“Then, it doesn’t matter where they come from”

Cultural Competence and its Construction among Public Health Nurses and Students in Maternal and Child Health Clinics in the Province of Eastern Finland

Satu Leppälä
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
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<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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<tr>
<td>QCA</td>
<td>Qualitative Content Analysis</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RQ</td>
<td>Research Question</td>
</tr>
</tbody>
</table>
ABSTRACT

BACKGROUND Public Health Nurses (PHNs) in the Province of Eastern Finland are facing a new situation when the families attending maternal and child health (MCH) services represent increasingly diverting cultural backgrounds. Cultural competency is a part of PHNs’ qualification demands in Finland, however little is known on the phenomenon in the study area at the moment.

AIM This study aims to describe how cultural competence is understood and constructed among PHNs and PHN students working and training in the MCH clinics in the Province of Eastern Finland.

METHODS Qualitative design was employed. Data were collected in five semi-structured individual interviews and two focus group discussions conducted in Finnish by author. Data were audio-recorder, transcribed and analysed through qualitative content analysis (QCA). Translation to English took place during the QCA process. The total number of participants was 15.

FINDINGS The participants perceived culture as a multi-dimensional phenomenon, and that specific skills are needed when meeting clients from different cultures. Cultural competence in this sample refers to a four-staged process which is highly affected by social processes and interaction between the PHNs, students, clients and other stakeholders in MCH care and community.

CONCLUSION This study can serve as an explanatory material to fill the knowledge-gap between the previously published theoretical studies on cultural competence and the grass-root level MCH work. The findings represent perceptions and experiences of highly educated, native Finnish sample working in a relatively rural province, and thus their transferability should be viewed with criticism.
ACKNOWLEDGEMENTS

I sincerely thank Dr Beth Maina Ahlberg, Dr Pia Olsson and Dr Carina Källlestål for guiding me through this exciting journey with their constructive criticism and friendly supportiveness. A big thank you belongs also to my Finnish supervisor, lecturer MNSc Raija Lappalainen who believed in my idea and made this project possible with her encouraging advises. My student colleagues at IMCH, thank you for providing me with your honest feedback and cheerful peer support, and most importantly, for always recognising which one was needed the most. IMCH Degree Course Administration, thank you for making the practical matters smooth and easy for us students in the department.

Thank you, Sanni Heikkinen, for being an amazing focus group discussion research assistant in addition to being an amazing friend. Emmi Särkkä and Vesa, thank you for hosting me during the data collection and letting me to turn your home into a temporary research office. My dear family and friends, thank you for your endless support in and outside of this project. And darling Arttu, thank you for reminding me of the simple joys of life in the days when this project felt overwhelming.

Lastly, I would like to thank the public health nurses working in maternal and child health clinics in the Province of Eastern Finland for inspiring this research project. This thesis is written for you.
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LIST OF ABBREVIATIONS</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ABSTRACT</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>ACKNOWLEDGEMENTS</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>INTRODUCTION</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>A Brief Review of the Literature</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>THEORETICAL FRAMEWORK</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>- Macro Theory: Social Constructionianm</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>- Middle Range Theory: Model on Cultural Competence by Papadopoulos, Tilki and Taylor</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>AIM AND RESEARCH QUESTION</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>METHODS</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Setting</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Sampling</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Participant Characteristics</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Individual Semi-structured Interviews</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Focus Group Discussions</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Qualitative Content Analysis</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>ETHICAL CONSIDERATIONS</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>- Confidentiality and Potential Risks</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>- Reflexivity</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>FINDINGS</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>- Section I: Operational Context</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>- Area-Specific Features in Understanding of the Cultural Competence</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>- Perceived Determinants of Culture</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>- Section II: Development Process of Cultural Competence and Social Processes Involved in it</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>- Everyone is a cultural being – Forming Cultural Awareness through Social Encounters</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>- Kind curiosity – Gaining Cultural Knowledge in MCH Work</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>- What goes around, comes around – Developing Culturally Sensitive Working Methods</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>- Then, it doesn’t matter where they come from – Reaching Cultural Competence in MCH Work</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>DISCUSSION</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>- Discussion on Findings</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>- Forming Cultural Awareness through Social Encounters</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>- Gaining Cultural Knowledge in MCH Work</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>- Developing Culturally Sensitive Working Methods</td>
<td>42</td>
</tr>
</tbody>
</table>
Reaching Cultural Competence in MCH Work ................................................................. 43
Methodological Strengths and Limitations ................................................................. 43
Beneficence and Contribution to the Existing Literature ............................................ 44
Conclusion .................................................................................................................. 45
REFERENCE .............................................................................................................. 46
Annex 1: Interview Guide ............................................................................................ 51
Annex 2: FGD Guide ................................................................................................. 52
Annex 3: Informed Consent • PHNs ............................................................................ 54
Annex 4: Informed Consent form • PHN students ...................................................... 55
“Most people, most of the time, are rational and sensible in their choices if we can understand the constraints they are under, what their priorities are, and what they are trying to achieve.”

(Green & Thorogood 2014 p. 25)
INTRODUCTION

Public Health Nurses (PHN) in the Province of Eastern Finland are facing a new situation when the families attending MCH services represent increasingly diverting cultural backgrounds. Cultural competency is a part of PHNs’ qualification demands in Finland, however little is known on the phenomenon in the study area at the moment. (1) This master’s thesis aims to examine Finnish PHNs’ and final year PHN students’ perceptions and experiences on cultural competence in Maternity and Child Health (MCH) clinics in the Province of Eastern Finland.

PHN training in Finland is a four-year programme in Universities of Applied Sciences. The training includes 240 ECTS credits of bachelor level studies, out of which approximately one third is guided practical training in hospital wards, community health care and private clinics. The degree includes qualifications of both Registered Nurse (RN) and PHN. However, whereas the RNs most often work in secondary or tertiary level health care, a large majority of the PHNs are specialized and employed in preventive primary health care, such as MCH clinics, school and student health care, or occupational health care. (2)

Development of the national network of MCH clinics in Finland began in the 1920s, and from the year 1944 the municipalities have been obligated by law to provide all the families living in Finland with free MCH services. The aim of the clinics is to secure the health and safety of the pregnant mothers and the children, and to promote the whole family’s health and wellbeing. (3)

Comprehensive and effective MCH care has been one of the most powerful factors to rapidly decrease the maternal mortality in Finland. Since the nation-wide MCH clinic network was launched, the maternal deaths per 100 000 live births have decreased from almost 600 down to 1,6 in 80 years. (3-4) The maternity allowance in Finland is tied to a pregnant woman’s attendance in the antenatal care with very successful consequences; currently 99,7 % of the pregnant mothers attend the antenatal health care and complete all the recommended check-ups. (3) Moreover, the MCH care system is not only seen as a place of provision of health care, but also as a significant reducer of socio-economic gaps within the population. The MCH services are free of charge and open for all the families regardless of the wealth and educational status of the people. (5)
Differing from many other European countries, PHNs are the professional group in response of the community-based MCH care in Finland, whilst midwives work primarily in the secondary and tertiary level obstetric and pre- and post-natal hospital care. Thus, the PHNs in the Finnish MCH clinics have somewhat the same training, responsibilities and job description as the midwives in community-based MCH care in many other European countries have. (6-9)

The Finnish Ministry of Education has launched a national guideline which states that all the PHNs should develop strong cultural competency during their training. (1) Cultural competency is also mentioned as one of the learning aims of the PHN program curriculums in the Finnish schools of health care. (6-9) However, to date there are no reports on the responsiveness of PHN education to culture related competence demands of the field conducted in the Province of Eastern Finland. (1)

Health care professionals in MCH care face new, changing competence demands in their work. (10) Migration from abroad to the Province of Eastern Finland has doubled from the beginning of the ongoing millennium. In the same timeframe, the number of deliveries of women from immigrant background in the area has increased by 250 %. (11) The immigrant population in the area is young in comparison to the native Finns, and the biggest proportion in the immigrant inhabitants are of reproductive age at the time of writing this paper. On the contrary, the overall population in the region represents very typical figure of an ageing population pyramid [Figure 1]. (12) Therefore one can predict that the immigrant population is the fastest growing user group of the MCH services in the area.
The number of people born in a country other than Finland and living in the Province of Eastern Finland is around 13,000 out of the total population of 570,000 in the area. The number of people whose mother tongue is other than Finnish in the area is approximately 15,000. By far the largest number of immigrants in the region originates from Russia. After that, the five next most common countries of origin of the immigrants are Estonia, Somalia, Thailand, Burma and China. Russian, Estonian, Arabic, English and Somalian are the most spoken languages after the Finnish language. Approximately one third of the immigrants in the area have migrated to the country due to family reasons, and a little over half because of studying or working. Nine per cent of the immigrant inhabitants are asylum seekers, and four per cents live in the Province of Eastern Finland on a granted refugee status.

