IMMIGRANTS' EXPECTATIONS AND EXPERIENCES OF CHILD HEALTH SERVICES

A STUDY OF AFRICAN FAMILIES IN JYVÄSKYLÄ REGION, FINLAND

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Abstract
The purpose of the study was to explore the needs, expectations and experiences of African immigrant families of child health services within Jyväskylä region, Finland. The aim of the study was to gain insight and increase care providers' understanding of care needs of the minority population from the immigrant's perspective.
The research method used to implement the study was qualitative method. Semi-structured interview questions were used to collect the data. Sampled study population consisted of three fathers and three mothers. Data collection period spread over three months. Content analysis method was used to analyze the data.
The study results indicated that the participants were generally satisfied with the services they receive from child health clinics. Nevertheless, language and communication were highlighted as some of the challenges to health care access. Subsequently, the role played by the interpreter was identified and over-emphasized in facilitating effective communication.

The results also pointed out that the participants' expectations were centered on cultural care; sensitivity to cultural diversity a major concern raised by the participants. Additionally, the study results indicated the other hurdles the participants felt they are facing while accessing specialized health care services, such as long waiting periods.

The study results would be useful to the health care providers, policy makers and other stakeholders in formulation, planning and implementation of culturally sensitive health care services.

Keywords
Immigrants, child health, Africans, expectations, experiences

Miscellaneous

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Koulutusohjelma
Hoitotyön koulutusohjelma

Työn ohjaaja(t)
Katainen Irmeli

Toimeksiantaja(t)

Tiivistelmä
Tämän tutkimuksen tarkoituksena oli selvittää afrikkalaisten maahanmuuttajaperheiden tarpeita, odotuksia ja kokemuksia suomalaisen lastenneuvolan palveluista Jyväskylässä. Tutkimuksen tavoitteena oli lisätä lastenneuvolan työntekijöiden ymmärrystä maahanmuuttajien neuvolapalveluiden tarpeista kulttuurisesta näkökulmasta katsottuna.

Tutkimus toteutettiin laadullisen menetelmän avulla. Tiedot kerättiin kolmen kuukauden aikana. Tutkimukseen osallistui kuusi henkilöä, kolme isää ja kolme äitiä, joilla oli neuvolaikäisiä lapsia. Kerätyt tiedot analysoitiin sisällönanalyysin avulla.

Tulokset osoittivat, että tutkimukseen osallistuneet olivat pääsääntöisesti tyytyväisiä lastenneuvolasta saamiinsa palveluihin. Epäkohtana vastaajat korostivat yhteisen kielen puuttumista ja viestinnän ongelmia lastenneuvolapalveluissa. Lisäksi tutkimukseen osallistuneet tunnistivat tulkin roolin ja korostivat sen merkitystä tehokkaan viestinnän syntymisen kannalta. Tutkimukseen osallistuneet kokivat myös, että lastenneuvolan henkilökunnan tulisi antaa heille mahdollisuus kertoa enemmän lasten kasvatukseen liittyvissä asioista omankulttuurinsa näkökulmasta.

Tuloksissa tuli esiin myös ongelmia, joita tutkimukseen osallistuneet olivat kohdanneet muun terveydenhuollon parissa. Tällaisena ongelmana esiin nousivat muun muassa pitkät odotusajat.

Tutkimustulokset hyödyttäisivät terveydenhuollon palveluiden tuottajia, päättäjiä sekä muita sidosryhmiä jotka laatiessaan, suunnitellessaan ja toimeenpannessaan monikulttuurisia hoitokäytäntöjä

Avainsanat (asiasanat)
Maahanmuuttajat, lasten terveydenhuolto, afrikkalaiset, odotukset, kokemukset

Muut tiedot

1 INTRODUCTION

During the past few decades, international migration process has been on the rapid upward trend in various spheres. Industrialization and liberalization in the economic world brought about the movement of people across regions, continents and nations. Europe has since then ceased to be the producer of immigrants but rather the receiver of the migrating population. (Khachani 2006, 9.)

Finland has equally had its share in this migration process. People with various cultural backgrounds have migrated to Finland for education, work or for asylum reasons. Individuals have either moved to Finland as already formed family entities or initiated family ties with the same ethnic backgrounds when already in Finland. As a result of the process, Finland has equally become a multicultural society; as such, the healthcare environments are also increasingly becoming culturally diversified.

Subsequently, the immigration trend has increased the need for multi-cultural services in social and health care sector for the minority populations in Finland. Although people have a social right to expect healthcare services which correspond to their culture, it is still a challenge to contend with while designing services for a multicultural population. (Clarke 2003, 24.)

The process of immigration is identified as a factor which could contribute to the health of the immigrants negatively due to differences in cultural values, norms, beliefs and health care policies. Individuals, families and communities have their own cultural values, morals and ethics they attach to health hence expectations from health care systems which in turn may influence their health seeking attitudes and practices. (Byrd & Clayton 2003, 455.)

In order to assess the quality of services offered, especially to the minority population, it´s imperative that health care providers get feedback from users

of these services in order to understand their expectations and experiences. According to Cortis (2000), it is necessary to examine client/patients' perceptions of nursing care they receive by listening to their voices which are important and irreplaceable source of expertise. Their voices would enhance clarification and understanding about the care giver and provide the linkage between ethnicity, conception of the quality of care and experiences. This may further lead to improved and acceptable care for the consumers of these services. (Cortis 2000, 111.)

As noted by French (2003), the dynamicity in healthcare environment has become a constant challenge for care providers due to multi-cultural interactions. As a result, French encourages the entire nursing profession fraternity to strive in order to understand the diversity of their clients. Thereby, be able to provide efficient and effective care. (French 2003, 252.)

The purpose of this study was to bring out African immigrant families´ needs, expectations and experiences of child health services in primary health care. The aim of the study was to gain insight and increase care providers understanding about care needs of the minority population from the immigrant's perspective. The results of the study could be utilized by care providers, policy formulators and other stakeholders to design culturally congruent services which would meet the needs and expectations of the minority populations.

The study commences by exploring different concepts of migration process and the relationship between culture and health. The study also presents the history and immigration background of Finland. This depicts the genesis of multicultural existence and the subsequent increased need for cultural care.

2 INTERNATIONAL IMMIGRATION

2.1 Immigration and integration

Immigration can either happen voluntarily or under forced circumstances. Most often, reasons for voluntary immigration are in search of financial stability, family reunification and education. On one hand, forced migration takes place when those involved in the process do not have any other choice but to leave their homes due to armed conflicts, political oppression or natural disasters. Under the latter category, the affected normally find themselves in divergent dilemmas, considering that, they usually have no time to prepare themselves emotionally and socially for the change. (Carballo & Mboup, 2005, 4.)

Factors which determine immigration process were described by Castle and Miller (2003) as pull and push. Push factors are associated with those things which force people to leave their homes, for example, demographic growth, low living standards, lack of economic opportunities and freedom. Pull factors are related to those factors which make people get attracted to particular destination, for example, educational and work opportunities.

Castle and Miller further suggest that migratory movements could generally arise from the existence of previous links between sending and receiving countries. These links could either be colonization, political influence, trade investment or cultural ties.

2.1.1 Consequences of immigration

Immigration process subjects individuals and families to various challenges. They appear to lose their social networks and tend to face difficulties whenever they strive to establish themselves in a new environment. The process may have negative impact on the individual family and even the entire community.

Sundquist (2001) explains that, forced migration will lead to losing social, cultural, and economic connections with one´s country of origin. It involves encounter with a different society, language, and a gradual adaptation to a new culture. (Sundquist 2001, 691.)

