al*'s (2011: 971-972) study from South Africa sets the unfortunate gold standard for depicting poor quality care leading to negative birth experiences. Participants describe being too intimidated to even ask midwives for help. When they did summon the courage to seek help, they reported that they were often ignored. While perhaps not as dramatic, other studies mention that participants wished that there would have been more staff available because they felt that staff were too busy to respond to their concerns.

Another issue reported concerns the fact that many participants came from cultures in which childbirth often involves the presence of several family members providing support, and this extended support was sometimes missed in their new home countries (Murray *et al*. 2010: 466; Wojnar 2015: 365). In other cases, however, participants were fairly pleased with the options available to them as far as being able to choose who they could have present for support during the birth (Wikberg *et al*. 2012: 643). This indicates that different cultures have different priorities regarding whom they wish to have with them during the childbirth experience, which is an important matter for midwives and nurses to bear in mind.

From a physical standpoint, participants in the Finnish studies found the delivery environment comfortable and safe (Degni *et al*. 2014: 356; Wikberg *et al*. 2012: 643). A very serious issue that was mentioned, however, is that in some cases analgesia was not provided during labor, even when patients asked for it (Tebid *et al*. 2011: 971; Wikberg *et al*. 2012: 643-644).

Especially bearing in mind possible language issues, caregivers need to be conscious of the emotional and physical needs of patients. Patients may be in unfamiliar settings without family or other support and may be unable or hesitant to express their fears, concerns, or physical needs such as for pain relief. It is the responsibility of healthcare workers to assess the patient's mental and emotional state through verbal and nonverbal communication, to be present for the patient, and to provide whatever support they can. Likewise, pain should be managed in an effective and responsible manner, along with other physiological requirements such as nutrition, hydration and ergonomics.

7.1.3 Expectations of the Childbirth Experience

Another factor affecting a woman's childbirth experience is whether or not their expectations have been met (Goodman, Mackey & Tavakoli 2004: 213).

For women who had previously given birth in other settings, these experiences naturally influenced what they expected during the birth in their new country. Women who had lived in their host country for a longer time or had gained some fluency in the local language, as well as some familiarity with the healthcare system and practices, reported that they were better prepared for the experience of childbirth. (Degni *et al*. 2014: 359; Murray *et al*. 2010: 464; Wojnar 2015: 365)

Healthcare workers should be aware that practices vary in different settings and it should not be assumed that because a woman has experienced childbirth before that she necessarily knows what to expect in her new surroundings. If the mother is familiar with childbirth according to the customs, settings or practices of her native culture and is not aware that the same options are not available to her in her new settings, this can lead to a feeling of not being in control and lead to a negative experience.

Accessible childbirth education during the antenatal period to familiarize newcomers with practices used in the host country is an obvious first step in helping immigrant mothers understand what to expect during the birth. This needs to take into account the woman's communicational needs, and outreach may be necessary to encourage educational opportunities to be utilized. Flexibility on the part of healthcare workers is also helpful; communication during the pregnancy to determine exactly what the mother's expectations are and being receptive to her wishes can help create a relationship of trust which carries into the birth. Documenting these wishes so that the staff in the labor ward are aware of them can help avoid conflict and disappointment during the childbirth experience.

Another expectation that was not always met was that of sensitivity toward the patient's cultural background and customs. While good intentions were appreciated, some participants in the various studies cited often expressed disappointment or feelings of dismissal when staff seemed oblivious to, and in some cases uninterested in, their cultural values and practices regarding childbirth. (Murray *et al*. 2010: 467; Wikberg *et al*. 2012: 642; Wojnar 2015: 363.)

While it is certainly no small task to go about learning the characteristics and customs of an unfamiliar culture, it is becoming more and more necessary to have ready access to such information in this time of ever-increasing migration. Education on principles of cultural competence as well as relevant aspects of individual cultures should be provided to both students and qualified professionals to develop the skills and knowledge required to provide care meeting the needs of this vulnerable group of patients. Nevertheless each patient should be viewed and treated as an individual to avoid stereotyping, which is one of the criticisms made of transcultural care (Andrews & Boyle 2012: 10).

7.2 Violations of Healthcare Ethics

The most serious implications of this literature review's findings involve potential and actual violations of patients' rights as enumerated by the international professional bodies of both nurses and midwives, as well as many other national and international healthcare professional bodies and the World Health Organization. The codes of ethics of both the International Council of Nurses and International Confederation of Midwives very clearly mandate that patients receive care which respects their dignity and autonomy, and is provided without discrimination or harm (ICN 2012: 2-3; ICM 2014: 1-3). The WHO (1994: 8) echoes these principles in, for example, "A Declaration on the Promotion of Patients' Rights in Europe".