A Brief Review of the Literature

Very little is known how the PHNs in the Province of Eastern Finland have faced this new situation of providing care to more and more culturally diverse clients. Most of the Finnish study on multicultural nursing focuses on a few larger city areas in the Southern and Western Finland. Only a little research on transcultural nursing and cultural competence has been conducted all in all in MCH care services in Finland (1), and in the few existing studies the Province of Eastern Finland is much underrepresented. To the author’s knowledge, the last master’s thesis study on culture-related matters in MCH care in Eastern Finland has been
conducted over 15 years ago (13), and the rest of the available studies represent mainly bachelor’s thesis studies conducted by nursing and PHN students.

Searches in Scopus, CINAHL, PubMed and Google Scholar databases on key words “Cultural competence,” “Trans-cultural nursing,” “Antenatal care,” “Child health” and “Finland” both in English and Finnish resulted no published research studies on cultural competence in MCH care in the Province of Eastern Finland. A few published studies on health care professionals’ cultural competence in general in Finland were found. On the contrary, a large number of bachelor’s level theses have been written on cultural competence in health care, both in (e.g. 10) and outside (e.g. 14, 15) of the Province of Eastern Finland. This shows that undergraduate students clearly find the topic interesting and important, but for some reason higher academic level research on the subject in Finland is lacking. Due to reliability issues the bachelor’s theses reports are not presented in this paper. Nonetheless, the reference lists of 10 most recent bachelor’s theses handling cultural competency in MCH care and published in the Finnish thesis database Theseus were reviewed in order to snowball more accurate literature for the background of this paper.

A quantitative master’s thesis study by Mulder (16) showed that 80 % of the health care professionals working in a hospital setting in the Western Finland perceived that their cultural knowledge was insufficient. The respondents reported needing more training in cultural competence, and finding it difficult to take cultural needs into consideration in care of patients with immigrant backgrounds. Majority of the respondents perceived multiculturalism as a positive asset in their work. Nevertheless, one third of the respondents reported that there was hidden racism in their work places. (16)

A mixed methods study by Sivén (10) found that over 70 % of the health care professionals working in a hospital in Joensuu, Eastern Finland, were interested in different cultures and would be eager to develop their cultural competence. Almost 90 % of the respondents perceived that there is racism against the people with immigrant background in Finland, and one in three believed that the racism extends to the health care work places. Qualitative data suggested that up-to-date training in cultural matters is much needed and hoped among the health care professionals in this area to prevent prejudices among them. (10)
A qualitative study on cultural issues in reproductive health care of Somali women in Turku, South-West Finland, stated that physicians lacked much in cultural knowledge, and that this caused feelings of frustration and helplessness in the physician respondents of the study. (17) Somali respondents from Turku, Vantaa and Helsinki (Western and Southern Finland) perceived that services they received in reproductive and maternity health care were good in technical and contentual quality. Nevertheless, there were lots of misunderstandings between the women and health care professionals due to language barriers. Moreover, the behaviour of the health care professionals was sometimes seen offensive, impolite and humiliating. (17)

THEORETICAL FRAMEWORK

Culture is a phenomenon that reflects learnt or adopted values, beliefs, norms and habits that are based for instance on individuals’ or communities’ geographical location, social habits, history, religion, language, cuisine, arts (1, 19-20), socioeconomic situation, sexual orientation, ethnicity and heritage. (20) People experience and react to life, and its changes differently because different cultural backgrounds give different views and starting points to observe and explain how the surrounding world forms and works. (1, 20) In this master’s thesis, the concept ‘culture’ is used to refer to all the matters listed above, with a special interest on how it is seen through the eyes of MCH care professionals and students in the Province of Eastern Finland.

Culture greatly effects on matters such as one’s perceptions on appropriate or desirable behavior, hierarchy within a family or a community, self-esteem, sense of cohesion, beliefs on health and illness, and traditions related to sickness, birth, and death. (1, 19-20, 22) Many of these are very prominent in the process where an individual seeks and receives help from the health care. (1) Questions how a mother and her family perceive pregnancy, labor, pain, discomfort, women’s status, intra-family roles and responsibilities are all affected by culture, as also are motherhood, parenting, and ways to show affection and love to the child. The same applies to preventive child health care, as e.g. desired parenting practices and early interaction between the child and the caregiver differ from culture to culture. (e.g. 23-24) From the health care aspect this means that all the clients using health care services have cultural perceptions on how health and childbearing are constructed and preserved, how disease and its treatment affect one’s life, and what is expected from the health care professionals when, or if, health
care is sought. (25-27) Here, concept of cultural competence is often used to refer health care professional’s willingness and capability to be aware of different cultures, including her or his own, and culture’s effect on one’s health beliefs and behavior. (1, 28-30)

Culture is very sensitive to alter and transform among the changes in the surrounding world. (1, 20) Thus phenomena such as globalization and increased numbers of migration within and between cultural and geographical areas result that not all the health care service users, as neither its providers share the same cultural health beliefs and values. (1, 21-22, 31-34) In addition, due to globalization and increasing socio-economic gaps between people, the culture of health care and health behaviour is currently under accelerated change. (31-33) Health care providers should have up-to-date information and competency to treat all their clients equally and respectfully. (1) Nursing education should therefore aim not only to transfer professional practitioner skills to students, as its traditional role for decades has been, but also help and guide them to understand and treat continuously more diverse client groups as holistic cultural beings. (35)

**Macro Theory: Social Constructionism**

Considering that the aimed results of this study hypothetically represent the reality for those participating this study, this paper has approached the concept of cultural competence from the aspect of social constructionism theory. Social constructionism theory claims that knowledge, or reality, is constructed in everyday interaction between people, and thus it should be reviewed in, and with consideration of its natural context, and taking into account that also culture is created by the social actions of people. Social constructionism theorists argue that unlike the positivist orientation of research studies, reality can, and does vary from context to context, and is defined by people living it, instead of external observer measuring it. (36-38)

**Middle Range Theory: Model on Cultural Competence by Papadopoulos, Tilki and Taylor**

This master’s thesis study utilises the Papadopoulos, Tilki and Taylor’s Model (30) on cultural competence, which describes it as “the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs. Cultural competence is both a process and an output, and results from the synthesis of knowledge and skills which we
acquire during our personal and professional lives and to which we are constantly adding” (30).

Papadopoulos et al. model (30) argues that cultural competence develops continuingly step by step from cultural awareness to cultural knowledge, cultural sensitivity, and finally to cultural competence. There, the process starts all over again as cultures diverse and change from time to time and context to context. Therefore, a perfect and absolute cultural competence is somewhat impossible state to reach, but rather a never-ending process of self-development and life-long learning. (30)

![Diagram of Papadopoulos, Tilki and Taylor’s Model of Cultural Competence](image)

**Figure 2.** Papadopoulos, Tilki and Taylor’s Model of Cultural Competence (30)

**AIM AND RESEARCH QUESTION**

This study was planned in cooperation with Savonia University of Applies Sciences School of Health Care, and the results will be used in development of PHN training in the Province of Eastern Finland. The underlying purpose is to serve better the multicultural families attending the MCH clinics in the area.
The aim is to describe how cultural competence is understood and constructed among PHNs and PHN students working and training in the MCH clinics in the Province of Eastern Finland. Specific objectives are to:

1) Illustrate the development process of PHNs’ and PHN students’ cultural competence, and

2) Describe the components of the social process involved in construction of cultural competence.

The research question is “How do PHNs and PHN students in Province of Eastern Finland perceive cultural competence and its construction in maternal and child health care work?”

METHODS

In this study the focus is in participants’ perceptions and lived experiences. Considering that very little is known on the topic in this context, and that the theory of social constructionism relies strongly on the idea of producing knowledge in social interaction, qualitative design was chosen to be employed (36). Individual semi-structured interviews and focus group discussions (FGD) were utilized to collect data from the participants.

Setting

Finland is a country of 5.4 million inhabitants located in the Northern Europe. It gained its independency from Russia in 1917 and since then has been a democratic republic. The country is divided in six administrative provinces by geographical location, of which the Province of Eastern Finland is at focus in this master’s thesis study. Over the history of the independent Finland there have been numerous different regional and administrative divisions for the provinces in Finland. To avoid obscurities in the description of the study region, this study uses the latest definition of the regional State Administrative Agency and refers to the area consisting the counties of North Savonia, South Savonia and North Karelia. (39)

The population in the study region is approximately 570 000, of which around half is concentrated in the five largest towns in the area. Almost one third of the population lives in
the countryside in extra-urban settings, rather far from the services. The population density is 9,33 inhabitants per one square kilometre, which makes the Province of Eastern Finland one of the most sparsely populated areas in the country. (39)

![Figure 3. Study Setting on the Map](image)

The dominant Finnish culture in the study area has been described as a mixture of Eastern and Western European cultures. Scandinavian and Russian influences have affected the culture for centuries before Finland gained its independency in 1917. From that on the country has steadily moved towards the West-European values of equality, democracy and social wellbeing. The local people in general seem to value honesty, privacy and punctuality. Hard work and rule of law are considered as important assets in life. The people are rather straightforward in their talk, and for example word for “please” does not exist in the Finnish language. People often address other people very informally, and it is not common to use titles such as “mrs” “mister”, “miss”, “doctor” and so on. Shaking hands is a normal way to greet new people, and it is important to look in the eyes when greeting and talking, since avoidance of the eye contact is often interpreted as a sign of mistrust or disrespect. (40-41)
Sampling

Purposive sampling was used to recruit participants for this study. Respondents were invited from five towns largest in population in the study area: Kuopio, Savonlinna, Joensuu, Varkaus and Savonlinna. Following flowchart illustrates the participant recruitment process.