Immigration process does not end by the entrance of individuals or families into the receiving country but the process continues with subsequent social integration into the new system. Due to the fact that different and distinct groups with diverse cultural values, norms and practices, are coming together to live in the same environment, the outcome of integration process usually tends to be unpredictable. When there is interest in maintaining one´s original culture, integration is always the option. In this case, there is some degree of cultural integrity maintained, while at the same time seeking to participate as an integral part of the larger social network.

On the other hand, other groups may opt to adopt completely the culture and values of the hosting community. In this way, then it will be considered that acculturation shall have taken place. Although acculturation is commonly reported in one direction; immigrants adopting host community´s values, beliefs and culture, it could also happen the other way round, that is, by the host country adopting the values and culture of the immigrant population. Through acculturation, it is reported that immigrants integrate easily with the hosting community. (Castro & Ruiz 2009, 280.)

Durden and Hummer (2006) point out that, immigrants and minority population have reduced entitlements in the host countries. They are prone to be subjected to poor living conditions, discrimination in work places and poor access to health care services due to political, administrative and cultural reasons. Therefore, it is being advocated by various agencies for policies which will reduce this trend by enhancing smooth transition for the immigrants. (Durden & Hummer 2006, 1321.)

2.2 Immigration and family cohesion

Immigration process is mentioned as one of the stressors of family cohesion. Typically, migration process may lead to changes in family roles and family dynamics. In cases where the family lack the ability to cope with migration stressors, then family conflicts may erupt such as domestic violence, intergenerational conflict or child abuse. Generally, migration process takes away family members from many of their relationships, community ties, customs and often languages. (Sanville 2002, 102.)

Immigrants tend to think that they have been stripped of their valuable relationships like close and extended family members, their best friends and neighbors. They may also think that they have been disposed from their social roles in the community which had provided them with culturally scripted notions on how they fit into the world. Therefore, immigration process imposes myriad challenges to the family and may hence cause remarkable influence on family cohesion. (Op. cit. p.104.)

Immigration process has been identified to occur in different phases. Each phase is characterized by different behaviors and experiences which often affect the health of immigrants both mentally and physically. In other words,

immigration process could be considered as one of the most stressful situations that a family has to contend with.

Immigration destabilizes family structure and interferes with the basic foundation of the individual's cultural organization and the family unit as a whole. Moreover, migration generates stress due to acculturation demands and different lifestyles from the immigrant´s lifestyle. In turn, immigration scatters families from their neighbors, the friends and traditions resulting in physical and psychosocial health problems hence affecting the well-being of the immigrant family. (Artico 2003, 164.)

2.3 Immigration history in Finland

History of immigration in Finland dates back to days of Swedish government rule which lasted over 600 years. Finland was under the Swedish government rule until 1809 when Finland was handed over to Russian government. Finland was under the rule of the Russians until 1917 when independence was achieved. An important immigration period is considered to have taken place during the period from 1890 until the Second World War. However, it is believed that it was until after independence that active immigration activity took place in Finland. (Tanner, 2004.)

During the Russian rule from 1890 until 1917, it is reported that there were at least 20,000 immigrants in Finland who consisted of; for example Swiss cheese makers, Bavarian brewers and Italian ice-cream makers. However, the biggest group of immigrants were the Russians whose total number was estimated to be over 15 000 by then. Following the subsequent collapse of the Soviet Union in 1991, Finland experienced the influx flow of immigrants with the Russians still toppling the order. (Tanner, 2004.)

Since 1970's, immigration trend to Finland has been rising erratically. By the end of the year 2000, the total number of immigrants had risen up to 103 682. The immigration trend changed significantly during this period and has risen steadily during the past decade.(Figure 1.)

At the end of the year 2010, the immigration statistics show that the number of foreigners in Finland had increased up to 167,962. Between the years 2005 and 2010, Finland has experienced an increase of about 54,037 foreigners in its population database which represents 47.4% increment. It is projected that the same trend will continue to prevail in the Finnish population in the coming years. (Korkiasaari & Söderling 2003, 11.)

Some of the reasons attributed to the immigration of persons to Finland, are for example; education, asylum seeking, in search of better jobs and family reunion purposes. Subsequently, the trend resulted in rapid increase of multicultural families in Finland. In the past few decades, the trend in multicultural marriages has increased significantly in the Finnish population. (Figure 2.)