From the literature reviewed in this work, the descriptions of unethical behavior of healthcare workers by the participants in Tebid *et al*'s (2011: 970-972) study carried out in South Africa were certainly the most shocking in both scale and severity. Accounts of nurses and midwives verbally abusing patients, using racist terms, threatening them with violence, withholding information and care as well as performing medical procedures without patients' consent, almost defy belief. The emotional recollections of the participants underline the effects that their treatment had on them. The violations of patients' dignity, autonomy and the right to adequate care free from discrimination in this study are glaringly obvious.

What may be less obvious are the more subtle incidences of these same violations which were present in several of the studies used in this literature review. Similar to the South African study and differing more in degree than nature, violations of the patient's right to autonomy, dignity, and care without discrimination are noted throughout the literature.

7.2.1 Autonomy and the Right to Informed Consent

The right to informed consent is a central concept when discussing a patient's right to autonomy. Informed consent for a procedure or treatment is given only when the patient has received all relevant information needed to make a decision (AMA 1981). This becomes an issue when language barriers hinder or prevent communication and understanding between healthcare providers and patients, making an informed decision difficult, if not all but impossible.

As noted earlier, examples of language barriers explicitly hindering patients' ability to provide informed consent during labor were noted in several of the studies used in this review. Beyond this, issues stemming from language and communication difficulties were cited by participants in every one of the studies, even if any effects on the capacity of patients to provide informed consent were not mentioned. In addition to a violation of autonomy, this could also be considered a barrier to a patient's access to care, as they may not understand the various options for care available to them.

Also noted in several studies was a lack of access to interpreters during childbirth; in some cases, even if interpreters were available, participants were not informed of this. Regulations regarding interpreters vary between countries. The United States, for example, requires that any facility that receives funding from the federal government provide translation services for patients free of charge; despite this, interpreter services are often lacking (Coren, Filipetto & Weiss 2009: 635). The Finnish Act on the Status and Rights of Patients (1992) requires only that a patient's mother tongue be taken into account as much as possible during treatment. Clearly there is a need for improvement in accommodating patients whose native language is not that of their host country.

7.2.2 Dignity, Respect and Care without Discrimination

The World Health Organization defines dignity as a person's inherent worth simply by virtue of being human, which cannot be diminished by such factors as race, gender, health status, or background (WHO 2015b: 1). As mentioned earlier, nurses and midwives are called upon by their professional codes of ethics to honor the dignity of their patients at all times. Unfortunately, that obligation is not always met.

The perceptions relating to behavior on the part of healthcare staff reported by the participants in the studies cited differ considerably. Both positive and negative experience were reported, the variance of which is natural considering the number of women questioned and the number of healthcare workers they encountered. Staff's intentions were either conscious or inadvertent, but regardless affected the way the women experienced childbirth.

One specific issue that was mentioned in several studies was that of female genital mutilation. Women who were circumcised consistently reported feeling self-conscious and were afraid that they or their culture were being judged.

Stereotypes and assumptions were commonplace throughout the literature, with tactless remarks and questions sometimes leaving women of various backgrounds angry or ashamed.

The research used in this literature review contains numerous examples of patients feeling that they have been treated disrespectfully, either on an individual level or due to their cultural or racial background. Obviously, neither of these are acceptable. Racism and discrimination may not always be as obvious as in Tebid *et al*'s South African study, but one should remember that healthcare professionals have an obligation to uphold the dignity of all patients in their care. Inappropriate behavior may be perceived as discriminatory even when it is not motivated by prejudice.

As was mentioned earlier, respect for the dignity of the individual is a central principle in the ethics of nursing and midwifery. The reality is, however, that healthcare workers are nonetheless human, and as such are subject to prejudices and preconceptions. This, of course, in no way excuses behavior which is discriminatory or otherwise inappropriate, it merely acknowledges the reality that healthcare workers are capable of such behavior, as unfortunate as it may be and as much as we, as future healthcare professionals ourselves, would like to believe otherwise.

Suggestions aimed at improving this situation include, for example, seeking continuous feedback from both patients and other employees in order to expose and provide consequences for insensitive and discriminatory behavior. Organizations should have a clear and well-disseminated policy regarding discrimination in place, and accountability for inappropriate behavior should be consistently enforced. Education on care that

acknowledges and respects the worth of all patients, regardless of race, gender, religion, or culture should be provided to students, as well as on a continuing basis for qualified healthcare professionals. It should also be kept in mind that, more than simply a violation of ethics, discrimination in healthcare may also be a violation of the law (Health Care Act 2010: sec. 2; Non-Discrimination Act 2004: sec. 2).