Figure 4. Sampling process flowchart

Both PHNs and PHN students were included to the study for two reasons. Firstly, the purpose of the study lies in the development of PHN training in the area. Therefore the PHN students who just have undergone the training programme were seen as the most accurate source of information on the experience of developing in cultural competency in the PHN training. Secondly, the PHN students had all completed 10 to 15 weeks’ guided internships in the MCH clinics during the past 12 months, and thus been in an excellent observer position for the need for cultural competence in the field.
Inclusion criteria for the PHN participants were a minimum of one year’s working experience in MCH clinic, and personal experience with meeting clients from different cultures. Inclusion criteria for PHN students was completed studies and internships as mentioned in the degree guide by the time of the FGDs. Naturally, voluntary willingness to participate the study was an inclusion criteria of both PHN and student participants.

All the respondents who were willing to participate in the study met the inclusion criteria and were included to the sample. One of the originally enrolled respondents cancelled the interview on the last minute due to personal reasons, but another respondent was found through snowballing.

**Participant Characteristics**

Five individual interviews of PHNs, and two FGDs of PHN students were conducted. There were altogether ten PHN student respondents participating the FGDs, five in each session, which adds up the total number of the participants of this study to 15.

All the participants were females, and born and raised in Finland. Eleven were originally from the study area. Four originated from other parts of the country and had moved to the region due to studying, working or family reasons. The PHN student participants’ (n = 10) mean age was 26 and median and mode ages were 23 years at the time of the FGDs. The PHN participants’ (n = 5) mean age was 50 years. They had worked in MCH care on average 11.6 years, working years in MCH clinic ranging from two to 15. It occurred in the interviews that all the PHN participants had completed some form of advanced level health care professional qualification in addition to their PHN degree, either through a university course or in other formal health care training institution in Finland.

**Individual Semi-structured Interviews**

Four individual interviews were conducted in the MCH clinics during the respondents’ working hours. In addition, due to very sudden and unpredictable logistical and scheduling issues, one interview was conducted via telephone. Both face-to-face as well as via telephone conducted interviews were audio-recorder on participant’s consent. The participants partaking the face-to-face interviews signed a written informed consent prior the interview, and the
telephone-interviewee gave her oral consent, and sent a signed written consent form to the author afterwards.

Only the respondent and author were present in the room during the interviews. Two of the participants answered a phone call during the interview, but no other interrupts occurred during the interviews. The participants did not receive financial compensation for their participation. However, following a typical Finnish custom, a package of coffee and cookies (total value approximately SEK 100) were brought to the clinic when conducting the interviews to thank the interviewees for participation.

A semi-structured interview guide was followed in the individual interviews [Annex 1]. It was pilot-tested on two PHNs before conducting the actual interviews. The questions were not asked in same order in all of the interviews in cases if the participant started spontaneously to talk about one or more of the initiated topics. To ensure flexibility, and to fulfil the criteria of good practice in qualitative research, in all of the interviews also additional follow-up questions (e.g. “You mentioned X. Would you tell me a little more about this?”) were asked in relation to the new topics that respondent had brought out during the interview. (22, 36)

The length of the interview audio-recordings was on average 43.4 minutes, ranging from 17 to 70 minutes. The last interview conducted via telephone was notably shorter than the other ones even though exactly the same topic guide was used in all the interviews. This might be resulted because of the telephone use. However, the participant interviewed via telephone had notably fewer years of working experience in comparison to the other PHN participants which could causally cause fewer amounts of personal experiences to share in the interview.

**Focus Group Discussions**

The FGDs were conducted in a class room in the facilities of the student respondents’ School of Health Care. The respondents, a moderator, that is, the author, and a research assistant were present during the FGDs. The research assistant was Sanni Heikkinen, a local PHN who currently studies midwifery and has completed a bachelor level course on research methods in health studies. She speaks the local dialect and understands the professional language and concepts, and was prepared to take notes on non-verbal communication, silences, distribution of conversation, overall atmosphere, and other observations during the FGD. The author was
the moderator of the FGDs, and her role was to present the opening question, to make follow-up questions, and make sure that everyone had a chance to speak when it looked that one or two participants started to dominate the conversation more than the others.

A FGD guide developed specifically for this study was followed in the two conducted FGD sessions [Annex 2]. A social opening took place when the respondents arrived to the classroom, that is, before the audio recorders were turned on. Thus, the session itself began directly with the introductory question. Students were shown two Finnish comic strips [Figure 5] related to misunderstandings between two cultures, and were then asked to discuss how they have learned to avoid cultural misunderstandings in their future job as PHNs in MCH clinics.
The FGD guide was piloted on a group of seven recently graduated PHNs from the Province of Eastern Finland who had been in working life for approximately one year after graduation. Thus, they would not have met the inclusion criteria of the student respondents, but were the best pilot group available on the given situation, schedule and resources. During the pilot-testing of the FGD guide it was learned that the respondents found the used comic strips culturally appropriate and able to arise thoughts on cultural competency, and that the opening question awoke conversation relevant to the research question.

Figure 5: The comic strips showed in the FGDs
The purpose of the FGDs was to collect data formulating in a social interaction, that is, the conversation within the group of informants. (36) The group dynamics was good in both of the sessions, the participants talked freely and the overall atmosphere was relaxed. The participants talked mainly to each other rather than the moderator, which is desirable when applying FGDs as data collection method. (36) They complimented each other’s sentences, asked questions, and reacted and reflected to what was said by the other participants. The FGD audio-recordings were 53 and 58 minutes long, and no remarkable differences in the length or conducting method of them occurred.

**Qualitative Content Analysis**

Interviews and FGDs resulted in 5 hours and 28 minutes of audio-recordings, and the written transcripts added up to total number of 131 pages of writing in font size 12 and spacing 1,15. Interviews and FGDs were transcribed in Finnish, and partially translated into English by the author to provide the English speaking supervisors of the project with an idea of the content of the transcripts. To increase the reliability of the data, the research assistant who was present in the FGDs transcribed randomly selected one to two minutes parts of the audio recordings of the FGDs, and transcripts were compared to the ones the author had transcribed.

Qualitative content analysis (QCA) as described by Graneheim & Lundman (42) was chosen for the data analysis method in this study since it enables the description of both what and how and allows both inductive and deductive analysis. Transcripts were read thoroughly, and meaning units were identified and condensed in Finnish. The Finnish condensed meaning units were then translated in English by author, and another master student, who is a native Finnish and English speaker, checked randomly selected translations of approximately 10% of the meaning units per one transcript to avoid inaccuracies in translated concepts. After this, the English meaning units were coded and categorised in English. Categories were grouped under five themes which are presented in the results section of this paper. Examples on QCA process are provided in Table 1.