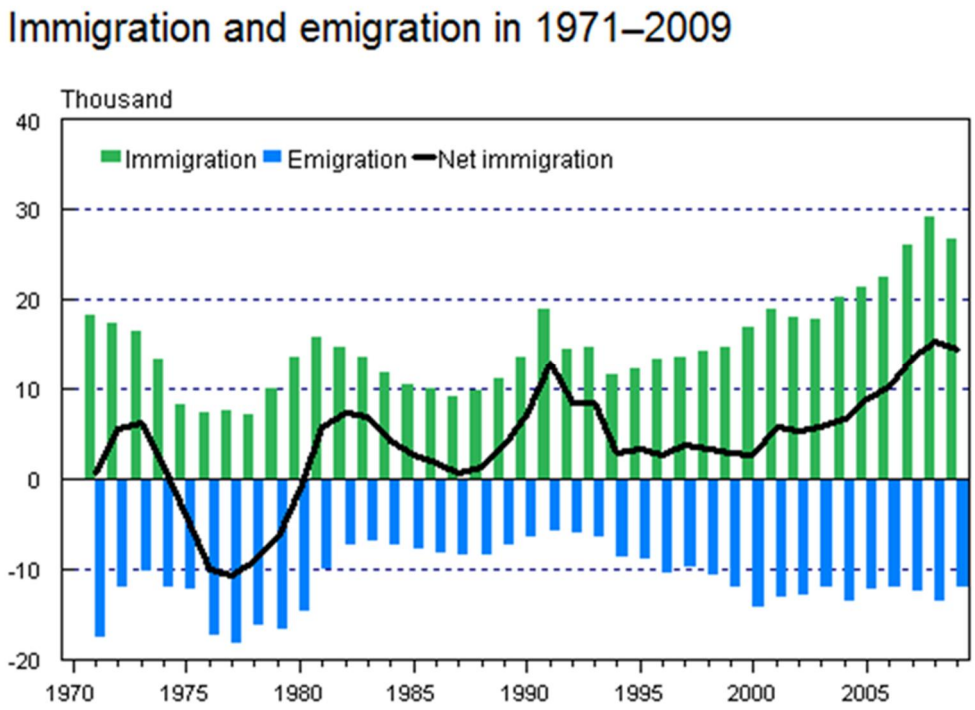

FIGURE 1 Immigration and Emigration in Finland

Source: Population Finland /Statistics Finland 2010

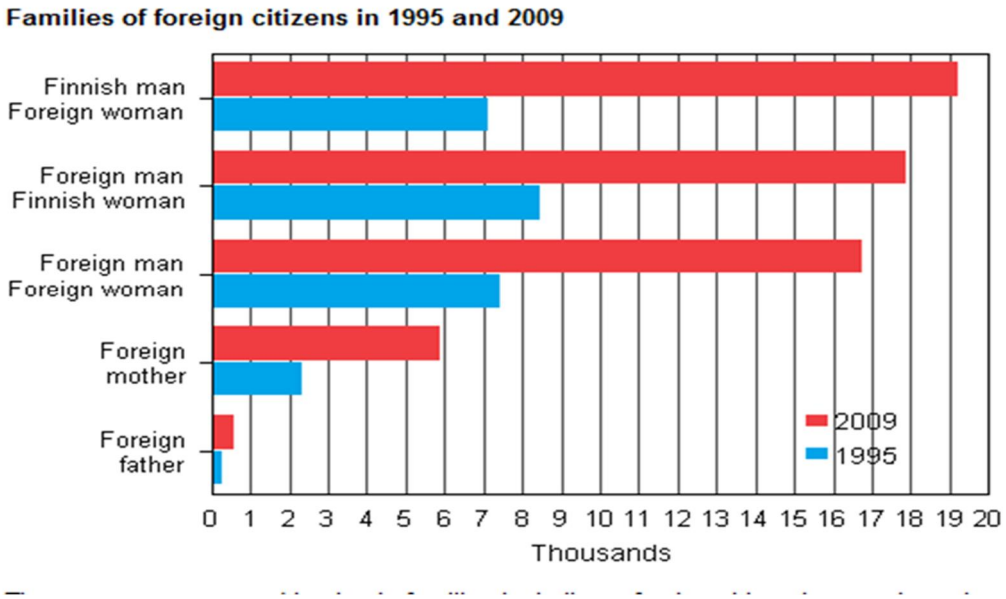

FIGURE 2Families of foreign citizen in Finland

Source: Population Finland /Statistics Finland 2010

3 CULTURE AND HEALTH

Cultures are dynamic and tend to differ amongst and between different communities. Cultural practices create situations that may pose the potential to foster or impede health. Culture is perceived to shape how people conceptualize health thereby influencing health related practices.

According to Lynam, Browne, Kirkhams and Anderson (2007), culture influences the manner in which the formal system plans, organizes and provides health care in a culturally diverse environment. Culture shapes immigrants' conception of health by influencing their attitudes and practices in health and health related matters. (Lynam et al.2007, 23-24.)

3.1 Cultural concept in caring

Cultural meaning from the world view perspective is very essential in understanding health, illness and care of humans (Berry 2002, 370). Communities have different values and practices attached to health, sickness and well-being of various members, for example; unborn, children, youth, adults and the elderly. Therefore, culture is considered as shaping health behaviors, and defines the roles and expectations of the clients and health care providers.

According to McKenna (2008), culture is learned, shared and transmitted values, beliefs, norms and life ways of a particular group that guides an individual or group in their thinking and making decisions in a patterned manner. She further expounds on the importance of culture and explains that it is an integral and essential aspect of being human and the cultural care aspect cannot be overlooked or neglected in the history of mankind in relation to care process. (McKenna 2008, 168-169.) This concept has been supported by

the evidence of more nurses desiring to become knowledgeable about cultures and showing willingness to assist clients from different cultures.

Cultural values, beliefs, norms and practices are transferred from one generation to another. Children act as the agents of this generational change. Older generation instills values and norms into the younger generation through practices which are exhibited in healthcare practices by different communities. (Berhanu 2008, 7.)

Studies carried out earlier, (Adjadjihoue and Ali, 2009; Imarhiagbe, 2006; Amandah 1994), to assess the impact of culture on health care access and utilization, elicited the strong effect of cultural heritage of people, which cannot be separated from the way they perceive health. The studies elicit how it further determines peoples' attitudes and practices in health and health related matters.

Despite the differences in geographical backgrounds of African population, some cultural values have been observed to cut across several communities. Elsafty (2001) argues that these similarities have impact on the health status of the African population whenever they emigrate and settle outside African continent According to him, there is a common denominator in culture that paints the picture of similarity among the Africans and tends to cut across the region, albeit in different levels. He notes the strong interrelationship between culture on one hand and the health status of the population on the other hand. In this aspect, he stresses that it is difficult to understand one without considering the other. (Elsafty 2001, 3.)

Individuals may have their own ways of assessing health and interpreting the signs and symptoms of the diseases which may be based on either past experiences or culturally inherited norms and values. For this reason, individuals, families and communities have designed generic ways to care for their members that uphold their own values, norms. Without understanding

these aspects in care, the process would be impeded hence compromise care and the care results. (Friedman, Bowden & Jones 2003, 232.)

3.2 Cultural Diversity

Leininger (2002) refers to cultural diversity as differences and variations which arise between and among cultural groups in life ways, languages, values, norms and other cultural aspects which make every group distinct from one another. (Leininger 2002, 53a.)

Luna (2002) maintains that, valuing diversity in health care will enhance the delivery and effectiveness of care physically as well as symbolically. She notices that, with the current globalization trend, cultural diversity is unavoidable even in the societies which are still considered homogenous. (Luna 2002, 139.)

Carballo, Julio and Zeric (1998) identify the gravity of cultural diversity. They postulate that, it is continually propelled by the ever growing political animosity in the developing countries, quest for further education, natural disasters and endless search for better working and living conditions. These factors and many others are compelling people to move away from their original residential places and settle in newer environments. (Carballo et al. 1998, 940.)

Diversity in culture has attracted the attention of global organization with the aim of harnessing the potential associated with it. UNESCO Universal Declaration on cultural diversity states that the world's wealth is in its diversity and dialogue.

Article 3 of UNESCO's constitution acknowledges the element of cultural diversity and its contribution to development. It emphasizes that cultural diversity widens options for everyone and it forms one of the basis of

development. This is not only understood in terms of economic growth, but also as a process to achieve more satisfactory intellectual, emotional, moral and spiritual existence. (UNESCO, 2002.)

3.2.1 Language and communication

Considering the dynamicity which comes with cultural diversity, language and communication patterns play a leading role on how healthcare services are delivered and received in a multicultural environment. Leininger (2002) emphasizes, it is imperative for care provider to understand both verbal and nonverbal communication pattern to be able to provide optimum care (Leininger 2002b, 126). Lack of common language will definitely call for the provision of an interpreter if care needs are to be fulfilled effectively and efficiently.

Wiking, Saleh-Stattin, Johansson and Sundquist (2009) conducted a research in Stockholm, Sweden to assess immigrant patients′ experiences and reflections pertaining to the consultations on primary healthcare services. The results revealed patients' satisfaction with the health services they received. However, the role played by common language in communication process was over-emphasized. It was recognized as a major facilitator to understanding, hence, improved quality of services. Despite the availability of the translators, the clients still expressed their concern about the difference in language. They stressed that lack of common language would impair consultation between the client and the doctor. The study emphasized how differences in communication languages and culture could jeopardize consultations and compromise care process. (Wiking et al. 2009, 294.)

3.2.2 Use of interpreters in care process

Adequate language skills contribute significantly towards a feeling of satisfaction among minority population seeking healthcare services. And lack of these skills would easily hinder smooth interaction thereby impeding efforts to meet cultural care needs. (Adjadjihoue & Ali 2009, 51.)

Sherrill, Crew, Mayo, Mayo, Rogers and Haynes (2005) conducted a study to ascertain barriers to health care for the Latinos in the United States of America. The results indicated that, lack of insurance, language barriers and cultural differences were the common barriers to health care access. Despite the well- structured health care system, common language as a means of communication played an important role in the process of healthcare service delivery and acquisition. (Sherrrill et al. 2005, 356.)

Similarly, Hadziabdic, Heikkila, Albin and Hjelm (2009) had conducted a study to find out the migrant's perceptions of using interpreters in health care. Their study concluded that the use of interpreters was necessary in health care provision in a multicultural environment. However, the participants perceived the use of interpreters as a hindrance therefore preferring face-face communication. Interpreters were considered to be a barrier between the client and the care provider as it was not possible to discuss sensitive issues with the care provider in the presence of an interpreter. (Hadziabdic et al. 2009, 462.)