Organizations also benefit from a workforce which reflects those whom they are serving (Purnell 2005: 8). Degni *et al*'s (2014: 358-359) study of ethnic Somali women in Finland includes the opinion of a young woman who, in addition to being a patient, was a student nurse who had worked within the Finnish healthcare system. She stated that although she believes the system itself is good, Finnish healthcare workers are not particularly competent when dealing with people from different cultures. Gaining the insight of new professionals who are familiar with these cultures will be invaluable in improving healthcare in a way which welcomes and benefits a society's newcomers.

8 Conclusion

The experience of childbirth is one of the most significant events in a woman's life and can have lasting effects for not only the mother, but also for the child and family. It is therefore vitally important to ensure that the childbirth experience is a positive one. Unfortunately, this is not always the case, as the findings of our research have shown. The most prominent barriers we have noted are communication difficulties, lack of cultural competence and a general lack of empathy. On the other hand, professional expertise was generally considered sufficient to facilitate a positive experience. The settings and practices used in the host countries were generally considered safe and comfortable, although sometimes were found to be overly clinical and unnatural.

These factors, in addition to affecting childbirth as experienced by the mothers, also jeopardizes their rights as patients and human beings. Healthcare professionals need to ensure through their practice that they consistently respect the autonomy and dignity of their patients. These principles are already mandated not only through professional codes of conduct but are also a legal requirement.

Although the discussion resulting from the findings of this literature review paints a somewhat grim picture, we feel that solutions to the problems presented, while not necessarily

easy, are quite straightforward and attainable. Education and access to information regarding diverse cultures and customs is key to tailoring personalized care for the increasingly diverse patient base that midwives and nurses will be required to care for. Treatment should take into account a patient's emotional as well as physical needs, including the need for information they require to be in control of their own care.

We feel that additional research into the healthcare needs of immigrant woman, especially regarding the childbirth experience, would benefit the healthcare profession. Research from more varied settings would be welcome, in order to compare and contrast the experiences of different healthcare systems; this would go some way towards determining if cases such as Tebid *et al's* study from South Africa are merely aberrations or are indicative of local or regional differences in healthcare culture.

Research could be conducted into specific immigrant groups, such as studies focused on refugees versus voluntary migrants to compare different experiences. Similarly, comparing and contrasting the experiences of different cultural groups within the same country can point out strengths and weaknesses within individual healthcare systems. Finally, more specific research into the intrapartum phase of childbirth could clarify what experiences arise exclusively during this stage.

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Appendix 1. Table of selected articles

Author, title, year, country	Study aim	Study design	Sample	Findings
Degni, F. et al. (2014). Reproductive and maternity health care services in Finland: perceptions and experiences of Somali-born immigrant women **Finland**	To explore immigrant Somali women's experiences of reproductive and maternity health care services (RMHCS) and their perceptions about the service providers.	Focus groups.	70 married Somali women aged 18-50 and mothers of 2-10 children.	Participants were satisfied with the RMHCS they received in Finland. Despite their satisfaction, the health care providers' social attitudes towards them were perceived as unfriendly, and communication as poor.
Murray, L. et al. (2009). The Experiences of African Women Giving Birth in Brisbane, Australia **Australia**	To acquire first-person descriptions of African refugee women's experiences of having a baby in Brisbane; • To describe the common essences that emerge from African refugee women's experiences of having a baby in Brisbane; • To share the knowledge produced through this study with service providers and community members.	Semistructured interviews. Husserlian phenomenological framework (emphasis on the lived experience and its aim to uncover universally shared experiences). Transcribed verbatim.	10 African refugees who had given birth in Brisbane. Nationalities: Sudan, Liberia, Ethiopia, Somalia All the participants had given birth to at least one baby in Brisbane.	Essences universal to childbirth such as pain, control, and experiences of caregivers featured prominently in participants' descriptions of their experiences. Their experiences, however, were further overshadowed by issues such as language barriers, the refugee experience, female genital mutilation (FGM), and encounters with health services with limited cultural competence.