**Table 1. Examples of QCA process**

<table>
<thead>
<tr>
<th>Meaning unit in the raw data</th>
<th>Condenced meaning unit</th>
<th>Code</th>
<th>Category</th>
<th>Theme</th>
</tr>
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...for example people from African background, and then of course, and then families from abroad, and like, rainbow families what one can think they’d have their own culture. Many kinds.” (PHN5)

...when meeting refugees, we have in these cases agreed that we use interpreters. (PHN1)

One shouldn’t go abroad only for the joy of going abroad, but thinking about what you can reach there. And when one finds that red thread, one might gain a lot from being there. (PHN4)

And if you always wouldn’t find a mutual language, they always are like... Express themselves with body language, or like that. One can express herself in so many different ways. You feel that no matter what obstacle there was inbetween, one becomes understood anyway. (Student7, FGD2)

<table>
<thead>
<tr>
<th>Determinants of culture</th>
<th>Operational Context: Overview of the perceptions on cultural competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families from abroad have their own culture</td>
<td>Families from abroad have their own culture</td>
</tr>
<tr>
<td>LBGT families</td>
<td>LBGT families</td>
</tr>
<tr>
<td>Agreement on interpreters</td>
<td>Multi-disciplinary support in the clinics</td>
</tr>
<tr>
<td>Encounters with people from different cultures</td>
<td>Everyone is a cultural being – Forming cultural awareness during PHN training</td>
</tr>
<tr>
<td>Body language can complement lacks in language skills</td>
<td>Non-verbal communication</td>
</tr>
<tr>
<td>Alternative communication methods</td>
<td>What goes around, comes around – Developing culturally sensitive working methods</td>
</tr>
</tbody>
</table>

The data analysis was initially started with a deductive approach of QCA since the underlying theoretical framework guided the research question and data collection tools, and the raw data emerged some clear patterns fitting to the existing framework on cultural competence in nursing. (30) Nevertheless, a notable amount of the meaning units emerged that more than what was asked was found. This led the final data analysis to combine the deductive themes which widened our understanding on the original theoretical framework (30) and the inductive findings. The inductive findings provided us with deeper and detailed knowledge on the social processes involved in construction of cultural competence, and information on the operational context where this development takes place at. Figure 6 was developed by author to clarify the inductive and deductive approaches in the data analysis.
ETHICAL CONSIDERATIONS

The Helsinki declaration (43) and The Responsible Conduct of Research (44) Guidelines were followed throughout the research process. All the participants were informed about the purpose and procedures of the study, and asked to sign a written informed consent to participate in the interviews or FGDs. Confidentiality was stressed, and no names, places, clinics, hospitals, or other details that can lead the reader to recognise the informants are published in the study report. The respondents were informed both in the invitation letter and before starting that participation is voluntary and that they have a right to interrupt at any point if they feel so. The English translations of the informed consent forms are provided in the Annex 3 and 4.

The Finnish system requires that the approval for thesis studies has to be gained from every health care district or other administrative organ where the data will be collected. Most of these parties also have their own specified application forms and policies for required
attachments. Therefore, approvals to conduct research were applied from the six involved Health Care Districts and the School of Health Care. Five out the six stakeholder organisations approved the application to conduct research, and only participants from organisations which had accepted the approval were included to the study.

 Confidentiality and Potential Risks

The participants of the FGDs were informed that in the final report they will be referred as “final year Public Health Nurse Students in a University of Applied Sciences in a town located in the Province of Eastern Finland”, and their written consent was asked on this condition. All informants were orally informed that as there are only two schools of higher education providing PHN programme in the study area, their year course could in theory be recognised. However, not all the students of the same year course participated, which makes it slightly less likely that one could guess who of the students could possibly have participated.

Another potential anonymity issue refers to the PHNs and their multicultural clients. The groups representing different ethnicities, languages or cultures in the Province of Eastern Finland are relatively few compared to for example the Helsinki Metropolitan Area (12, 39), and it is possible that immigrants originating from a certain geographical area are commonly known to live in a certain suburb or part of a town. The refugee policies of the municipalities vary in the area, and it is possible that for many years all the refugees coming from a certain country are placed in only one or two towns in the whole of Finland. Thus, should any case descriptions come up during the interviews or FGDs, there is a theoretical possibility of tracking a single client or a family if the respondent could be connected to a certain country of origin, ethnicity, culture or current hometown. To fade both the participants’ and their clients’ hometowns, the PHN interviewees were recruited from five municipalities largest in population in the study area. For the same reason, the decision of not mentioning any single nationalities or subcultures in the data was made.

 Reflexivity

I, the author, am a female RN, PHN and a master student in International Health at Uppsala University, department of Women’s and Children’s Health. I have completed practical training in two MCH clinics in the study area in 2012, and been working as a RN in primary and tertiary level hospital wards in the study area. None of the clinics where I have interned or
worked were included to the study, and I did not know any of the participants of this study beforehand. During the time of conducting the data collection and analysis I have had no professional bindings to any institutions providing health care in the study area. The research project was financed on my personal income and savings. Thus, I have had no professional or financial conflict of interest as the author of this paper.

I have lived in the study area for approximately 15 years, living several periods abroad and elsewhere in Finland during that time. Considering this and my working experience, I am rather familiar both with the geographical, cultural and professional contexts of this study. During my studying and working in the area I oftentimes came across situations where health care professionals were puzzled as to face patients or clients who represent other than the dominant Finnish culture, or speak other than Finnish language as their mother tongue. This experience, my educational background in maternal and child health, and my personal interest to cultural minorities’ rights in health care facilitated the idea of this research project.

The participants did know that I am a student of international health with a special interest in multiculturalism in nursing and care, and this might have created a risk that they might have felt pressured to answer in a more liberal and permissive way than what they might honestly have thought. To avoid this, I stressed in every single interview and FGD session that all opinions and perceptions are highly appreciated, and that in this interview or FGD there are no right or wrong answers or opinions. On the other hand, being a student might have been an asset in the FGDs where the participants might have seen me rather as a peer than an external researcher. This could have had a positive effect on the relaxed and free atmosphere of the sessions.

**FINDINGS**

The findings of this study are presented in two sections. First section describes the perceptions of culture and its determinants among PHNs and PHN students in this setting. The second findings section handles the development of cultural competence and social processes involved in it.
Section I: Operational Context

The inductive data analysis produced two descriptive categories on area-specific features in understanding of the concept of cultural competence, and perceived determinants of culture. Together these categories form an operational context for the development process of cultural competence in this setting.

Area-Specific Features in Understanding of the Cultural Competence

It was perceived that cultural encounters are not everyday life in this area. The participants estimated that the Province of Eastern Finland is culturally rather homogenous, and that it is a regular, yet rather rare occasion that a PHN meets a family representing culture other than the dominant Finnish one. The PHN participants reported that they would have clients with whom they perceive to need cultural competence approximately once a week to a couple of times a month. Some student participants described that during a ten to 15 week long practical training in certain MCH clinics it is possible that a student doesn’t necessarily ever meet clients from “different cultures” whereas in some clinics there is a possibility for cultural encounters every week.

"We don’t really have immigrants so much, or we don’t have the immigrant centre in here [in this town].”

(PHN5)

Thus, the themes of social processes described from this point can, and should, be constructed on the assumption that cultural competence was a rather well-known phenomenon as a concept, but still a comparatively rarely practiced skill due to few perceived cultural encounters in this setting. Facilitated by the above-mentioned contextual situation, it was discussed in all the interviews and FGDs at some point that cultural encounters are something one must to “overcome,” “survive,” or “have courage with,” and that require special preparedness from the PHNs.

“Well, the first appointment always makes you nervous. And what makes you nervous is perhaps that you don’t know if the client understands what I say and then vice versa.”

(PHN1)

“Then, it could have been anything that entered the door, or any kind of problem, then it was, yeah, an incredible challenge always, and always you could wipe the sweat after the encounter, that yeah, I survived this again.”

(Student 2, FGD1)
Perceived Determinants of Culture

The participants were very vague and multifaceted when defining what determines one’s culture. Families originating from abroad were seen as the most visible cultural group. By far the largest number of the participants’ experiences and stories on cultural competence referred to the encounters they had had with clients who had immigrated to Finland from foreign countries. Participants also described cultural differences between people originating from different areas within Finland, and that this affects their way to communicate and behave in the clinics.

“These, like, are they called sub-cultures then or how, well them we do have. That you really can think of different religions, then this [being from a certain Finnish area], or coming from [elsewhere in Finland], then you notice that also in Finland we do have different cultures.”

(PHN2)

In some clinics the family’s socioeconomic situation, number of parents and children, the parents’ age and sexual orientation defined how the PHNs perceived their cultures. Substance abuse and drug cultures, as well as long-term diseases were also mentioned as cultures that affect MCH care. However it was not elaborated in the interviews and FGDs more clearly how this is seen in practice. Different religions arose as a strong determinant of cultural habits especially in regard to contraception and family planning.

“These well... religious groups, where there is sort of like... Maybe in the family there is disagreement on... For instance right... That for example the ninth child is on the way, and the mother no longer wants to have more children, and would like to use contraception but the religion denies it...”

(Student4, FGD1)

All the different determinants of culture that were perceived among the participants are listed in the following Figure 7. The determinants in the boxes are codes resulting from the QCA of the data, and they are organized in area- and individual-oriented categories that partially overlap with each other. For instance, religion can be seen both as a dominating character in a certain geographical region, as well as an individual choice. The clients’ socioeconomic status had in some interviews and FGDs to do with the part of town where they lived, where they had originated from, how educated they were, and what was their occupational position in the society.
Figure 7. Participants’ perceptions on different determinants of culture

Section II: Development Process of Cultural Competence and Social Processes Involved in it

Inductive data analysis on different social processes involved in the development of cultural competence resulted altogether 15 categories, which fall under four deductive themes. The themes were named after quotations from the data. The first theme *Everyone is a cultural being* describes when and how the PHNs begin to be aware that culture needs to be considered in the MCH process. *Kind curiosity* refers to gaining cultural knowledge in MCH care in detail through curious and active interaction with clients, colleagues, peers and community. *What goes around, comes around* condenses an idea that the clients’ behaviour and acts – both challenging and rewarding ones – reflect the level and success of culturally sensitive MCH care. *Then, it doesn’t matter where they come from* concludes the ultimate perceived idea of cultural competence; all the clients should receive good quality care basing on their individual needs, no matter what culture they represented.