Clients liable to use the services of in interpreter tend to feel incapacitated since they have to depend on the interpreter in order to acquire health care services. To gain clients' confidence and capture their trust in the use of interpreters, it imperative that the care provider is fully involved in the process where applicable in order to reduce misunderstanding and enhance quality care.

3.3 Culturally competent care

Cultural competence requires of elaborate understating about personal values, desire to know about others and the willingness to inquire more about phenomenon in order to gain better understanding about the relevant issues (Berlin 2010, 24).

According to Cortis (2003), care is termed as moral pursuit derived from one source and centered on the beneficent attention of one person shown to the other. Yet it is argued that, if such language is to have real poignancy, it must be designed with an inclusive agenda towards meeting the needs of all within the community. (Cortis 2003, 77.)

Leininger (2002) describes caring as those activities and actions designed towards supporting and assisting individuals or groups with evident or anticipated needs to improve, ease, heal or change their life ways, conditions or face handicaps and/or dignified death (Leininger 2002a, 47).

Care is intertwined in culture and at the same time, forms the integral part of culture. The complicity in the care and culture phenomenon, constantly challenges nurses to understand the culture component at every stage in multicultural care environment.

A study was conducted in Stockholm, Sweden to assess cultural competence in primary health care services, interaction between primary child health care nurses, parents of foreign origin and their children. The results revealed that cultural incompetence of nurses jeopardized smooth interaction and rapport creating between parents of foreign origin and nurses. (Berlin 2010, 45).

Cortis and Kendrik (2003) contend that, cultural dimensions of nursing have been constantly ignored and many members of ethnic minorities have felt marginalized or isolated in health care matters (Cortis & Kendrik 2003, 77).

The impact of culture has continued to attract more attention in cross and trans-cultural care. Both the client and the service providers' perception of health and illness are strongly pegged on their cultural heritage hence may determine the outcome of caring process.

Marcinkiw (2003) considers cultural care competence as a process in which the care provider strives continuously to achieve. It is worth appreciating that they continue to portray ability and effort to work effectively within the cultural context of individuals or communities with diverse cultural or ethnic backgrounds. It is argued that in order to become culturally competent, it is required of one to develop self-reflection, practice and facilitated feedback regarding one´s values, attitudes and perspectives in regard to the care provided. (Marcinkiw 2003, 175.)

Additionally, Leininger (2002) argues that culturally competent care could only take place if individuals, the groups, the families and the communities cultural care needs and patterns are known to the care provider and are used appropriately. This could only be possible if a proper and professional assessment is done, decisions made and right help identified for the client or patient. Without identifying the basic and immediate health needs of the client, the results of the care may not be meaningful to the recipient hence may illicit lack of cooperation from the client thereby delaying the care process. (Leininger 2002b, 119.)

Similarly, findings from another study done in Tampere, Finland on marginal communities indicated the likelihood of inaccessibility to healthcare services if barriers are not identified and adequately addressed. Language and communication were some of the barriers to health care access identified by the study. The study also elicited the important relationship between cultural diversity, innovation and creativity, economic welfare and growth and their contribution to quality care. (Adjekughele 2003, 65.)

3.3.1 Cultural Care Theory and Sunrise Model

Leininger's Sunrise Model has been used to illustrate how cultural care could be developed in considerations to different domains in order to meet holistic care needs of individuals, families and the community. The model is designed to explain, describe and predict nursing similarities which are generally focused in caring in human cultures. In this model, Leininger uses worldview, language, ethno-history, environmental context and both generic and professional systems to illustrate comprehensive and holistic view that has influences on cultural care. (Andrews 2008a, 8.)

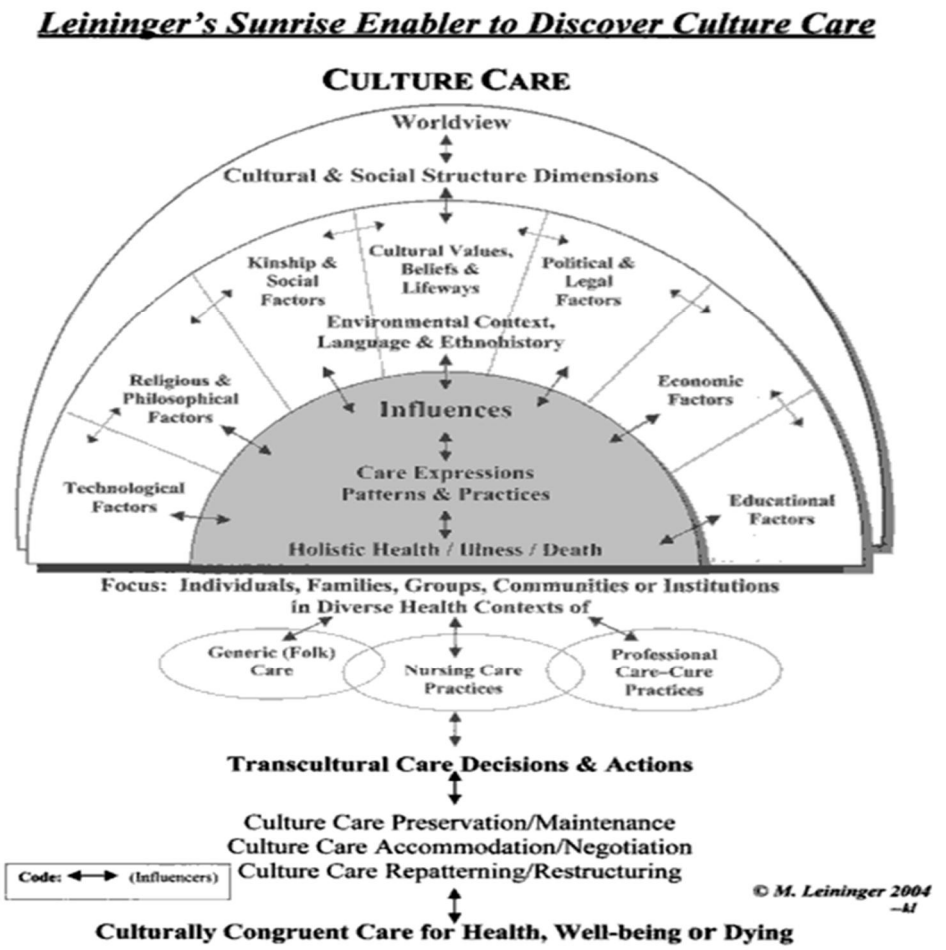

FIGURE3 Leininger´s Sunrise Model to depict Theory of Cultural Care Diversity and Universality (Leininger 2005, 230).

The Sunrise Model (figure 3), depicts different domains of cultural needs. In the model, there is possibility of developing more comprehensive understanding of client´s cultural needs; however, the focus of the research could still be zeroed only on one or two domains. In this way, it is appreciated that the model provides flexibility while still creating a solid ground for research. The researcher of the study focuses on the three modes of nursing decisions and actions.

1. **Cultural care preservation or maintenance**

According to Welch (2002), cultural care preservation or maintenance is attributed to the attitude of a particular group or community´s strive to retain or preserve relevant cultural values or norms. The process consists of the activities designed to assist, support and enable the people of a particular culture retain or preserve specific values and norms that aid their well-being, recovery from illness or face handicaps and/or death.(Welch 2002, 509.)

2. **Cultural care accommodation or negotiation**

This mode of nursing decisions and actions is associated with efforts to drop hard line values or norms and negotiate with the professional health care provider for beneficial or satisfying healthcare results. The efforts to attain the objective of cultural care accommodation or negotiation lies heavily on the care providers. They are charged with the responsibility to initiative assistive, supportive and facilitative actions which will help designated cultures negotiate for beneficial or satisfying health care outcome with professional care providers. (Welch 2002, 509.)