Seo, J. Wooksoo, K. Dickerson, S. (2014). Korean Immigrant Women's Lived Experience of Childbirth in the United States **USA**	To understand Korean immigrant women's common experiences and practices of utilizing health care services in the United States during childbirth.	Semistructured telephone interviews.	A purposive sample of 15 Korean immigrant women who experienced childbirth in the United States within the past 5 years was recruited.	During childbirth in the United States, participants faced multifaceted barriers in unfamiliar sociocultural contexts yet maintained their own cultural heritages. They navigated the unfamiliar health care system and developed their own strategies to overcome barriers to health care access. Korean immigrant women actively sought health information on the Internet and through social networking during childbirth.
Tebid, R. et al. (2011). Implications for nurse managers arising from immigrant women's experience of midwifery care in a hospital **South Africa**	The researcher aimed at exploring and describing the immigrant mothers experiences during pregnancy, labour, birth and the postpartum period at some Government Hospitals in the Gauteng Province of South Africa. Understanding these experiences assisted the researcher to describe the implications for nurse managers of maternity units to support midwives with caring for immigrant mothers during pregnancy labour, birth and the postpartum periods.	After purposive sampling, phenomenological interviews were conducted until data saturation occurred.	The target population included nine immigrant mothers living in the inner centre of Johannesburg who, for the first time, attended, had antenatal clinics, laboured and gave birth at a Government Hospital in the Gauteng province of South Africa. Nationalities: Not mentioned. Supposedly, refugees and asylum seekers from Zimbabwe, Mozambique and other African States (the biggest immigrant groups)	The findings indicate that nurse managers should ensure that midwifery care of immigrant mothers comply with the ethical–legal context of the South African constitution. Actions should be taken in combating issues related to impaired maternal–midwife relationship, lack of cultural sensitivity and psychological distress.

Taniguchi, H. and Magnussen, L. (2009). Expatriate Japanese women's growth and transformation through childbirth in Hawaii, USA **USA**	The purpose of this study was to describe the meaning of the childbirth experience for Japanese mothers who gave birth soon after relocation to Hawaii.	Descriptive, using Colaizzi's phenomenological approach.	10 Japanese expatriate women. Inclusion criteria: (i) Japanese women who were born and raised in Japan; (ii) the childbirth experience occurred during the first 3 years of residence in Hawaii (primipara); (iii) having a live child between 6 and 10 months old; and (iv) having a Japanese partner. Age range: 24–39 years.	The major findings of this study consisted of four theme categories: the challenges of living overseas, the challenges of motherhood, reaching the goal of motherhood, and relationships with others. The implication arising from this study for caregivers is that it is necessary to understand culturally sensitive care that meets the individual needs of women in each transition.
Wikberg, A. Eriksson, K. & Bondas, T. (2012). Intercultural Caring From the Perspectives of Immigrant New Mothers **Finland**	To describe and interpret the perceptions and experiences of caring of immigrant new mothers from an intercultural perspective in maternity care in Finland.	Interviews, observations, and field notes were analyzed and interpreted.	Seventeen mothers from 12 countries. Australia (1), Bosnia (3), Burma (1), Colombia (1), Estonia (3), Hungary (1) India (1), Iraq (2) of which one was Kurdish, Russia (1), Thailand (1), Uganda (1), and Vietnam (1) All the mothers were first-generation immigrants.	Most mothers were satisfied with the equal access to high-quality maternity care in Finland, although the stereotypes and the ethnocentric views of some nurses negatively influenced the experiences of maternity care for some mothers. The cultural background of the mother, as well as the Finnish maternity care culture, influenced the caring. Four patterns were found. There were differences between the expectations of the mothers and their Finnish maternity care experience of caring. Caring

				was related to the changing culture. Finnish maternity care traditions were sometimes imposed on the immigrant new mothers, which likewise influenced caring. However, the female nurse was seen as a professional friend, and the conflicts encountered were resolved, which in turn promoted caring.
Wojnar, D. (2015). Perinatal Experiences of Somali Couples in the United States **USA**	To explore the perspectives of Somali couples on care and support received during the perinatal period in the United States.	Semistructured individual interviews, interviews with couples, and a follow-up phone interview. Colaizzi's method guided the research process.	Forty-eight immigrant women and men from Somalia (26 women and 22 men) who arrived in the United States within the past 5 years and had a child or children born in their homelands or refugee camps and at least one child born in the United States. All of the participants resided in the Pacific Northwest.	Data analysis revealed an overarching theme of Navigating through the conflicting values, beliefs, understandings and expectations that infiltrated the experiences captured by the three subthemes: (a) Feeling vulnerable, uninformed, and misunderstood, (b) Longing for unconditional respect and acceptance and (c) Surviving and thriving as the recipients of health care.