The above described development steps are constructed in a causal manner as illustrated in the Figure 8. This means that from left to right, all the preceding categories contribute to the
development process of cultural competence, but only the ones stated under the theme can be straightforwardly linked into them.

![Diagram](image)

**Figure 8.** Development process of cultural competence and social processes involved in it

**Everyone is a cultural being – Forming Cultural Awareness through Social Encounters**

The data shows that development of cultural competence is an ongoing process which begins from the personal desire and social upbringing of the PHN. As an operational concept cultural competence was usually heard for first time shortly after the student enters the university, and it appears constantly as a part of different courses during the studying time in different forms of challenges. As a result, the PHN student becomes aware that culture is something that needs to be considered in MCH care, but does not necessarily know yet in detail what needs to be considered.

The process of cultural competence in MCH work was perceived to be built very solely on an individual’s ability and willingness for encounters with people from varying backgrounds, and learning from them. Not only learning on cultures different from the dominant Finnish
culture, but also understanding one’s own culture was seen as important outcome of these encounters.

“If we learned to understand our own [culture], it would increase our understanding of the foreign clients too.” (PHN4)

“...that one would have knowledge that people come from different cultures and religions and habits, and how one could... Like, approve and respect the family’s way...” (PHN5)

Open-minded attitude, motivation and positive mind-set were seen as personal characteristic facilitators of the cultural awareness. The origins for these features were seen to be based as far as to the PHN’s own childhood and upbringing. The participants discussed that one needs different social encounters to understand that culture is everything and everywhere – also in the MCH work. These encounters can occur both in formal PHN university training, as well as on PHNs’ and students’ free time. Participants described that their own experiences of formulating cultural awareness had developed in situations such as specific university courses, during student exchange, in contact with foreign exchange students in their home town or clinic, and in personal hobbies and other free-time activities. These details came up repeatedly from participant after participant, and both in the FGDs and interviews.

Student5: “And then we went through some specific cultures, what experiences we have and what is mediated and the teacher also held some sort of lecture on it...”

Student 3: “Yes (- - -) and then you also awoke to think, like, those own cultural, what you could have had, that if you have different experiences and then you think about them too and...”

Student4: “…and the concept too, that what the culturalism means, like, one could first think about the refugees and immigrants, but that it is also ours too...”

Student3: “...a thing within us, that everyone herself is a cultural being.” (FGD1)

Kind curiosity – Gaining Cultural Knowledge in MCH Work

In the final studying year’s advanced level practical trainings in the MCH clinics, as well as when entering working life, the PHNs start to identify detailed cultural needs of their clients attending the MCH clinics. These can be very practical issues, such as diverting nutritional practices during pregnancy, or different concepts of time, but also more comprehensive
matters for instance in relation to a client’s ability to manage formal information, and family’s perceptions on the rule of law in the context. Little by little through contacts and encounters with clients, colleagues and other stakeholders the PHNs gain knowledge on these specific needs, and begin to link certain values and beliefs into certain behaviour and habits of their clients.

“...those who work with culture, with people from different cultures, well from that you get more [knowledge] and understanding to it. That these features with these, and these are like this, of course, and then you can, like, utilize those things and... respect them.”

(PHN2)

The participants described very richly and in detail what kinds of specific cultural needs their clients using MCH services have, and how they have tried to respond to these needs. In the data analysis this information was classified as cultural knowledge since it refers highly to health beliefs and practices determined by the client’s cultural characteristics and values. Field visits, interpreters, and experience exchange with colleagues and students came up as potential ways to gain cultural knowledge. Some also searched information from the internet and text books, but mostly the participants agreed that cultural knowledge cannot be studied beforehand, nor be learned by heart from a paper, but is constructed in an active and reflective interaction with other people.

“Meeting the person is more effective than reading from a paper”

(PHN4)

“It could be familiarisation for example, or some kind of study visit for example to a reception centre, or in a community, like, or a meeting place, or wherever. That it doesn’t necessarily need be like cramming from a textbook.”

(PHN 5)

The PHNs and students all stated their clients as the most accurate and common source of cultural knowledge. The high appearance ratio of the meaning units referring to the importance of asking questions indicated that the participants could not stress enough how big role the continuous curiosity and self-development has in their work. It also came up in interview after interview that asking questions from the client requires courage, and against the participants pre-existing odds, the clients hardly ever felt insulted when consulted on their cultural background and its effect on the MCH issues.
Student3: “In the practical training you learned that one doesn’t need to know everything about the other culture. That like, kind curiosity is good, like, and really often the clients were friendly too and then told you if I didn’t know something...”

Others: “Mmm...” [noding]

Student3: “…that then it went nice and smooth then that you taught each other to understand there then.” (FGD1)

Culture was seen as an underlying determinant, and sometimes also as a challenge in clinical work in regard to matters such as desired diet during pregnancy, compliance of micronutrient supplements and oral contraception pills, perceptions on family planning, medical procedures and PHNs job description. Sometimes the women originating from very disadvantaged settings needed very comprehensive guidance on oral birth control pill usage. In some cases PHN had to find culturally accepted alternatives for the Finnish nutrition guidelines to ensure the pregnant mother’s micronutrient intake. Participants also reported that sometimes they felt pressure to persuade the families to give their infant vitamin D supplements, or to vaccinate the children if the parents’ culture leaned strongly on nature medication.

“…Vitamin D! In Finland, it’s recommended, it might be for example these [people from area X] or perhaps [from area Y] that don’t, they only use medicines when they’re really sick. It might be really hard to explain that no, you just have to take it. And that hey, you just have to give it to the child, right away, start to give it to the baby.” (PHN1)

PHNs reported some families being notably sensitive when it came to hygiene in the clinic, and ensured several times during the appointment if the PHN has used sterile instruments and has disinfected her hands before the intimal examination. According to one PHN participant, some families tend to bath their baby every single day, which was seen to be in a clash with the official Finnish recommendations of the MCH clinics, and caused wonderment in the PHN. In some cultures as long as the post-partum bleeding continues the woman is seen as “impure” which limits not only the mother’s physical movement inside of the family house, but also the PHN’s since she needs to be aware which rooms they can use in the house when calling a home visit to the recently delivered mother. The participant explained this behaviour with the family’s culture and its underlying values of purity and strict hygiene code.

“That when you knew a little about these things, you didn’t go, when making a home visit, you didn’t go there, the files were not spread out on the kitchen table because the
mother can’t come there. You would sit in the living room then.” (PHN1)

Another PHN participant had to arrange the timings of some of her appointments according to the hierarchy codes in the family’s culture. Her clinic was located in the upper floors of a community health centre, and when there was an older, i.e. more respected family member visiting the ground floor of the health centre facilities, the younger members were not allowed to physically “rise” above this elder in the building. This caused some cancellations and re-bookings to her timetable during the working days.

“The younger people can’t be on different floors, that a younger person can’t be, like, above the older, like, in a block of flats. And here [in this town] this clinic is [upstairs]. And then we had this family here; the grandmother was on the ground floor, and then we had to organise a little to be able to follow these culture rules. But... Then we had to change the day, that we couldn’t have the family here in the clinic on the same day.” (PHN5)

What goes around, comes around – Developing Culturally Sensitive Working Methods

The next stage of the development process of cultural competence refers to putting the cultural knowledge into action, and adapting the family’s cultural needs into the guidelines of the Finnish MCH clinics. This would mean for example knowing which of the foods in the official nutrition recommendation guidelines are not culturally accepted by the client, recognizing the causal potential risk of micronutrient deficiency during pregnancy, and then finding a compensatory food supplement that the client can and wants to use.

“But how would the pregnant woman get calcium from the Finnish food then? Sometimes we just have to agree that you use these calcium tablets then because no, they cannot drink milk. They aren’t used to using it in their culture.” (PHN1)

In addition, PHNs reported that they adapted their communication methods with the clients in relation to their education level, language skills and availability of interpreters. They sought creative solutions to deliver the message to the client when there was no mutual language between the PHN and the family.

“Sometimes it feels like we’re repeating the same thing again and again. Then you have to look into a mirror, that am I saying this thing in too complicated a way? That should it be simplified, or should some other words be used?” (PHN4)
The participants reported that oftentimes the nursing relationship becomes more deep and personal with the immigrant families than with the native Finnish clients. They suggested that this could be a result of the situation that when a family has rather recently immigrated to Finland, the PHN is often one of the few social contacts they have in the new home town. Thereby it was perceived that PHNs in the MCH clinics have a specific role in cultural integration of the immigrant families to Finnish society, and they seemed to act as a link between the health care system and the immigrated family.