3. **Cultural care re-patterning or restructuring**

Cultural care re-patterning or restructuring is associated with clients' efforts to reorganize, change or modify one's lifestyles in order to embrace new and beneficial health care practices. It is argued that while working with the client to reorder, change or modify the life ways, it is important to respect client's cultural values and beliefs. (Welch 2002, 506.)

Within these three categories of domains, it is suggested that a co-participant involvement approach is applicable whereby the client and the professional

use their knowledge for culturally congruent care within these three specific groups of domain. (Leininger, 2002c, 82.)

From another point of view, it is argued that in the field of caring sciences, people from different ethnic minority groups are prone to vulnerability due to inadequate health care policies. Consequently, this has led to insufficient access to health care or cultural incongruence and independence in the healthcare system which has further led to provision of unsatisfactory healthcare services. (Meleis & Lipson 2003, 70.)

4 FINNISH HEALTHCARE SYSTEM

Healthcare services in Finland fall under the Ministry of Social Affairs and Health. The Ministry is charged with the responsibility of formulating implementation, monitoring and evaluation of national policies related to health and social care services. The aims of Finnish healthcare policies are geared towards health promotion and disease prevention, prolonging people´s health and improving the lifespan of their functional ability. Finnish health care policies also strive to safeguard the possibility for everyone to have good and quality life by eliminating health differences between population groups and by reducing the rate of premature deaths. (Ministry of Social Affairs and Health 2009.)

Public health care services in Finland comprise of primary healthcare and specialized hospitals care. Municipalities have the mandate to provide primary healthcare services to its residents. Primary healthcare services are basically addressing individual's health needs and the environment where they live. These activities are aiming at maintaining and promoting the state

of health for every cohort in the society. Primary health care covers the maternity, child welfare clinics, school health care, medical rehabilitation and mental care. (Primary health care act 66/1972.)

A municipality may provide these services by itself or may do so in collaboration with several other municipalities. Some municipalities purchase nearly all their health center services from private providers. Each municipality belongs to a particular hospital district, each of which contains a central regional hospital. (Ministry of Social Affairs and Health 2009.)

Finland is divided into 20 hospitals districts; in addition, the semi-autonomous province of Åland forms its own district. There are five university hospitals which provide specialized levels of treatment. (Ministry of Social Affairs and Health 2010.)

4.1 Child health services

Why child health services

Children are considered the beckon for the future in any society. Care given to them and support offered to their parents go a long way as a nation´s investment for posterity. Societies depend on children for furtherance of the future generation. Children are cared for, nurtured and provided with socialization. The survival of culture for any society depends on the transmission of values and customs from one generation to another which solely relies on children for continuity. (Andrews 2008b, 116.)

Child health service is a phrase used to denote different services offered by the society to promote and enhance the well-being of children in the society. It is applied for various services targeting both health and social services for families and their children. For the purpose of this study, child health services refer to professional activities offered by the public health nurse and family

doctor to children of ages 0-6 years-old to promote their health, enhance growth and development and achieve disease prevention goals.

Families with divergent cultural norms and values who live in Finland are accessing child health services from clinics which are referred to as neuvola in Finnish. Individual family´s perception and understanding concerning health would be considered to play a vital role in general utilization of health care services.

Child health services are focused on disease prevention and health promotion, it's importance could be easily under scored by prospective users if the information relayed to them is not clear enough to illicit the importance of the services. This concurs with Rundle (1999) who emphasizes on the importance of family´s perception and understanding of health, origin and meaning of well-being, illness and recovery as a major factor in the health care provision and utilization. Parents are the primary custodian of children's rights and they deem to understand and accept child health services and the environment where these services are offered in order to maximize utilization of these services. (Rundle 1999, 12.)

4.2 Child health services in Finland

In Finland, like many other countries, child health services are provided free of charge. The objective of child health services is mainly to promote the health of children and to provide care for the families by reducing inequality among different families. The role of the child health clinic is to monitor and support the physical, psychological and social development for children below the age of six years. The services also aim at supporting parents in the up-bringing, good child care and to foster good relationship between the parents. (Ministry of Social Affairs and Health 2010.)

It is recommended that child health clinics arrange 16 appointments with the doctor and the public health nurse. The appointments are recommended and scheduled as deemed necessary. The public health nurse makes a home visit before and after the birth of a child, and at other times as necessary. (THL, 2010.) Administration of vaccines is also undertaken in the child health clinic according to immunization programme. Immunization process forms one of the core indicators in evaluating utilization rate of child health services. Every country has its own specific immunization schedule assigned by the World Health Organization which differs from one region to the other.

Immunization, for example, today, is recognized for the satisfactory progress it has made in some regions, but in others, coverage is still stagnating at undesirable levels. Immunization programmes, however, have made such inroads by reducing the burden of ill-health. (Chan &Twinn 2003, 166.)

In many countries, it has completely changed the health care profile. There is now need for new strategies with more integrated approaches. This will ensure that the changing spectrum of problems is efficiently dealt with by broadening the focus of care from the child's survival to its growth and development. World Health Organization (2005) report recognized this element and stressed that it is what is needed today from a public health point of view and it is also what families expect of health care institutions. (WHO, 2005.)

5 THE RESEARCH PURPOSE AND RESEARCH QUESTIONS

The purpose of the research is to describe the African immigrant families' needs, expectations and experiences towards child health services within Jyväskylä region.

The research questions are:

1. What are the needs and expectations of African immigrant families of child health care services?

2. What are the experiences of the African immigrant families of child health services received?

The aim of the study is to gain insight and increase care providers' understanding about the care needs of the minority population from the immigrants' perspective. In other words, the objective of this study was not to review or measure the competence of the health care professionals, however on the basis of the experiences from the African families, the health care services could be designed in a manner that they would be culturally congruent to African immigrant families and other minority populations.

The results produced by the study could be used to develop health care services which are sensitive to immigrants health needs and would satisfy the needs of the minority communities in Jyvaskyla and in Finland as a whole.

6 STUDY METHODOLOGY

A qualitative research method used to implement the study. Qualitative research is accredited with being subjective than objective, hence provides a platform for uncovering the complex and holistic world of the participants. (Creswell, 2003, 51.)

Since the purpose of the study was to bring out the voices of African immigrant families´ needs, expectations and experiences on child health services, qualitative research method deemed appropriate as it allows for the subjective feelings of the respondents to emerge freely.

In addition, Avis (2005) states that qualitative research is concerned with providing an enterprise to capture social events from participants' point of view and as an insider of the social life. The in-depth description of events explores the meanings people attach to past experiences and identifies the social structures that shape these meanings. (Avis 2005, 4.)

According to Lobiondo-Wood, Haber and Kranovich-Miller (2006), qualitative research is conducted in natural setting and uses words or text rather numeric as data to describe experiences being studied. Data collected from qualitative research aids in understanding experiences or phenomena that affect participant's daily life situations. And for that matter, these data could be used to develop theories, improve care for relevant population or used as a recommendation for further research. (Lobiondo-Wood et al. 2006, 28.)

6.1 Study Participants

The participants of the study were drawn from the African immigrant population residing within Jyväskylä region. Access to the study population was gained through the City of Jyväskylä office. A formal request was put forward to the City of Jyväskylä office through the Chief Medical Officer which was accepted. The head of public health nurse was thereafter informed who later coordinated the process through various child health clinics.