“What goes around, comes around. As I am such a blabbermouth, they might feel that from this person, from this person we can also ask something personal. That pretty often my clients ask who I am and where I come from. [- - -] Because it is a part of integrating the families, to integrate them to find their place in this Finnish society. And when they find that place it’s a lot easier for them to be here, and it’s easier for us Finns to meet them, foreigners” (PHN 4)

PHNs usually share some of the most intimate and private events in the family’s life, such as issues in a couple’s intimate relationship and sexuality, the first information about the onset of pregnancy, and home visits very shortly after the baby is born. The participants thought that perhaps because of this the families from certain cultures, and especially in conditions where their social peers were far away in another country, tended sometimes to attach emotionally to the PHN, thank the PHN excessively for her services, and show their gratefulness in many ways which were often unusual or overwhelming for the PHN. Participants had been invited to visit the client’s home countries, they were given expensive gifts, and in the home visits they were provided with excessive dinners and coffee servings, which was seen both as a positive gesture and made the participants feel themselves appreciated and important, but on the other hand also was sometimes experienced as confusing or uncomfortable.

“And then, when the PHNs again went there, they didn’t, like, understand, that no, the PHN, she has only a certain amount of time that she can be there in their home... And then... then that... The serve many kinds of food [laughs with a smile on her face] and then that, if you refuse and don’t take something. That is it to them, like, insulting, you think about these things sometimes. Then I would take something.” (PHN1)

“At least for me, it is a little confusing how thankful they are for the service they’ve had” (PHN4)

“They are, like, very grateful folks.” (PHN3)
Here, participants reported moments of success and personal joy when their working methods had met the exceptions of the clients, and that the immigrant clients’ thankfulness helped them to carry on in their job. Both student and PHN participants reported meeting clients from different cultures as motivating and rewarding, and many were happy when they had a chance to utilize and practice their language skills with the immigrant clients. Especially the student respondents perceived that cultural encounters empowered the students themselves, as they often were the ones with the best language skills in the clinic. They had a chance to contribute to the MCH care process in a way that their supervisor would not have been able to do due to more limited language skills.

“She [the client] was really happy that she could talk about things properly, that someone understands her. It was, for myself, really rewarding experience, that I could then inform the PHN that this and this is the background, and this and that is what she wishes.” (Student4, FGD1)

As a shadow side for gratefulness and satisfaction to the received services and help, the cheerfulness and positivity of the clients from certain cultures covered in some reported cases an urgent need for care and psychological attention. Sometimes the clients did not report their existing health problems. The participants believed that it is caused partially because of the high value placed on balance and modesty, and partially because they wanted to express their thankfulness to the PHN by causing as little trouble for her as possible. Therefore the participants were convinced that the care relationship needs to be built on bilateral trust and acceptance to help the clients to feel comfortable to report also on the negative experiences, and recognise the underlying traumas, distress or physical conditions.

“At least in the beginning, you’d always offer that if you need some help, you could talk about those… And there you always needed to ask how are they feeling and what kind [of experiences] they have had, symptoms or like this. And now when you are here [in Finland], it’s good. But then when you have been here for a little longer, and the kind of hype passes, then they [symptoms] start to come.” (PHN3)

Despite the participants reported good intentions and successful experiences in cultural sensitivity, there were also many situations where different medical and health care cultures clashed and caused emotional distress to both clients and the PHNs. The clients’ cultural needs, predictions or wishes were not always fulfilled, and sometimes the PHNs exposed to the eruptions of the client’s dissatisfaction and anger. One participant had had a difficult experience when the health care bureaucracy had denied a client from getting all her the
health care records, and the client could not understand how this could happen since in her home country she would have been with no doubt able to have them.

“And of course, when a woman [from a certain country] comes, it sometimes feels almost frightening. That somehow, someone might behave very intimidatingly. Especially if something has gone wrong.” (PHN1)

Another participant had met a family with extremely strict refusal toward vaccinations, which complicated the normal child health care procedure a lot and caused emotional tensions between the family and the PHN. This also caused some observable disagreement within the focus group where the issue was voiced by one of the participants. Both moderator and research assistant noted that the other four participants changed in their body language and facial expressions notably whilst “Student1” was describing how she had managed with this vaccinate-negative family.

Student1: “They had good reasoning why they don’t take the vaccination, then why should we go on about it even though there is some recommendation that should be followed? That are you doing something wrong if you don’t recommend them [the vaccinations]?”

[The other four participants appear to disagree] (FGD1)

Participants reported several situations where different concepts of time had caused frustration and inconveniences. PHNs had to use their limited and strictly regulated clinical working time on administrative tasks, such as re-organising the appointments and re-ordering interpreters when the families had come late, or had not appeared to the clinic. A different kind of negative distress was caused by an issue which one PHN reported. She had suffered from remarkable emotional distress when nursing refugee families with very traumatic experiences in their home country, and felt that the stories of the clients followed her to her home and free time.

“It was, on the other hand, such a tough experience, that you hadn’t really thought what people experience in their lives before they come here, and what they brought with them. All those experiences and... recovering from that, it took some time, I must say.” (PHN3)

Nevertheless, both discomfort and joy caused by the clients’ behaviour seemed to facilitate the development of cultural sensitivity. Fear of unintended insult made the PHNs try even
harder to understand the clients’ culture and its role in the MCH care. It also encouraged them to seek new coping methods for stressful and challenging situations. There, cultural sensitivity reflects what the PHN does for the client’s cultural needs and by what means, how the client responds to this, and then again how the PHN reacts to this response.

*Then, it doesn’t matter where they come from – Reaching Cultural Competence in MCH Work*

The data suggests that as the underlying motivation to put on the development process of cultural competence, also its ultimate result is to meet every single client as an individual, respecting their values, habits and background as they are. Thereby the steps mentioned previously in this chapter lead into cultural competence, which can be described as a stage of a PHN’s professionalism where one is experienced and eager enough to acknowledge culture’s effect on the MCH care process, able to identify specific cultural needs of the families, and actively and successfully find ways to respond to these needs.

It was perceived important that the PHN matches the client’s cultural needs up with the official MCH regulations, and yet provides the family a chance to keep up with their cultural identity, and by a chance strengthens it to use it as a resource in MCH care. One PHN participant had noticed how in some cultures the fathers participate extensively in the infant and child care, and attend the appointments much more often than for example the Finnish fathers. Here, she perceived it as important to praise the fathers’ commitment and make them feel like equally responsible with the mother for the children. Another PHN participant described how she motivated the families to follow the evidence-based MCH guidelines in areas such as vaccinations and nutrition by following actively the published research studies from the client’s home country or continent and through that increasing the family’s ownership on the issues.

“And when I have international studies as background information, those I aim to point out, particularly to my international clients. [- - -] With foreigners I consciously aim to tell that this issue has been studied in your home country as well, and we use the same procedures. That we have... That this world belongs to everyone... And the study results belong to everyone.”  

(PHN4)

Participants stressed the importance of overcoming the personal discomfort or emotional distress, and courageously but sensitively discussed issues such as FGM, women’s rights and
family violence with the clients who they estimated that would need specific attention in these topics due to cultural characteristics. It was obvious from the participants’ voice tone and body language that even during the individual interviews the PHNs found these topics as challenging and partially difficult to talk about. However, they described experiences of gathering their courage and discussing the above mentioned sensitive issues in an assertive and professional way. The PHNs also felt responsibility to educate the clients on the laws surrounding marital violence and the Child Protection Act, and women’s rights on sexual autonomy and activity.

“Maybe in those FGM situations it is difficult, like, to respect the religion or the culture, that... But then again, like, to try to be professional and understanding in that situation, but yet at the same time, like, firmly tell them that it is against the law, that one cannot do that.” (PHN5)

Lastly, it emerged that through meeting multicultural clients in the MCH clinics, the PHNs improved in general professional and clinical skills, and felt that they were able to provide better quality care not only for the clients from abroad or diverting cultures, but also in the general population level. It was perceived that when paying attention to cultural issues and needs, the PHNs felt that they have become more sensitive to ask about individual preferences, values, beliefs and habits from all of their clients, regardless their cultural background.

“It deepens my own professional know-how because you give 110 per cents to the client all the time, and whatever themes you handle, explaining them takes, maybe like more time as well, but most importantly, you need to be notably more precise.” (PHN4)

**DISCUSSION**

The aim of this study was to describe how cultural competence is understood and constructed among PHNs’ and PHN students’ cultural competence in MCH clinics in the Province of Eastern Finland. The objectives were to understand development of PHNs’ and students’ cultural competence, and to and to describe the social processes involved in its construction.
Discussion on Findings

As most of the previous research on cultural competence in Finnish health care has approached the topic from the immigrant aspect (e.g. 13-18), it was not a surprise that all the participants mentioned the families originating from abroad as the most common cultural group using MCH care services. However, issues such as family size, number of parents, socio-economic situation, and health and disease were also seen as potential determinants of culture. Discussion on these subcultures and their effect on MCH care process was very limited or absent in all the interviews and FGDs. Thus, it can be interpreted that even though participants clearly perceived that culture is not defined only by having certain ethnic or geographical origins, yet the latter determinants of culture affect their work by far the most.

At the time of the data collection the Finnish parliament voted for the legal status of same-sex marriage, and LBGT rights were discussed excessively in the national media. This could have effected that most participants mentioned LBGT families separately as their own culture, but could not explain why and how representing sexual minorities affects one’s health beliefs and culture in MCH clinics. This finding complements well the premise that not only culture itself, but also perceptions on it are continuously changing phenomena, and are highly affected by the surrounding contexts and times. (1, 20)

Vast majority of the detailed descriptions of participants’ personal experiences on cultural competence relied on the encounters with immigrant and refugee families. This perhaps could suggest that the individual-oriented culture determinants are not as remarkable or visible in the MCH clinics as suggested in the results section. A conclusion can be drawn that there are multiple different cultures in the study area, but not all of them have a perceived impact on the PHNs’ work in MCH clinics [Figure 9].
Figure 9. Found determinants of culture and their perceived impact on PHN’s work

**Forming Cultural Awareness through Social Encounters**

Childhood upbringing, possibility to encounters with people from different cultures, and university lectures, assignments and exercises were factors that had enhanced the participants’ cultural awareness during their studying years. Several studies from other Western high-income countries support especially the lectures’ and reflective assignments’ facilitating role in development of nursing students’ cultural awareness. (45-48) Less evidence-based literature is available on the effects of informal cultural encounters, which were some of the key findings within the theme of cultural awareness in the present study.

International student exchange experiences’ effects on cultural awareness have been previously researched both in Finnish (49) and other high-income contexts. (50-52) Their findings, as well as those captured in the present paper indicate that international clinical training does facilitate development of students’ cultural competence. (50-52) As an additional property to the student exchange programmes, this study found that receiving international students indicates more cultural encounters for the local PHNs and students and hence benefits their development in cultural competence.

**Gaining Cultural Knowledge in MCH Work**
Barriers in communication was spontaneously raised as a challenge to cultural knowledge in all the interviews and FGDs. Similar findings on language barriers has been described e.g. in Finnish (17-18) and Swedish (53) studies on Somali-born women using maternal health care services. The language barriers potentially limit the participants’ understanding on the cultural needs of their clients and thereby might restrict the PHNs’ cultural knowledge. The communication issues guide us to criticize into what extension the claimed findings actually represent cultural competence per se rather than language skills or causes of lack of them. Even though the data clearly suggests that there is an impervious need for cultural knowledge in MCH work, the importance of language education should probably be stressed more in PHN training, more interpreters should be available in the area, and immigrants should be provided with more effective language training. These recommendations are supported by studies from the USA (54) and Belgium. (55)

The participants mentioned self-directed information seeking from books and internet sources as a rather inefficient method to gain cultural knowledge. However, previous studies indicate that when combined to social encounters such as clinical training or field visits, the classroom and literature-based studying methods can increase both perceived (56) as well as statistically measured (45, 48, 57) cultural competence significantly in nursing students. Therefore there is a well-rationalised reason to provide the PHNs and students with up-to-date written material on cultural nursing also in the future.

**Developing Culturally Sensitive Working Methods**

This theme illustrated how cultural sensitivity requires unending reflection and observation to respond to the acknowledged cultural needs of the clients. Continuous response observation, instant feedback from the clients, alternative communication methods, and creativity and adaptability when choosing working methods were important factors to reach this level of cultural competence. As a result of this stage, it seemed that clients the PHNs benefited in many ways from the social processes affecting the cultural sensitivity.

Emotional distress played a significant role in many ways within this theme. In addition to frustration due to above discussed language barriers, also building a trusting, open and unbiased relationship between the client and PHN was sometimes seen as a challenge due to cultural differences. Cultural understandings of the clients’ appropriate ways to show
gratitude to the PHN confused the participants. All the above mentioned issues were reported by midwife participants in Degni et al. study. (17) In the present master’s thesis the participants described the encounters requiring cultural sensitivity mostly as very positive experiences, whereas the referred paper concluded the participants’ attitudes towards cultural encounters somewhat in a more negative way. (17)

**Reaching Cultural Competence in MCH Work**

In relation to the Papadopoulos et al model, the data clearly shows that through tolerance of discomfort and assertive communication skills the PHNs do turn the challenging cultural encounters into strengths and positive experiences in their work. This results personal and professional development in overall clinical skills, and increases the quality of care of all the clients using the MCH services. A literature review by Callister (58) states that cultural competence of health care professionals creates “*significant improvements in the health and well-being of women and children*”. Therefore cultural competence in MCH is a topic which should not be overlooked in the training of future PHNs and in life-long learning of those already in the working life.

**Methodological Strengths and Limitations**

There are some methodological limitations in this thesis study. Since the author’s professional background is in clinical rather than academic work, it needs to be considered that this study is conducted by a beginner in research studies, and thus its scientific value should be viewed with a critical eye.

The author’s familiarity with the context was definitely an asset when designing the study and recruiting the participants, but it is also included some risks for the objectivity of the study. Cultural and non-verbal nuances during the data collection might have been missed only because of the fact that the researcher was culturally blinded to observe them. As “*fish don’t know they’re in water*” (59), one is seldom able to objectively sense essential issues in her own native culture, and therefore this study possibly lacks in description of the participants’ cultural environment. To provide the reader with more objective and detailed overview of the context, a literature-based description on the dominant local culture was provided in the Methods chapter of this paper. (40-41)
Due to the recruitment method there is a possibility that only people with positive experiences on cultural encounters reported their willingness to participate the study. Earlier studies from this setting show that racism and prejudices are existent in health care services (10, 16) and therefore it is obvious that this thesis was probably not able to describe the whole variety of PHNs’ opinions and experiences on cultural competence in the study area. It needs to be considered that an individual participant’s personal characteristics and history presumably affected her perceptions on cultural competence even more than this research design was able to capture, which limits the transferability of the findings. Furthermore, all the PHN participants had completed an additional college or university level degree course on top of their PHN degree, which in this context predicts higher level of approval towards cultural diversity and less racist attitudes in comparison to population with secondary education diploma or a lower university degree. (60)

Gender has been proven to be a significant covariant in attitudes towards immigration (60), and even though the 15 female participants do represent well the gender distribution in MCH care work in general (61), they still represent only one gender group’s perceptions and experiences. All in all, these findings are drawn from data collected from highly educated, native Finnish women living and working in a relatively rural province, and thus the findings apply mainly in this context.

**Beneficence and Contribution to the Existing Literature**

This master’s thesis studied PHNs and PHN students’ cultural competence from the social constructionism’s aspect, and managed to explain some of its possible underlying development mechanisms in MCH care setting. Complementing the macro theory of social constructionism (37-38), it seems that as hypothesised in the point of departure of this study, the development process of cultural competence in MCH clinics is constructed very strongly in social interaction between the PHNs and different stakeholders in the study area.

The theory described by Papadopoulos et al. (30) fits almost seamlessly to the development process of cultural competence found in the participants of this study. This probably leaves the reader with a well-justified question of the usefulness of the study – why was this research needed if the findings were already known? The findings of this study confirm to some extent
that Papadopoulos et al. model (30) is an accurate theory when researching PHNs’ cultural competence in this context. Thus this paper has the potential to benefit further research on cultural competence in settings and samples similar to those previously described. Other potential beneficiaries are PHNs, students, and training providers, as this study can serve as an explanatory material to fill the knowledge-gap between the previously published theoretical studies on cultural competence in the field of health care, and the grass-root level PHN work.

**Conclusion**

The conclusive key finding of this study is that PHNs and students in the MCH clinics construct their cultural awareness and knowledge through interactive and reflective day to day research on the needs, challenges and possibilities that their clients and their cultures create. Social interaction and instant feedback response in the care relationship facilitate the development processes towards cultural sensitivity and finally to cultural competence. It needs to be remembered that while the culturally diverse client groups create a new kind of challenge for the MCH clinics, simultaneously they themselves most often response to that need by educating the health care providers. As a result, all the clients using MCH services, regardless of their cultural, religious or ethnic background benefit from PHNs’ cultural competence, as it seems to lead them towards the following mind-set of good quality MCH work:

“**If I’m able to meet them genuinely, human being as a human being, then it doesn’t matter where they come from**”

(PHN 4)
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Annex 1: Interview Guide

**Social opening** takes place when arriving to the clinic. The interview setting will preferably be a silent room with a closable door, and a chance to put the audio-recorder on a table close enough to both the interviewee and interviewer.