The selection of the participants for the study was done through purposive sampling. As illustrated by Burns and Grove (2001), purposive sampling is suitable for qualitative studies since it creates option for the qualitative researcher to decide for subjects with particular characteristics. This is appropriate in order to increase theoretical understanding of some facets or phenomenon being studied. (Burns & Grove 2001, 376.)

Six parents took part in the interview for the study. They consisted of three fathers and three mothers though only one pair presented for the interview as a couple. The rest of the interviews were conducted to individuals.

The participants who took part in the study met the selection criteria since they were adults over eighteen (18) years-old, had African ethnic background, and had children below school going age. They live within Jyväskylä region and had used child health services for more than once. They had also to speak either English or Swahili.

6.2 Data Collection

The data collection process lasted for over three months spreading from the month of September till November 2010. However, before the actual interview, a pilot study was conducted. As stressed by Polit and Beck (2004), pilot study is important as it tests data collection instruments, sample recruitment strategies and the feasibility of the study. Pilot study also gives the researcher opportunity to test the adequacy of the research design and the logistics of the main study. (Polit & Beck 2004, 196.)

Therefore, pilot study helps the researcher to identify any faults with the study design which could be rectified before the actual study. In brief, pilot study maybe used by the researcher to gain experience of administering the data collection instruments for the subjects and by doing so, it helps to test the validity of the interview questions and any other data collection tools. (Porter & Carter 2000, 24-25.)

A prior arrangement was put in place for briefing in order to ensure the participants had sufficient information about the study. At the same time, a letter of introduction was issued to the potential participants to provide them with more information about the study. A consent form was also provided to the participants whereby some gave signed consent while others consented verbally. Thereafter, the participants and the researcher agreed on the appropriate venue and time for the interview.

Two interviews were conducted in participants′ homes which were the convenient places for the participants. One interview was conducted in the child health clinic while another interview took place in business premise of one participant after the end of day′s business work as this was the convenient place for the participant.

The initial interview questions were prepared in English language. Later the interview questions had to be translated into Swahili for the sake of the participants who were not conversant with the English language. Three interviews were tape recorded while the fourth one was written down manually as the participant was hesitant to accept voice recording. Each interview lasted approximately 45 minutes. In each case, the services of the interpreter were not required as both the participants and the researcher spoke and understood the same language as either English or Swahili.

6.3 Data Analysis

Data analysis forms another important stage in research process and it is equally important to identify the appropriate method to apply as it will contribute to the end results of the study. For this study, the analysis of the data was based on the content analysis method.

According to Cavanagh (1997), content analysis as data analysis method is considered flexible especially for nurse researcher as it provides the opportunity to have objective and systematic means whereby phenomenon could be described and quantified. (Cavanagh 1997, 5.)

Elo and Kyngäs (2008) emphasize that, content analysis makes replicable and valid inferences from data by providing knowledge, representing facts and by giving new insights as a practical guide into an action. The aim of content analysis is to attain condensed and a broad description of the phenomenon being studied by creating concepts or categories describing the phenomenon. (Elo & Kyngäs 2008, 108.)

Audiotapes and field notes were transcribed for easy analysis. As encouraged by Polit and Beck (2004), verbatim transcription is a special step in preparation for data analysis. They further stress the importance of ensuring

transcription accuracy that would reflect the totality of the interview experience and would facilitate efficient analysis. (Polit & Beck 2004, 572.)

Recorded tapes were transcribed immediately after every interview. Although the interview tapes were transcribed word for word, some information was intentionally omitted such as participants' names and significant others which could easily reveal their identity. Transcribed interview notes produced averagely 4 A4 page notes per each interview. The researcher then read through the transcribed notes several times to get the meaning out of the expressed participant´s views. Burns and Grove (2005), refer to this process as immersion in the data. It helps in familiarizing with data and it involves reading and rereading notes and transcripts, recalling observations and experiences until researcher becomes immersed in the data. (Burns & Grove 2005, 547.)

The next step was assigning different colors to the transcribed text. Color highlighting marks were used to distinguish each piece of the transcript allocated to a theme and sub-headings arising within the same theme. Participants´ responses which fell under the same theme were highlighted with the same color. At the end of this coding process, a summary of the participants' responses was made and each response was grouped under particular theme. (Appendix 1.)

7 RESULTS

7.1 Participants´ background information

The sample of the study population consisted of six participants, of which three were males and three females but only one pair presented for the interview as a couple. Two interviews were conducted to single individuals and one was conducted to a group of two individuals. The data collection period was three months.

The ages of the participants ranged between 24 and 39 years-old. The participants hailed from various parts of the African continent; West, East and Central region. All the participants reported having lived in Finland for longer than two years. Four of the participants were married while two were single parents. All the participants had attained up to ordinary level of education from their various countries of origin while three among them had attained university level of education too. All of the participants were able to communicate in more than one language and could understand some Finnish language. Three of the participants were caring for their first children while the other three had more than one child. The youngest child below the school going age was 10 weeks-old while the oldest child was 4 years-old.

7.2 Participants´ perceptions of child health services

Most participants described child health services to include weighing the baby, measuring height and head circumference and giving immunizations. Their description went further to include examinations done by the doctor to the baby in child health clinic. Participants' description of child health services also brought the mother into the picture as one of the recipients of these services. This is illustrated by the following comment:

Child health services are immunizations given to the baby and care given to the baby and the mother.

Participants had a general feeling that child health services are associated with the care given to the baby from birth. Immunizations and health education to the mother or to the parents were mentioned to be part of these services.

7.3 Participants´ expectations of child health services

Most participants centered their expectations of child health services on how their children should be cared for considering that they had a foreign cultural and racial background. They expressed how and what care they expected to receive from child health clinics which will conform to their cultural norms and values. Most participants expected the health care provider to handle them with respect, empathy, equality, confidence and trust. They also expected the care provider to communicate to them effectively while being sensitive to their cultural variations. One participant had these views to express:

……When I visit neuvola, I expect the nurse to handle me and my child with respect and dignity without considering our origin….

Some participants also expressed their expectation of child health services to provide preventive services which are able to protect the child against the diseases and promote healthy development for the child. At the same time some participants expressed their expectation of equality and to be granted opportunity to make their contributions towards the services provided. One of the participant's views is expressed as follows:

….Our expectation is that the nurse will be respectful to us and be ready to accommodate our views as parents with foreign background…….

Some of the participants who were caring for their first born babies expressed their expectations to find advice on child care especially regarding breastfeeding, clothing, sleeping and feeding of the baby. They also expressed their expectation to receive more information about health services in Finland especially how to find help when baby is sick or faced with emergency. One mother had this to say:

In Finland, almost everything is different from my own country. Here we feed on different foods; we put on different clothes and lead lifestyle which is totally different from our native lifestyles. Therefore, I expect the nurse to advise me on how to care for my baby putting into consideration these factors.

7.3.1 Culturally oriented care

Most participants described elaborately how children are cared for in their own communities. They expressed the important role played by the parents in the upbringing of children in their various communities. Some participants went further to voice out the specific individual parent's role as viewed from cultural perspective in some communities. Almost every participant expressed an expectation that the care provider would offer them services which conform to their cultural values.

Some participants expressed their expectation and desire to see the immigrants' views integrated in the care and be given a chance as individual, family and the community to make their contributions in the child health care. They expressed their views from their communities′ point of view especially how first time parents are taken care of. Their views brought out the

important position occupied by the elderly mothers in child rearing. One participant had this to say:

> *If I were to live here with my mother, then she would take over the responsibility to care for my baby. She would consider me unable to handle the baby well as a first time mother. This would be even displayed during visits to child health clinic. The nurse would be expected to notice this and address my baby's issues through my mother.*

One participant also expressed strongly his desire to see his cultural values and practices integrated in child health practices. By doing this, he expects the system to support him and help him maintain his mainstream culture while he lives in Finland. His views are expressed as follows:

> *……I have heard that in Finland, circumcision to the male child is not allowed. But it is my wish that it would be possible to perform it to my child someday if God blesses me with a male child. This is one of the strongest cultural practices back in my community and I would like to practice it in my family…….*

7.3.2 Communication and information dissemination

Majority of participants expressed their concern and expectation towards listening and information dissemination ability of the care provider. Almost every participant expected the nurse to listen to them attentively while providing care to their children. They expected the system to provide them with relevant and necessary information pertaining to the services offered in the child healthcare clinic especially in language they can easily understand.

The participants also expressed the role played by common language in communication and the importance of translators. They expressed how ineffective communication could be and even lead to misunderstanding in the absence of an interpreter.

Some of their views were expressed as follows:

> *I can speak some Finnish but not sufficient enough to use in neuvola, therefore I use a translator. It would not have been possible to communicate with the nurse without a translator since I speak only French and my mother tongue and the nurse speaks Finnish and English only. I am grateful that I was able to have a translator in child health clinic……*

Although most participants expressed appreciation for the services of the interpreter, some had different views concerning the interpretation process in general. Some participants expressed their concern on how concise the interpreter could be to keep the original meaning of the issues raised by both parties in child health clinic. One participant had this to say:

> *I have used the services of the interpreter but I think it would be good if I had explained myself directly to the nurse. I sometimes doubt whether the interpreter tells the nurse exactly what I had meant to tell the nurse and vice versa……..*

7.4 Participant´s experiences of child health care services

In general terms, most participants expressed that they had received the best possible care for their children and they professed satisfaction of these services. They termed these services as superior and easily accessible in comparison to the availability of the same services from their own countries of origin.

7.4.1 Friendly and accessible services

Most participants narrated the good interpersonal relationship they had experienced with the nurse at the child health clinic. The nurse demonstrated wholesome care for the baby and did not only concentrate on the growth monitoring and immunization but demonstrated holistic care to the child. This was appreciated by the participants especially when they had to reflect

on the type of services offered in child health clinics in their home countries. One participant had this to say:

> *Nurses at neuvola are friendly. When you visit there they ask you how the baby slept, how the baby´s breastfeeding is. All these questions they ask while smiling with you and checking the baby. This is very different with the clinics back in my own country. Back there, they are only concern with weighing the baby and giving immunizations.*

7.4.2 Continuity of care

The participants also expressed their satisfaction with the continuity of care provided from antenatal clinic to child health clinic. During the interview, one mother expressed how she had enjoyed the services of the same public health nurse both during pregnancy and in child health clinic. She was excited about such arrangement and attributed it to confidence building and trust development between the care provider and the client.

In that respect, she had this to say:

> *I had the same nurse taking care of me during my expectancy period and the same still takes care of my baby. This is good arrangement. I did not have to start telling again the same story I had told in äiti-neuvvola. Although I have confidence in every nurse, I would rather prefer to be attended to by the same in both clinics if possible. I have got used to this nurse and created even stronger relationship with her……..*

7.4.3 Inaccessibility to other healthcare services

Although majority of the participants expressed how accessible child health services were, they had a different opinion when seeking other healthcare services. Participants had expected to access other healthcare services readily as it was possible with child health services. When this turned out to be the opposite, they did not hide their dissatisfaction. These reservations were

expressed especially by the participants who had used child health services but at the same time required specialized healthcare services for the same children. Some of their views are expressed as follows:

> *My baby was born with a problem which needed her to be attended by a surgeon. This was not possible immediately and I had to wait for too long. I had contemplated to see a private surgeon if I had got the financial ability……..*

Generally, most of the participants expressed their dissatisfaction regarding accessibility to other health services especially those who had sought healthcare services other than child health services in primary health care. Majority were satisfied with the quality of care provided but dissatisfied with the process of acquiring these services. One participant had this to say:

> *I find it so easy to bring my daughter here to neuvola but it is totally different story when I have to see the doctor for other services other than child health services. One is either required to call the health center or visit it only to book appointment. I sometimes wonder why one cannot be allowed just to walk in and see the doctor immediately……*

The majority of the participants thought that the process delayed their access to the doctor. Therefore, they made recommendations and suggestions to include the shortening of the waiting time. In their opinion, doing so would improve the services by making it easier and faster to access the services of a doctor whenever needed. Some of these views were expressed by one participant as follows:

> *……I think there is problem with the appointment booking system. It is too slow for somebody who is sick. The waiting time should be reduced for patients to see the doctor faster than how it happens nowadays……..*

8 DISCUSSION

8.1 Ethical consideration

Ethical issues arise in all types of research. Ethics is always associated basically with issues to do with values, what is right and wrong. Koskinen (2003) refers to morals as the social customs of human behavior which defines what is right and what is wrong both in practice and in theory (Koskinen 2003,84).

In research studies involving human subjects, there is need to maintain confidentiality and anonymity of the research participants in the use of research results and publication of research findings. In the study, the author ensured that the ethical issues were addressed appropriately.

Research permission was acquired from the City of Jyväskylä since the participants were to be sampled from child health clinics within the City of Jyväskylä. The researcher received permission from the Chief Medical Officer for the City of Jyväskylä to sample the study population through child health clinics.

Additionally, an introduction letter was prepared and presented to the participants before the interview period. The letter explained the area of the study, the purpose and aim of the study. The letter also explained that the results of the study will be presented at the JAMK University, School of Health and Social Studies. A copy of the same will be made available in the Library for the School of Health and Social Studies.

Together with the letter of introduction, a consent form was also sent to the participants explaining that the study was voluntary. The consent form also explained that the privacy and confidentiality of the client will be observed. The form also explained that the information given may be taped for those

who have consented but the tapes will be erased after use. The participants will be free to withdraw from the study without any reprisal. As such, the participants having understood the nature of the study gave either signed or verbal consent.

Therefore, ethical guidelines pertaining to research involving human subjects were applied in this study. The participants were guaranteed their rights throughout the study process.

8.2 Validity and reliability

The quality of research work is measured by the validity and reliability. Validity refers to how much the researcher has adhered to the outlined measures; that is, how much the research has measured what it ought to have measured. Harber and Lobiondo-Wood (2006) emphasize that, a valid instrument would truly reflect the concept it was designed to measure (Harber &Lobiondo-Wood 2006, 335).

To guarantee validity, the interview themes and questions were formulated from the research questions. The interview questions were pilot tested and changes made before conducting the actual interview. The study participants were sampled in collaboration with the public health nurse through the child health clinics. The sampled participants represented different regions of African continent and they participated in the study out of their free will. During the data collection process, it was ensured that the participants were free to choose venue and time of the interview and this provided flexibility.

Fain (2004) describes reliability as the consistency whereby a study instrument measures what it was designed to measure (Fain 2004, 128). For reliability to be calculated, the researcher has to make the clear documentation of

procedures in order to demonstrate the consistency of the whole process (Silverman 2010, 290).

In the study, face- to- face interview method was used which ensured that the questions asked were clearly and adequately answered. Since the same language was used in interviewing, the chances of misunderstanding were reduced. The services of an interpreter were not required. Additionally, the interviews were conducted, transcribed and analyzed by the researcher hence minimized the chances of misinterpretation.