Respondent will be informed orally about the study, and asked to read the informed consent form and undersign or reject her or his approval to participate the study. Respondent has a chance to ask questions. The audio-recorder will be turned on, and the interview will start. Following themes will guide the interview, however, not necessarily they all will be asked if it seems that the interviewee comes out with their content among other responds.

1. **Respondent characteristics**
   - How long have you been working as a PHN in maternity and child health care, and when and where did you graduate?

2. **Clinic characteristics**
   - Would you familiarize me shortly with the clinic you work in?
   - E.g. which professionals are working here, how many PHNs you have here, how many families you serve, and is there anything specific in this clinic compared to the other clinics in this town, or other towns in this region?

3. **Experiences and Perceptions on Cultural Competence – what is it?**
   - For you, what does cultural competency mean in public health nursing?
   - Can you recall any situations in your job where you have needed cultural competency? Would you tell me more about it/them?
   - Would you describe what on your opinion or experience is good cultural competency? Can you give any examples, either from real working life or an imaginary example?
   - What on your opinion is poor cultural competence? Can you give any example, either from real working life or an imaginary example?

4. **Experiences and Perceptions on Construction of Cultural Competence – how is it built?**
   - What, on your own opinion or experience, has affected on your own development in cultural competency? You can name as many factors as you like.
   - What do you think in general would be a good way for a PHN to develop in cultural competency?
   - Did you ever have to supervise PHN students during their internship in this clinic?
     - If yes, how did you perceive their aims and objectives to develop in cultural competence during their internship?
     - What kind of possibilities and challenges on your opinion there are in this clinic / area to reach the goals related to cultural competency, set either by the students themselves or the local Schools of Health Care?

**Closing:** Interviewee will be thanked, and asked if the she or he wants to tell anything more, or to correct something, or to make any questions for me. Audio-recorder will be turned off.

**After the interview:** Field notes and a short summary on observations during the interview will be written as soon as possible after the interview. Transcribing will be started no later than on the next day, and field notes will be used to compliment the audio-recordings.
Annex 2: FGD Guide

FGDs will take place in a class room at a School of Health Care facilities. It is familiar environment for both respondents, and for the author and research assistant. The chairs and tables in the classroom will be arranged into a one large table for six to seven seats so that everyone is able to see and hear each other. There will be two tape recorders which will be placed on the table so that all respondents are in equal distance from one recorder.

Respondents are informed about the purpose of the study in the beginning of the FGD session. Respondents will be informed that discussion is recorded and they are asked to give a written consent to participate the study before beginning the actual FGD.

Ground rules will be set in the beginning. Respondents will be asked to talk one at the time, the moderator’s and research assistant’s roles are explained. It will be highlighted that the conversation is confidential and all opinions, experiences and stories are highly appreciated, and it will be stressed that I am interested in getting respondents’ own perceptions, which means that there are no right or wrong answers in any of the questions.

FGD will be started with a social opening; greeting all the participants and thanking them for participation. **Introductory question** will follow the social:

“We are to talk today about cultural competence in maternity and child health care. I would like to start with showing you two comic strips on different encounters between two cultures. These gentlemen in the comic strips would probably have needed some cultural competence in order to avoid misunderstandings between different cultures.

You all are now almost finished with your four years PHN studies. What do you think you have learned during your studying years, either at school, in internship, private life or elsewhere about cultural competence, if especially thinking of your future work as public health nurses?

- *Heimo Vesa* (a Finnish name)! *Do you remember me?*  
- *Farran Al-Rashed*, my colleague from Kuwait!  
- *Where is your wife Irma?*  
- I think she’s in the ladies room  
Back in Kuwait:  
- *...they keep their women in separated rooms!*

*Jarla, P. Fingerpori. Published in Helsinki Times on March 2nd 2009*
In a trip in the USA

Back in homeland:
- You know, the Jews have to wear stars there!

**Follow-up questions** such as
- ‘You mentioned (- - -), would you tell me a little more what you mean by this?’
- ‘Does someone else have same kinds of experiences?’
- ‘Does someone have a differing experience or opinion?’

will be asked as seen necessary.

If it starts to look that spontaneous conversation will not arise, or if it begins to deviate into irrelevant subjects, **transition questions** are used to encourage the conversation to go on, or to lead it back to the subject.

**Possible transition questions:**
- “You mentioned earlier (- - -) as a way to promote one’s development in cultural competence. Can you or someone recall any other factors that could improve cultural competency in maternity and child health care work?”
- “You are studying, and most of you have interned in the Province of Eastern Finland. How do the geographical area and its inhabitants effect on PHN’s cultural competency here?”

**Ending question and closing:**

Moderator will keep on track on the clock during the FGD and starts closing the session when the 60 minutes starts to be over, or earlier, if it seems that no new topics arise from the group and everyone seems to have had a chance to share their perceptions and experiences on the subject. To start the closing, moderator will summarise shortly what has been talked during the session, and then asks if anyone wants to add or correct something, make a conclusion, or ask questions for me concerning the study or the FGD.

All the participants are thanked for coming. Fika will be served after the FGD session for all invited students, participated they the study or not.

**After the FGD:** Audio-recorders will be turned off. Moderator will write a short field note summary on the initial thoughts after each FGD session. Research assistant and moderator go through their notes, and check if they agree on the observations they have done.
Annex 3: Informed Consent • PHNs

Dear Public Health Nurse,

You have chosen to participate master’s thesis study ‘Cultural Competency in Maternity and Child Health Care clinics in the Province of Eastern Finland’. Before we start the interview I would like to ask you to read the text below and agree or disagree with the conditions of participating the study.

The purpose of this study is to explore how training in cultural competence in public health nursing could be developed in order to provide local PHNs and School of Health Care with information and tools to serve better the multicultural families using the Maternity and Child Health Care clinics in Province of Eastern Finland.

It is optional to participate this study. You are allowed interrupt the interview at any point, even without explaining why you wish to do so.

There will be no consequences for withdrawing from the study, and e.g. your employee and colleagues will not be informed if you choose or choose not to give an interview

All the information you give in this interview is confidential. The interview will be audio recorded, transcribed and translated in English language. To protect your and your clients’ anonymity, your name, clinic or town will not be mentioned neither in the transcript or the translation, nor in the final report of the study. To provide the readers of the study with some background information about the sample participated in this study, you are asked to fill a short anonym questionnaire on your age, years in working life, and the location of the School of Health Care you graduated from.

The data is stored electronically and is available only for the researcher and the supervisors of the project in Uppsala University and Savonia University of Applied Sciences.

The results of the study will be published as a Master’s Thesis in Uppsala University in May 2015, and by a chance in a national health care journal. If you wish, you and your clinic will be provided with a copy of a Finnish translation of the study in an electronic form in June 2015.

□ I ensure that I have been informed about the details mentioned above both orally and in writing.
□ I give my consent to audio-record the interview and use it as a data of this study.
□ I have decided not to participate this study, thank you.

____________________________________  __________________________________
Date                                             Signature
Annex 4: Informed Consent form • PHN students

Dear Public Health Nurse Student,

You have chosen to participate master’s thesis study ‘Cultural Competency in Maternity and Child Health Care clinics in the Province of Eastern Finland’. Before we start the focus group discussion I would like to ask you to read the text below and agree or disagree with the conditions of participating the study.

The purpose of this study is to explore how training in cultural competence in public health nursing could be developed in order to provide local PHNs and School of Health Care with information and tools to serve better the multicultural families using the Maternity and Child Health Care clinics in Province of Eastern Finland.

It is optional to participate this study. You are allowed interrupt the focus group discussion at any point, even without explaining why you wish to do so.

There will be no consequences for withdrawing from the study, and e.g. your lecturers, professors or student colleagues will not be informed if you choose or choose not to participate the focus group discussion. You are most welcome to the lecture held after the focus group discussion sessions, as well as having the fika served after the lecture, chose you to participate the study or not.

All the information you give in the focus group discussion is confidential. The session will be audio recorded, transcribed and translated in English language. To protect your anonymity, your name or town will not be mentioned neither in the transcript or the translation, nor in the final report of the study. Your group will be referred as ‘Final year public health nurse students in a School of Health Care located in the Province of Eastern Finland’. To provide the readers of the study with some background information about the sample participated in this study, you are asked to fill a short anonym questionnaire on your age and your place of origin.

The data is stored electronically and is available only for the researcher and the supervisors of the project in Uppsala University and Savonia University of Applied Sciences.

The results of the study will be published as a Master’s Thesis in Uppsala University in May 2015, and by a chance in a national health care journal. Your School of Health Care will have a copy of the published study. If you wish, you will be provided with a copy of a Finnish translation of the study in an electronic form in June 2015.

Please see page two to accept or refuse to participate the study.
☐ I ensure that I have been informed about the details mentioned above both orally and in writing.

☐ I will participate the focus group discussion, and I give my consent to audio-record the session and use it as a data of this study.

☐ I will not participate the focus group discussion, thank you.