8.3 Discussion about the main findings

The purpose of the study was to describe African families' expectations and experiences of child health services. The aim was to make their voices be heard and develop insight into their expectations and experiences as a minority community using child health services in the City of Jyväskylä. Thus, to enable care providers understand better the clients from different cultural backgrounds.

According to the findings of the study, there was a general consensus among the participants revealing overall satisfaction of the child health services. The level of professionalism and cordial interaction exhibited by the health care providers acted as a source of motivation for child health services clients especially the mothers. The study also revealed that most of the participants' expectations were averagely met during their encounter with child health services.

However, language and communication formed part of the very pertinent issues raised by participants concerning child health services. Effective communication in caring process is a vital contributor to quality care. The absence of common language hence the use of interpreters, has been identified

to enhance communication process by reducing the chances of misunderstanding. For that reason, it would be the prerogative of the care provider to ensure efficiency and effectiveness of the translation process. (Wiking et al. 2009, 290.)

In other words, the improper use of translators has been identified as one of the barriers to smooth communication process between the clients and healthcare providers. It is therefore, paramount to adhere to professionalism in the use of translators in health care provision in order to achieve the best results. (Hadziabdic et al. 2009, 462.)

In breaking communication barrier where common language is lacking, the use of interpreters has been recommended. The same is applicable in the study whereby the participants appreciated the role played by the interpreter. Despite the fact that most of the study participants had demonstrated ability to communicate in Finnish, it was still a challenge when it came to finding the right words to use in explaining health related situations either to the doctor or to the nurse as highlighted by the results of the study. Therefore, there is need to consider incorporating cultural aspects in nursing care; ability to command foreign languages by care providers dealing with multicultural communities is vital in breaking communication barrier hence improved access to health care services.

According to Garret, Forero, Dickson and Whelan (2008), the absence of effective communication in healthcare may render inadequate care access or lead to inappropriate assessment, diagnosis and treatment (Garret et al. 2008, 214).

One area that is still a challenge in today´s healthcare service provision is the ability to develop culturally sensitive and competent services which will meet the diversity of needs for these ever increasing patients and clients with multi-cultural backgrounds. Clerk (2003) citing Valtonen (1999) noted the

importance of cultural competence for social and health care providers as a prerequisite in eliminating migrant´s isolation and poor health seeking behaviors. Lack of culturally competent caregivers coupled with high threshold in gaining entrance into many services, tends to deny immigrants essential services which they are rightly entitled. (Clarke 2003, 24.)

The results of the study also highlighted the value the respondents attached to family from cultural perspective. It is worth noting that failure by care provider to recognize roles played by different family members may in turn jeopardize care process. Culturally sensitive assessment process will definitely elicit roles played by different family members hence mitigating role confusion which may have resulted into family conflict. In this way, the confidence of the family could be achieved, their cooperation harnessed with the resultant effects directed towards health promotion and disease prevention. (Friedman et al. 2003, 175).

The results of the study also highlighted the displeasure registered by the participants pertaining to the accessibility of other health care services. Dissatisfaction experienced by the participants due to what they term as long waiting period, could be attributed to lack of sufficient information by the immigrants on the structure and functionality of the Finnish health care system. On the other hand, factors which enhance access to some people may work in the opposite direction for others. For example, securing an appointment by telephone or internet could become tremendous barrier to those who lack the required skills or access to the technology. At the same time, others may find themselves lacking language skills hence find it difficult to express self without face-face contact. (Clarke 2004, 282.)

Child health clinics could be utilized for the dissemination of health related information for individuals, families and the entire community especially for the immigrant population. By doing so, the important and relevant health

information would have been conveyed and the potential users prepared for any eventuality pertaining to health related issues.

Additionally, the first time mothers expressed their desire and expectations for information on the general care for newborn babies. Considering that they are novice parents in a totally different environment, health information offered to them contributes significantly towards health promotion and disease prevention. It would be worthwhile to invest extra time in preparing first time mothers towards the parenting role.

The major responsibility towards provision of child health services which are culturally sensitive to the immigrant needs is vested heavily on the public health nurse. The nurse acts in the center stage to link the client with the health care services. Therefore, it remains to be a challenge for the entire health care system, to support the efforts of care providers in sharpening their skills in handling clients with multicultural backgrounds.

8.4 Conclusion and Recommendations

In conclusion, the study demonstrates the general satisfaction for the users of child health services. This affirms the results of earlier studies which had illustrated similar findings. However, the cultural care needs of the minority population remain to be the special area of focus for the nursing profession and the entire health care fraternity. It is imperative for healthcare providers and other stakeholders in health care sector, to continue striving to embrace cultural care practices in order to meet the health care needs of the ever growing immigrant population in Jyväskylä and in Finland.

The study also recommended further research which could involve a larger study population with more emphases on the role of fathers among the minority population especially the African fathers in child rearing and care.

Such a study would give further insight in the structure of the family and help care providers make better family assessment and plan for appropriate and relevant care towards disease prevention, health promotion and holistic wellbeing for individuals, families and the entire community.

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Appendix 1: Background information and interview themes

1. Sex: Male/Female,

2. How old are you?

18-25

26-3536-44

45-55

3. Marital status. a) Married b) single c) divorced

4. Which region of Africa do you come from?

a) East West b) South c) North d) Central Africa

5. What is your level of education?

a) Primary (b) Ordinary (c) College/Tertiary (d) University level

6. How long have you lived in Finland?

7. What other languages do you speak?

8. How many children do you have and how old are they?

Perceptions and expectations

In your own opinion, what do child health services mean?

How would you describe child health services and what activities are included in these services?

Could you describe what expectations you had during your first visit to child health clinic?

Experiences

Do you have any past experience with child health services in your own country? If yes, could you briefly describe about it?

How many times have you visited child health clinic here in Jyvaskyla?

Could you describe how your first encounter with child health services was like?

What would you describe as the best experience with child health services?

Have you ever had an experience which you did not like in the child health clinic? If yes, could you describe how it was?

What services do you receive in child health clinic?

How do you describe these services if you have to compare them with your expectations?

Do these services meet your expectations? If No, what would you suggest to be included in these services?

What general comment do you have to give for improvement of child health services?

Appendix 2: Letter of introduction

Dear participant,

I am a student nurse at JAMK University of Applied Sciences undertaking Bachelor Degree in Nursing. Currently, am carrying out my bachelor thesis project on the topic "Immigrants Expectations and Experiences of Child Health Services". The aim of this study is to increase understanding about nursing care for clients with different cultural backgrounds. About 3-4 families will be interviewed during this study. During these interviews, questions will be asked related to your expectations and experiences about services received at child health clinics within Jyvaskyla region. The results of this study will be presented in JAMK University School of Health and Social Studies. A copy of the same will be available in the School of Health and Social Studies library. The interviews will be conducted in the months of October and November 2010.

Please feel free to contact me without hesitation about any question(s) that may arise concerning this study.

Thanks in advance for your cooperation and participation.

Yours sincerely,

Leonard Apondi

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Appendix 3: Consent form

I hereby, do give permission to the researcher to interview me and get information concerning African families' expectations and experiences about child health services. I understand that the interviews may be tape recorded. I understand that the recorded tapes will be erased afterwards. I also understand that my privacy and confidentiality will be observed throughout this process. I understand that the information received may be published, but my name will not be associated with the results. I am free to deny answers to specific questions during the interview. I also understand that am free to withdraw my consent and terminate my participation at any time without any penalty.

I am free to contact the researcher at any time by phone or e-mail on any issue that may arise regarding the research or my rights as a participant.

Participant´s signature: Place and date: