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**NURSES' EXPERIENCES OF MULTICULTURAL CLIENTS  
IN SEXUAL AND REPRODUCTIVE HEALTH CARE IN  
KOKKOLA**

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**ABSTRACT**

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<p>This study focused on the nurses' experiences with multicultural clients in sexual and reproductive health care in Kokkola. The purpose of the study was to describe nurses' experiences when facing multicultural clients in sexual and reproductive health care. The goal of the study was to gain information for the development of the nursing practice and education in the field of multicultural nursing.</p> <p>The research was conducted by combining both qualitative and quantitative research methods. The data was collected by a questionnaire using closed and open-ended questions. The target group was 65 nurses working in the field of sexual and reproductive health. The number of the final participants was 33.</p> <p>The results indicated that most of the participants had experiences with multicultural clients weekly or monthly. Almost 70% of them had faced some sort of difficulties. Language and communication issues were frequently considered to cause the problems. It was stated that most of the participants' willingness increase their knowledge in multicultural nursing.</p>		
<b>Key words</b> Cultural competence, culture, multicultural client, sexuality, transcultural nursing.		

## **ABBREVIATIONS**

SPSS            Statistical Package for the Social Sciences

WHO            World Health Organization

## **ABSTRACT**

## **ABBREVIATIONS**

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## INTRODUCTION

People are moving from their countries of origin to totally new environments because of various reasons. In Finland there are a growing number of foreigners. The number of immigrants in Finland was 155 705 in the end of year 2009 (Väestökisterikeskus 2010). The residents of Finland with ethnic origin are not included in that number.

The health care in Finland is about to face many challenges because of internationalization. People from other cultures with different mother tongues are entitled to become treated as equally as native Finns. According to ethical principles in health care, every individual should be treated and respected equally (Brusila 2008). Every individual's all needs should be achieved in the health care services despite different ways of understanding health, sickness, life, death, individual and community. Finnish culture is quite individualistic and it may be hard to understand a patient from a very communal society. Misunderstandings can rise from different viewing points. Understanding between different language groups can be enhanced by using interpreters. The most important features of health care professionals are ability to understand patients/clients, sensitivity, interaction skills in order to respect the patient and professional knowledge. (ETENE 2004.)

Nurses and physicians are privileged to encounter patients in their most private and intimate matters in all cultures. There is a possibility to embarrass or insult the client unintentionally in the caring process without adequate knowledge of a client's culture. Sensitive approach and respect to client's culture enables compliance to treatment even if there is a communication problem. (Brusila 2008.)

Privacy of sexuality is characteristic in most of cultures. Discussing issues related to sexuality with outsiders may be new to some clients. Apart from that, discussing these issues with foreign language may be difficult. Knowledge about sexuality might also be insufficient. There are no words for issues related to sexuality in all cultures. (Ryttyläinen & Valkama 2010.)

There are different attitudes and norms in different cultures concerning matters in almost all areas in everyday life (Brusila 2008). This study is interested in factors related to sexuality and reproductive health and effect of these cultural specialties to implementation of nursing care. The purpose of the study was to describe nurses' experiences in facing multicultural clients in sexual and reproductive health care. The goal of the study was to gain information for the development of the nursing practice and education in the field of multicultural nursing.

The research was conducted by combining both qualitative and quantitative research methods. Data was collected by using a questionnaire with closed and open ended questions. Closed questions were analyzed by Statistical Package for the Social Sciences (SPSS) 18.0 program. Results from open-ended questions were analyzed with content analysis.

The interest to the topic has risen while studying in a multicultural group of students. Experiences with members of other cultures have raised the willingness to investigate this topic. The content of a book 'Seksuaalisuus eri kulttuureissa '(Sexuality in Different Cultures) by Brusila (2008) also increased the interests of this research study.

## **MULTICULTURAL HEALTH CARE**

### **Multicultural clients in Finland**

In 2010, there were 167 954 foreigners permanently living in Finland. It does not include those with admitted Finnish nationality or asylum seekers. The number is growing. (Tilastokeskus 2010.) In the end of year 2010, there was 54 912 dual nationality holders in Finland and in statistics these persons are considered as Finnish citizens (Sisäasiainministeriö 2011).

Family relations are common reason for moving to Finland. Multicultural families usually include a Finnish man and a foreigner woman in the family. In 2009, there was 19 000 such cases reported in Finland. There is 4.2 % from all families that have at least another parent foreigner or the only parent is a foreigner. A number of 224 388 (4.2 %) population in Finland speaks some other language than Finnish, Swedish or Sami as their mother tongue. An amount of 248 135 people born abroad were living in Finland in the end of year 2010. Nearly, 39 % of them have Finnish nationality and rest of them have other nationalities. The most important factors for social integration of foreigners were found to be: having a work place, security, health services and Finnish or Swedish language skill. (Sisäasiainministeriö 2011.)

Multicultural client in this study refers to all individuals from minor cultural groups living in Finland. It includes also Finnish speaking cultural minorities.

### **Transcultural nursing**

Other terms used to describe transcultural nursing are multicultural-, intercultural- and cross-cultural nursing. (Andrews & Boyle 2008.) Madeleine Leininger has developed a theory of transcultural nursing. According to Leininger (2002), "Transcultural nursing has



been defined as a formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned life ways of cultures to provide culturally congruent, meaningful, and beneficial health care to people. “ Transcultural nursing takes into consideration patients’ or clients’ cultural background with all its dimensions in offering care. People cannot be separated from their cultural and social background. These factors have to be considered in providing care.

Nursing field deals with ethical issues frequently and challenges may arise more often if patients/clients come from different cultures. A patient/client from another cultural background may have differentiating health beliefs compared to the caregiver. The practices that are seen positive in a caregiver’s culture may be taboos and understood as a negative in a patients/clients culture. Nurses may encounter the problem of whether to discuss about the issues or not. They may consider if they should inform patients/clients about the practices that are beneficial according to the nurse’s culture but in the patient’s/client’s culture these are seen as a negative practice or taboo. (Maier-Lorentz 2008.)

Nurses and physicians encounter patients/clients in their most private and intimate matters in all cultures and plan the care to individual needs. Therefore, it is crucial for the health care workers to take into consideration also cultural preferences of the patients/clients. This can be achieved by increasing the level of cultural awareness and discuss the cultural preferences of the patients/clients with them. This shows the importance of having transcultural nursing in the syllabuses of the institutions that offer nursing education. (Brusila 2008; Maier-Lorentz 2008.)

## **SEXUALITY AND REPRODUCTIVE HEALTH**

### **Sexuality**

Sexuality belongs to the human rights and is part of being a human. It is part of a life cycle. It makes expressing and experiencing love, tenderness, intimacy, romanticism and passion possible. Aging, illness or disability does not make sexuality to disappear even though it may have an effect on the manifestation of sexuality. Sexuality is often a remarkable resource in life. Positive attitude towards sexuality, gaining information, sexual health services and respecting sexual rights forms a base for good sexual health. Sexual health is a part of total health. (Ryttyläinen & Valkama 2010.)

Sexuality consists of a person's sexual development, biological gender, sexual orientation, sexual identity and propagation. Attitudes, values, beliefs and relationships with other people are ways to express one's sexuality. It belongs to humanity throughout a life. (Väestöliitto 2010a.)

Matters related to sexuality are the most private and sensitive to majority of people. Attitudes towards sexuality are adopted from surrounding culture and religion already in childhood and later on. Sexual drive is seen dangerous to society if not regulated. Religions have been in a key role in regulation of behavior in order to protect communities and individuals throughout the history. Regulations have been targeted especially to control women's sexuality. (Brusila 2008.)

Therefore, to understand better sexuality in other cultures it is also important to understand our own culture. Our culture affects the way we consider customs and norms in different cultures.

## **Reproductive health**

The World Health Organization's (WHO) determines reproductive health as follows:

Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (WHO 2011.)

Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO 2011.)

## **Sexuality and reproductive health in multicultural health care**

Attitudes towards sexuality are learned during childhood in cultural and religious context. Privacy of sexuality is characteristic in most of cultures. There are variations in different cultures and religions about the values, norms and outlooks in gender roles and family life. (Ryttyläinen & Valkama 2010.)

Nurses are more often to encounter clients and patients from different cultures and religions in health care. They are expected to be able to help these clients in matters related to sexuality as well. The most important quality in a nurse is his/her respectful and open attitude towards different cultures. Knowledge about different cultures and their health habits is beneficial too. Nurses are demanded to offer same quality of care to all clients despite their cultural background. The best way to understand multicultural clients is to listen to them carefully because they are the experts of their own culture. Open discussion and dialogue are important in multicultural nursing. (Ryttyläinen & Valkama 2010.)

It is stated in Finnish legislation that patients/clients have right for a good quality of health care. His/her care should be organized and he/she should be treated in such a way that does

not insult his/her human dignity. His/her conviction and privacy should be respected. Native language of the patient/client, his/her individual needs and culture should be taken into consideration in his /her care and treatment. (Laki potilaan asemasta ja oikeuksista 17.8.1992/785.)

The main ethical principles in facing clients from different cultures are humanity, human dignity and equality. Confidentiality forms base for the relationship between nurse and client. Clients from different culture may have negative experiences from health care services and he/she may be unaware of professional confidentiality. (Ryttyläinen & Valkama 2010.)

Discussing issues related to sexuality with outsiders may be new to some clients. Thus, discussing these issues with foreign language may be difficult. Knowledge about sexuality might also be insufficient. There are no words for issues related to sexuality in all cultures. In those cases, other expressions should be used. Sufficient time should be reserved to discuss and help clients to talk about matters related to sexuality. (Ryttyläinen & Valkama 2010.)

An interpreter should be available if there is a language problem between a client and a nurse, preferably same gender with a client when discussing sexual issues. Relatives, friends, neighbors or children of a client should not be used as an interpreter because it may hinder the ability to discuss delicate matters. (Ryttyläinen & Valkama 2010.)

Häkkinen (2009) studied the needs of immigrants are achieved in health services in South Ostrobothnia. Every tenth of the participants (all of them were women) replied that the gender of the health care professional matters due to their culture or religion. Gender issue is not always related to culture. Same gender in intimate examinations eases the process. Most of the participants have an effect on the gender of the caregiver. They also understood that it is not always possible to have a health care worker with the same gender.

Pregnancy and childbirth are seen as more than just biological events in all cultures. The pregnancy is a transition period for a woman in her way of becoming a mother. Her social status changes after delivery. Women are protected from harms during pregnancy by following beliefs, customs and behavior models. It affects women's life in all areas. There are positive and negative beliefs in cultures to control pregnancy and child birth. Their aim may be to safeguard the upcoming delivery or to prevent morning sickness. Negative beliefs are to control woman's environment, functioning in the society, working, sexuality, and expressing emotions. Health care system has more concise way to consider pregnancy. (Abdelhamid, Juntunen, Koskinen 2009.)

### **Sexuality in Finnish religion and culture**

An individual's own cultural background affects the way he/she perceives another cultures (Abdelhamid, Juntunen, Koskinen 2009). Therefore, it is appropriate to look into own cultural specialties to understand better different cultures. The majority of Finnish people (87%) belong to the Evangelical Lutheran Church of Finland while 50 000 of Finns are orthodox. There are only a few thousands belong to other religious communities. The remaining of 8% does not belong to any religious group. (Kontula & Haavio-Mannila 2004.) However, Church services are not attended very actively among Evangelical Lutherans. The stand of the religion has declined during the last decades and it does not have a great impact to the sexual lives of Finnish people. (Kontula & Haavio-Mannila 2004.)

It is possible to have a sexual life in Finland without marriage and it has become more acceptable for single persons. Most of the couples live together before marriage and some of them do not get married at all. The quality of the relationship is valued more than its religious or civil form. (Kontula & Haavio-Mannila 2004.)

The Social and Health Ministry of Finland have set up a working group to develop the first national programme to promote sexual and reproductive health of couples and individuals.

According to the programme, counseling related to sexual health is integrated to be part of health care services in preventive care and nursing. Equality between genders and needs of minorities and special groups should be considered in this matter. (Sosiaali- ja terveystieteiden ministeriö 2007.)

## **CULTURALLY COMPETENT CARE**

### **Culture**

Phenomenon of culture is ever-changing and not a static as it may be understood. There are changes that modify circumstances and conditions in cultures in different ways over time. Every moment and event in a person's life acts in a cultural framework. The day of birth, getting married or remaining single, illness and wellness and dying have its cultural features. (Leininger 2002.)

It was stated by Duffy (2001) in the literature review by Williamson and Harrison (2009) that there are also variations inside cultures. There is no homogenous group of people thinking and acting exactly the same despite the fact that they are from the same culture. Generations and different groups form cultures to be rather heterogeneous.

### **Cultural competence**

Cultural competence means a person's ability to consider his/her clients cultural background in providing care (Häkkinen 2009). Cultural competence can refer either to an individual or organizational cultural competence. In this this context, the focus is on an individual cultural competence. It consists from a person's integrated skills, knowledge, beliefs and attitudes which enhance to encounter someone from a different culture. (Andrews & Boyle 2008.)

The term cultural sensitivity is often used in almost the same meaning as cultural competence. The ability to accept differences in people, the skill of empathy and good communication and interaction skills are requirements of cultural sensitivity. (Abdelhamid, Juntunen, Koskinen 2009.)

Andrews & Boyle (2008) have used Campinha-Bacote's definition of cultural competence. According to that cultural competence, it is an "on-going process in which the healthcare professional continuously strives to seek ability and availability to work effectively within the cultural context of the client (individual, family, and community). This process involves the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters".

Cultural desire is a person's genuine interest towards different cultures. It is a characteristic to be motivated and offer care for people from all cultures. The health care professional with cultural desire aims to become "culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters." Cultural desire forms a base for developing cultural competence. (Campinha-Bacote 2011.)

Cultural awareness involves a person's ability to recognize his/her own attitudes and cultural background. He/she also recognizes client's cultural values, traditions and problem-solving skills. This helps him/her to become aware of prejudices and racism towards other cultures. (Abdelhamid, Juntunen, Koskinen 2009; Campinha-Bacote 2011).

Cultural knowledge is the educational base of different cultures. A culturally knowledgeable person understands multicultural clients' viewpoints. He has ability to understand differences and similarities. Biological, physiological and psychological variations in different ethnic groups are understood. Societal defects related to cultural minorities are understood in cultural knowledge. (Abdelhamid, Juntunen, Koskinen 2009; Campinha-Bacote 2011).

Cultural skill is the ability to take into consideration the client's culture when assessing, planning and implementing of nursing care. (Abdelhamid, Juntunen, Koskinen 2009; Campinha-Bacote 2011).



Cultural encounters refer to the person's interest to seek situations of cultural interactions to learn about different cultures. The person may consciously seek or avoid situations where would be an opportunity to have a cultural interaction. These encounters may provide a valuable information to prevent stereotyping and modify formed beliefs. (Abdelhamid, Juntunen, Koskinen 2009; Campinha-Bacote 2011).

Williamson & Harrison (2009) have found out that culture can be approached from two different aspects: cognitive aspect which consists of language, location, beliefs, values and traditions, and structural aspect which consist of social position. Reviewed literature in their study was found to focus mostly on the cognitive aspects of culture.

### **Nurses experiences of cultural competence**

Tuokko (2007) has described cultural competence of health care professionals from their own experiences. The results pointed out that a part of the respondents have positive attitude towards clients from different cultures and cultural factors are also considered in the care process. Another part neither have positive attitude nor consider cultural factors in the care. The culture's influence has been noticed via experiences in practice. Culturally sensitive approach helps to achieve more efficient care and enables collaboration with the client. Counseling is not adequate because of language problems. It also causes selection of clients according to cultural background. Stereotyping attitudes were present among participants. (Tuokko 2007.)

Huttunen (2006) described experiences and ideas of health care professionals about cultural competence in gynecological sampling. According to results, cultural competence consists of following levels of competence: professional, theoretical, ethical, customer service (and using one's own personality in it), communication, cultural, social support and "soft" competence which mean nurses ability to create a positive atmosphere. Campinha-Bacote's meter of cultural competence was utilized in the study and according to that, the cultural competence of the nurses was on the level of cultural awareness. Cultural

competence was left on each worker's own responsibility and it creates great individual differences between the staff members. (Huttunen 2006.)

Sainola-Rodriquez (2009) has researched transnational competence of the health care professionals. According to results, health care professionals have raised the need for education related cultures. They did not consider that the education in their field has prepared them for multicultural encounters.

Dogan, Tschudin, Hot and Özkan (2009) have studied experiences of Turkish patients about the care in Germany. German health care personnel were also questioned about the care offered to Turkish patients. It was found that Turkish patients had “needs for good communication, physical contact and understanding of their culture-based expressions of illness”. Health care professionals experienced that they need to be educated with Turkish culture. Also language barriers should be reduced.

Leval, Widmark, Tishelman, & Ahlberg (2003) analyzed that Swedish midwives considered sexuality among circumcised African female patients. The results revealed that midwives have a very limited knowledge of a circumcised patient's sexuality. They also did not know ways to gain information due to cultural barriers. Desire to deepen their knowledge was recognized. It was also discovered that social context and men's role make women powerless. However, antenatal clinics and labor wards were places to left norms in cultures and between genders aside.

Michaelsen, Krasnik, Nielsen, Norredam, & Torres (2004) have studied attitudes of health care professionals towards immigrants in Denmark. Immigrants and their family members were considered to be more demanding and stressing clients compared to others. The level of education affects the results. Assistant nurses with lower education achieved the most negative attitudes.

## **Challenges in multicultural nursing**

Nursing has been affected by globalization. Many nurses have been in contact to other cultures either by traveling abroad or by meeting patients from different cultures. Working environments have become more diverse. Nurses' profession has changed due to globalization and has different requirements than earlier. There are more patients, settings are diverse and responsibilities include supporting, education and managing patients in addition to direct nursing care. The International Council of Nurses (ICN) informs nurses to promote "an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected". This environment would base on justice, respect and willingness to work for others benefit. According to findings, all nurses have not been willingly to promote such an environment. (Dogan, Tschudin, Hot & Özkan 2009.)

Providing culturally appropriate care to achieve the needs of a client is challenging nursing practice. Nurses need to have knowledge about clients' beliefs, customs and values related to health care with the aim of providing holistic care that considers the individual. Interest to learn about different cultures and open-mind are required from nurses. Competence to culturally sensitive care is based on transcultural knowledge. (Maier-Lorentz 2008.)

Hoye & Severinsson (2008) have found factors that caused distress in intensive care nursing of multicultural clients and among their families. These factors were professional status and gender issues, communication challenges, impact on work patterns and responses to crises. Altogether the main factors causing stress among nurses were due to differences in language, culture and ethnicity. Nurses are seeking to receive more knowledge about other religions and cultures to decrease cultural diversity.

Language barrier is seen as a real difficulty in multicultural nursing (Dogan, Tschudin, Hot & Özkan 2009). It was seen as the greatest issue to hindering the process of counseling patients (Häkkinen 2009). Communication with members of other cultures was estimated to be difficult by graduating nursing students. Even 12 % of the students were found to

avoid situations with persons from a different culture. Co-operation with representatives of other cultures was seen challenging. (Hirvonen & Salanterä 2002.)

It is more time-consuming to counsel clients speaking foreign language. Elucidating issues during counseling and preparation for the meeting needs more attention. It was found that counseling of foreigners is sometimes inadequate due to language issues if compared to Finnish-speaking clients. (Häkkinen 2009.)

It is necessary to use an interpreter with clients who do not share a same language with the health care professional. However, the communication through interpreter can be problematic. Translation from word to word is generally used practice by interpreters. It may lead to lack of 'adequate, individualized information' to the client. Understanding illness and cure have different variations. Some people can understand them only in certain contexts. It may be necessity to have 'cultural interpretation' to enable one to understand the information. "This means that the interpreter must have, for example, adequate knowledge of both western biomedicine, anatomy and physiology, and how the relevant society functions, as well as of the patient's understanding of illness aetiology and treatment practices, to be able to bridge the abyss that may separate nurse and patient." (Hanssen 2004.)

Another problem by having an interpreter is that they need to be reserved beforehand and it is not possible in acute need for example, in first aid. The lack of female interpreters is also problematic. It cannot be guaranteed that patient/client understands the information correctly via interpreter. An interpreter needs to be equipped with good knowledge of medical vocabulary and education in the field of health care. (Koskimies & Mutikainen 2008; Lukkarinen 2001.)

The dominating role of a man in families has been experienced as a problem with some immigrants. Interpretation in these families is problematic if the woman with no language skills has to communicate through her husband. There is an ethical dilemma of whether

accepting this practice in the family or should there be a non-family member interpreter. (Lukkarinen 2001.)

The health care workers way to consider cultures provides information of the level of cultural awareness. Low level of awareness could be indicated if cultures are seen as clearly separated entities from each other. Clients are considered primarily as representatives of their cultures in the restricted way to see cultures. Health worker that is being aware of own attitudes towards cultures shows higher level of cultural awareness. If the health care worker is not aware of his attitudes, he might not recognize the cultural differences or may think that they do not matter in providing care. (Häkkinen 2009.)

Hirvonen and Salanterä (2002) have stated that the preparedness of graduating nursing students to provide cultural care. According to results, the knowledge and attitudes of the students were good in average but cultural knowledge, attitudes and cultural awareness had deficiencies. There were variations in the students' interest to encounter multicultural clients. Some of the students had supported their clients in a positive manner while some had even avoided situations of encounters.

Hirvonen and Salanterä (2002) Mentioned that the differences in syllabuses of different Universities of Applied Sciences concerning multicultural nursing. Coherent syllabus and recurrent interaction with other cultures showed connection to the students' good knowledge and attitudes. Nursing education should include teaching of cultural knowledge and skills that are necessary in gaining cultural competence. The students should start to understand cultural beliefs, customs and values in health care. Health care facilities should be responsible for increasing the cultural competence among staff members by organizing education. (Maier-Lorentz 2008.)

## **PURPOSE OF THE STUDY AND RESEARCH PROBLEMS**

The purpose of the study was to describe nurses' experiences when facing multicultural clients in sexual and reproductive health care. The goal of the study was to gain information for the development of the nursing practice and education in multicultural nursing.

1. What kind of experiences nurses had in the care of multicultural clients in issues related to sexuality and reproductive health?
2. What kind of information they needed in order to meet the needs of multicultural clients?
3. Where they gained the information of a multicultural client's sexuality and reproductive health?

## **RESEARCH METHODS**

Triangulation in nursing research has been carried out by the integration of qualitative and quantitative methods to minimize the disadvantages of these separate methods. The aim of the triangulation has increased the validity of researches. Triangulation refers to the use of several methods in order to achieve completeness of the investigated phenomenon. Methodological triangulation was carried out in the study by the combination of qualitative and quantitative research methods. Advantages of both methods were utilized by triangulation. (Polit & Beck 2008.)

A questionnaire was used as data collection method. The questionnaire included closed questions that measured the quantity of the phenomenon and open-ended questions that measured the quality of the phenomenon. Closed questions were analyzed with SPSS 18.0 program. As for quantitative data collection, the material can be written in numeric form so that it is easy to form tables from the results. It also allows easier analysis with statistical programs. The qualitative method is more holistic and therefore, it offers broader viewpoint to the topic as combined together with quantitative method. The results from open-ended questions were analyzed with inductive content analysis. (Hirsijärvi, Remes, & Sajavaara 2004.)

Versatility and flexibility are the advantages of questionnaires in data collection (Gerrish & Lacey 2006). The advantage of a questionnaire is the possibility to include more participants to the study. It is efficient and time saving method. (Hirsijärvi, Remes, & Sajavaara 2004.) Designing a questionnaire for a study requires careful preparation. Its reliability and validity has to be tested by a pilot test (Gerrish & Lacey 2006).

### **Data collection and analysis**

Data was collected with a self-developed questionnaire including open and close ended questions. The questionnaire was developed from the base of previous studies and

literature to answer the research problems. Pilot study was carried out with two public health nurses out of the target group. They were provided with the information about the study and purpose of filling in the questionnaires. They were informed that the results of their answers would not be used for any other purpose than developing the questionnaire. They were also requested to provide feedback about the questionnaires. According to results from the pilot study, the questionnaire was further developed to investigate the phenomenon more precisely. One question was removed and some of the questions were modified to be understandable. Thesis instructor approved the questionnaire before sending to the target group. The questionnaire (APPENDIX 4) was first prepared in Finnish language and modified several times before producing the final version. It was translated also into English language (APPENDIX 3).

The questionnaire was divided according to the research problems. It was compartmentalized to background information, nurses' experiences, needs of information and to sources of information. There were 28 questions in the questionnaire. Some of the questions were re-organized into more suitable compartments during the analysis of this study. Background information included questions about age, education, work experience and work place. Nurses' experiences of multicultural clients' sexuality was investigated with open-ended questions. Needs of information was researched with close-ended questions and with few open-ended questions.

The questionnaires were handed to the target group in co-operation with the Head Nurses of antenatal clinics, delivery ward and maternity and gynecological polyclinics. In antenatal clinics, the questionnaires were handed through internal mail system and returned to the researcher in closed envelopes. In hospital and polyclinics, the questionnaires were placed in staff's coffee rooms accompanied with boxes where the questionnaires could be returned. The answering time was two weeks and one additional week because there were only few returned papers after two weeks.

Inductive qualitative content analysis was utilized in this study to analyze answers to open-ended questions. Analysis of the data was started by opening the envelopes and return



boxes. All questionnaires were numbered (1,2,3). It was carried out to make it easier to return into some answers later on if necessary. Inductive content analysis is a process that is described by Miles and Huberman (1994) to include the three steps. Firstly, the material is reduced into smaller units. Second phase is clustering of the material which means separating it into groups and at last the third step is the formation of theoretical concepts out of the material. (Tuomi & Sarajärvi 2009.)

Contents analysis is often described as simplifying the data to recognize and form themes. The collected data is organized into smaller units and named according to content and themes. After that, the units were further categorized in groups under different concepts. Categorical distinction was performed to define themes. (Polit & Beck 2008, 517.) The process of inductive content analysis in this study is described in APPENDICES 1 and 2.

Qualitative analysis process was started by transcribing open answers to the computer and reading through the collected data several times to form a holistic picture. At the same time, the data was already tentatively classified to form a field for a later categorization. It was carried out by reading the data to found out repetitive themes and words that could be placed into same category. Classification was performed first on a paper to form categories and then, with computer.

Closed questions in the research were no-yes questions and Likert-scale questions with 5 options: totally agree, partially agree, cannot say, partially disagree and totally disagree. Few questions contained with multiple choice where respondents were able to tick as many options as possible. These answers were analyzed with SPSS 18.0. Survey designed study is usually analyzed quantitatively (Hirsijärvi, Remes, & Sajavaara 2004).

Quantitative analysis of the data was carried out by first reviewing the material and inserting all collected answers from closed questions into SPSS 18.0 statistical program. Variables were named and provided with values. Distribution tables and graphs were formed with frequencies and percentages to form results from the analysis.

Findings of the closed questions were reported in written form, tables and graphs. Meanwhile, the findings from qualitative open-ended questions are reported in written form.

### **Target group**

The nurses working in the field of sexual and reproductive health in Kokkola Health Care services formed the target group for this study. It included registered nurses, public health nurses and midwives working in maternity polyclinic, gynecological polyclinic, labor ward, antenatal clinics and family planning clinics. A total of 65 and all were included in the target group. The term nurse is later used to describe representatives of all these groups.

### **Ethics, reliability and validity of the research**

Permission to conduct the study was applied after receiving an approval of the research plan. Permission to carry out the research was applied and approved in September 2011 by the Central Ostrobothnia Central Hospital Director of Nursing and Managing Director and Kokkola Health Care Centre Nursing Director.

The right for self-determination of a target group was followed by respecting the autonomy to join the research by filling-in the questionnaire. The questionnaires were handed to each unit. In hospital, the questionnaires were left in their coffee room with returning boxes. In antenatal clinics, the questionnaires were sent to each of the target group by inner mail system. All the participants were provided with adequate information about the research to decide to join. (Abdelhamid, Juntunen & Koskinen 2009).

The participants in the study received a questionnaire with an accompanying letter. The letter was sent to clarify the background information of the study and privacy issues. According to Gerrish & Lacey (2006), an accompanying letter is sent to the participants to

clarify reason for sending the questionnaire and informing about the study. It should also clarify the reasons for the data collection and handling of the data after carrying out the research. The letter should provide the information whether the questionnaire is anonymous or not. It should also mention the way data will be handled, protected and reported. "Usually consent to participate is confirmed by return of a completed questionnaire" (Gerrish & Lacey 2006). All of the answers were processed anonymously and confidentially. The researcher was the only one handling the filled-in questionnaires. Questionnaires were properly disposed after data analysis.

The reliability and validity of a questionnaire had to be tested. Validity means that the developed questionnaire actually measures phenomenon and answers to the research problems. If the results would be the same after repeating the study again, it is considered reliable (Gerrish & Lacey 2006). This was tested by filling-in the questionnaire with a sample group. According to feedback, the questionnaire was modified to be more precise. Reliability of a qualitative study can be improved by describing precisely the implementation of the research. There are several statistical methods developed to evaluate the reliability in quantitative studies. (Hirsijärvi, Remes, & Sajavaara 2004.)

Triangulation of the qualitative and quantitative methods was utilized in the study. The results from the questions in both methods were supporting each other which increased the reliability and validity of the research. (Virtuaaliammattikorkeakoulu 2012.)

## RESULTS

### Background information

The questionnaire was handled originally to 65 participants. 33 of the questionnaires were returned. The response rate was 51 %. The participants were asked questions about their age, education, work experience, and workplace to form background information. Respondents were nurses, public health nurses and midwives working in Central Ostrobothnia Central Hospital delivery ward and maternity clinic, and antenatal and family planning clinics.

Table 1 shows that the greatest age groups among participants were 26-35 and 36-45 years (75.8%). There were no younger respondents than 26 years of age.

TABLE 1. Age groups

Age group	Frequency	Percent	Valid Percent	Cumulative Percent
26-35	13	39,4	39,4	39,4
36-45	12	36,4	36,4	75,8
46-55	3	9,1	9,1	84,8
56+	5	15,2	15,2	100,0
Total	33	100,0	100,0	

The greatest professional group among participants shown in Table 2 was midwives 60.6 %. The second group were public health nurses with 21.1%. Registered nurses formed 15.2% of the participants.

TABLE 2. Education

Education	Frequency	Percent	Valid Percent	Cumulative Percent
Other	1	3,0	3,0	3,0
Registered nurse	5	15,2	15,2	18,2
Public health nurse	7	21,2	21,2	39,4
Midwife	20	60,6	60,6	100,0
Total	33	100,0	100,0	

It is shown in Table 3, that the participants had working experience. About 78.8 % of them had work experience from six years to 16 years or more. Only 6.1 % had one year or less of work experience.

TABLE 3. Work experience

Work experience (years)	Frequency	Percent	Valid Percent	Cumulative Percent
<1	2	6,1	6,1	6,1
1-5	5	15,2	15,2	21,2
6-10	8	24,2	24,2	45,5
11-15	3	9,1	9,1	54,5
>16	15	45,5	45,5	100,0
Total	33	100,0	100,0	

#### **Nurses' experiences in the care of multicultural clients in issues related to sexuality and reproductive health**

Table 4 reveals that only 3% had encountered multicultural clients daily. Almost 70% of the participants encounter them weekly or monthly. One third had encounters rarely than that.

TABLE 4. Meeting clients

I meet multicultural clients in my work	Frequency	Percent	Valid Percent	Cumulative Percent
Rarely	9	27,3	27,3	27,3
Monthly	12	36,4	36,4	63,6
Weekly	11	33,3	33,3	97,0
Daily	1	3,0	3,0	100,0
Total	33	100,0	100,0	

### **The concept of sexuality according to nurses**

Almost all of the participants were able to explain the meaning of sexuality in their own words. Sexuality was considered to be a basic need that consists of physical, psychological and social dimensions. Experiencing one's sexuality was understood to be individualistic by most of the participants. Masculinity, femininity, tenderness and intimacy were explained to be part of sexuality. Life-long sexuality from childhood to death was mentioned by many respondents.

*“Basic need that is related to relationships and natural need to get tenderness and proximity.”*

*“Sexuality is a sector that remains important throughout the life. Everyone experiences it individually.”*

*“Individual's experience of being a woman/man. Experiencing satisfaction is relation to another person and other relationships too. Safety and cohesion with another person.”*

### **The concept of multicultural client according to nurses**

There were many different answers in explaining the concept of a multicultural client. Many of the participants referred to a different cultural background for example home, mother tongue, religion and customs. Some mentioned that multicultural client is a person that moved to another country from free-will or has been forced to. Most of the participants determined that it means foreigners outside Finland. Only one stated that it could also be a Finnish person from cultural minority.

*“Comes from another culture.”*

*“A person that comes outside Finland.”*

## **Nurses' experiences with multicultural clients**

Experiences related to sexuality and reproductive health of multicultural clients were described from different perspectives (APPENDIX 2). Cultural variations in gender roles, delivery customs and the role of the religion were recognized by the participants. Most of the respondents had experiences of the dominant role of male in the client's family and decision making. They had encountered clients who were not able to use any contraception methods because men do not approve it as it is not practiced by some cultures. Contraceptives were experienced as a difficult topic with multicultural clients. The role of the religion also disapproves the use of contraceptives. Gynecological examinations of women were often required to be carried out by female professionals. In delivery customs, there have been experiences of leaving men outside the delivery room but mostly delivery customs have not brought up many differences between cultures.

*“Contraception has been the problem sometimes. Man does not approve any contraception method and woman comes to have an abortion time after time..”*

*“All religions do not approve contraception.”*

*“In deliveries everybody behaves similarly.”*

Multicultural clients' views on pregnancy, decency and sensitive character of sexuality were brought up by the respondents. Participants described two different ways their clients consider pregnancy. To some of the clients it is just normal part of life, and to some of them it as a taboo. Decency in delicate matters was described as women feeling ashamed if they have to undress or talk about intimate matters. Sexuality is a difficult issue that clients want to avoid discussing about.

*“Sexuality is a topic that is not really talked about.”*

*“Intimacy is “protected” more.”*

Factors affecting to equality of care such as lack of adequate material with different languages, problematic communication and staff's ignorance towards multicultural clients were noticed by nurses. Lack of cultural knowledge of the nurses was also seen hindering the equality of care.

*“Multicultural clients are not informed very well or at all.”*

*“Not enough information about their cultures to provide appropriate counseling.”*

Communication skills are based on language skills of the nurse and the client. Participants have evaluated their language skills to be average or good in English which is the most often used language with multicultural clients. In addition, Finnish and Swedish languages were used with multicultural clients. Language skills of the clients varied from good to not existing. Some of the clients can speak only their mother tongue which was problematic especially during deliveries. Non-verbal communication was used frequently by the respondents in the care of multicultural clients. Hands, gestures, facial expressions and sign language were used to aid communication. Lack of common language was experienced to be challenging.

*“Common language makes contact easier.”*

*“Non-verbal communication and gestures are in use.”*

*“Experiences have been frustrating. I have had the information but no language to be able to help the client.”*

Cultural skills had to be utilized in the planning of care if there was a language issue. Gender roles had to be remembered by requesting a female interpreter for a woman client. Some of the respondents had experiences of using the client's husband as an interpreter, and it has been difficult to obtain the woman's own voice heard. Men as an interpreter have also been considered to be problematic when discussing issues such as breastfeeding or delivery. Cultural differences challenge the care because there are no common concepts and terms in all cultures.



*“Interpreters are often men and they cannot come to delivery or examination that reveals woman’s body.”*

*“Sometimes a spouse has been an interpreter, which makes to wonder about reliability.”*

*“It feels that information does not reach the woman if there is a male interpreter.”*

The level of communication was found to effect on the quality of care. Misunderstandings are common and there is no reliability if the interpretation is always performed correctly. Basic information was usually offered but emotional issues were not discussed because of inadequate communication or language skills. Clients may not be understood fully or at all if common language is missing. Many of the respondents had experiences with interpreters. Interpretation on the phone was often in use. Interpretation was stated to be more time-consuming but many had positive experiences. Limitation of interpretation was the inability to arrange it in sudden cases. In addition, there was no guarantee if translation is carried out correctly. Still, it was considered to be very important to have an interpreter if there is no common language.

*“Phone interpretation is frequently used. Client’s worries are not always understood.”*

*“Getting interpreter to delivery is difficult because they have to be reserved beforehand.”*

### **The need of information to meet the needs of multicultural clients**

The need of information from the participants to achieve the needs of multicultural clients was investigated through several closed questions and two open questions to offer more specific information. The need of information was analysed in four areas adapted from Campinha-Bacote’s model of cultural competence. These were cultural knowledge, cultural desire, cultural awareness and cultural skills.

## Cultural knowledge

Cultural knowledge of the participants was determined according to the results in four closed questions and in two open questions. Findings indicated that most of the participants experienced that the level of knowledge is sufficient but at the same time, almost the same number is aware of that more education is necessary.

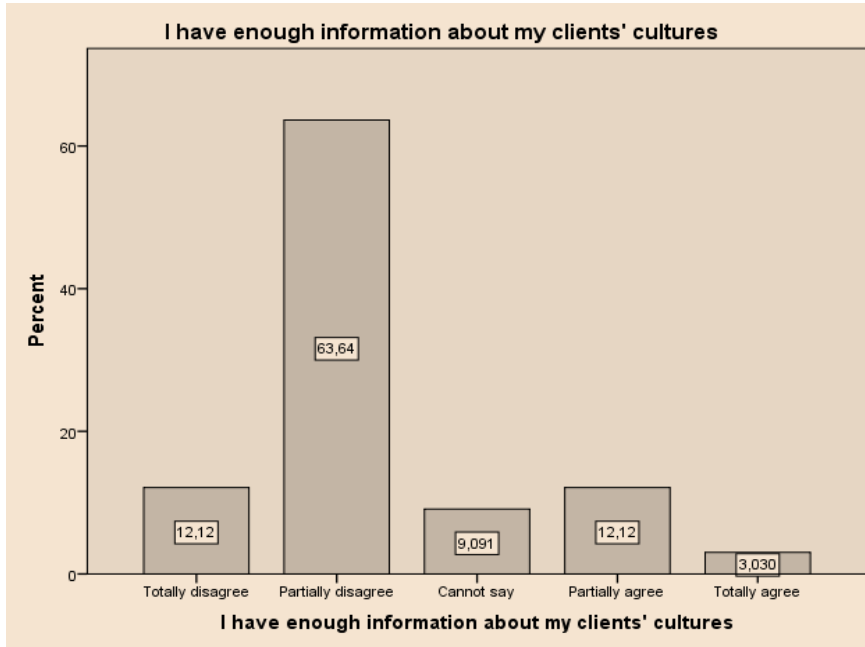
Almost 70% (n=23) of the participants totally or partially agreed that they have encountered difficulties with multicultural clients while 24.2% (n=8) partially disagrees. Only 3.0% (n=1) totally disagrees with that.

Major issues that were considered to cause difficulties with multicultural clients were language (n=31), communication (n=20) and lack of knowledge in different cultures (n=16). Other issues were cultural habits, values and norms (n=14), the different concept of time (n=13), using interpreter (n=12), beliefs related to health/sickness (n=11), gender roles (n=10). Minor issues were religious issues (n=7) and differences in non-verbal communication (n=4). Findings from open-ended questions also supported the results in Table 5.

TABLE 5. Difficulties in multicultural nursing

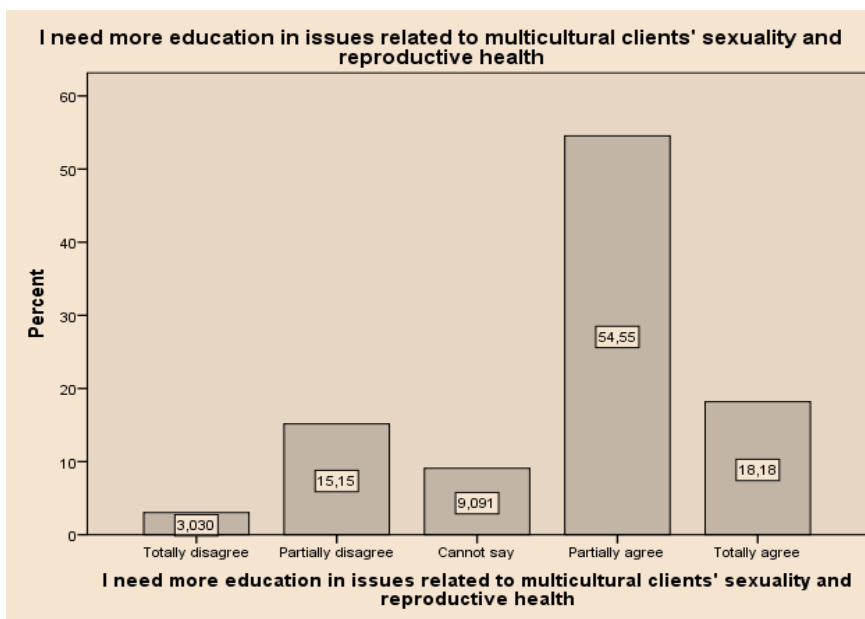
Difficulties has been related to:	Responses		Percent of Cases
	N	Percent	
Cultural habits, values and norms	14	10,1	45,2
The different concept of time	13	9,4	41,9
Language	31	22,5	100,0
Beliefs related to health/sickness	11	8,0	35,5
Differences in non-verbal communication	4	2,9	12,9
Using interpreter	12	8,7	38,7
Communication	20	14,5	64,5
Lack of knowledge in different cultures	16	11,6	51,6
Gender roles	10	7,2	32,3
Religious issues	7	5,1	22,6
Total	138	100,0	445,2

Graph 1 reveals that more than 75% (n=25) of the respondents totally or partially disagreed to have adequate information about the cultures of their clients'. Only 3.0% (n=1) totally agreed of having sufficient information.



GRAPH 1. Cultural knowledge

The majority of the participants 72.7 % (n=24) totally or partially agreed to the need of more education to be able to achieve the needs of the multicultural clients in the field of sexuality and reproductive health (Graph 2). Only 3.0 % (n=1) considered that they do not need to educate themselves.



GRAPH 2. The need of education

Participants were questioned to specify types of information and education they would need more in issues related to sexuality and reproductive health of a multicultural client by an open question. Three categories of needed education and information were formed according to the answers: cultural knowledge, sexuality and reproductive health in different cultures, and cultural sensitivity.

Many of the participants mentioned that general information about cultures, gender roles, religion, beliefs, wishes, customs, daily routines and values. Education was considered to be needed in order to increase cultural knowledge.

*“Basic information about other cultures and what things we should especially consider in our work.”*

*“General information about different cultures and religions. What are the roles of men and women in a relationship? Does a woman have a right to decide about having children?”*

Approximately half of the respondents needed to gain more knowledge in sexuality and reproductive health in other cultures. More information was wished in cultural dimensions of sexuality, sexual behavior, relation to contraception, pregnancy, delivery, puerperium, beliefs in femininity and sexual health, sexuality after delivery, breastfeeding, and female genital mutilation. Few of the participants requested information especially from the matters concerning the greatest groups of foreigners in their area.

*“Sexuality, contraception and delivery.”*

*“Puerperium, pregnancy.”*

*“Cultural background, matters related pregnancy, delivery and puerperium, is there different customs?”*

Apart from that, the respondents stated the need of education in interaction skills with sensitive issues multicultural clients. They had uncertainty to talk about sensitive issues with the clients.

*“How to talk about sensitive issues and taking care of the relationship?”*

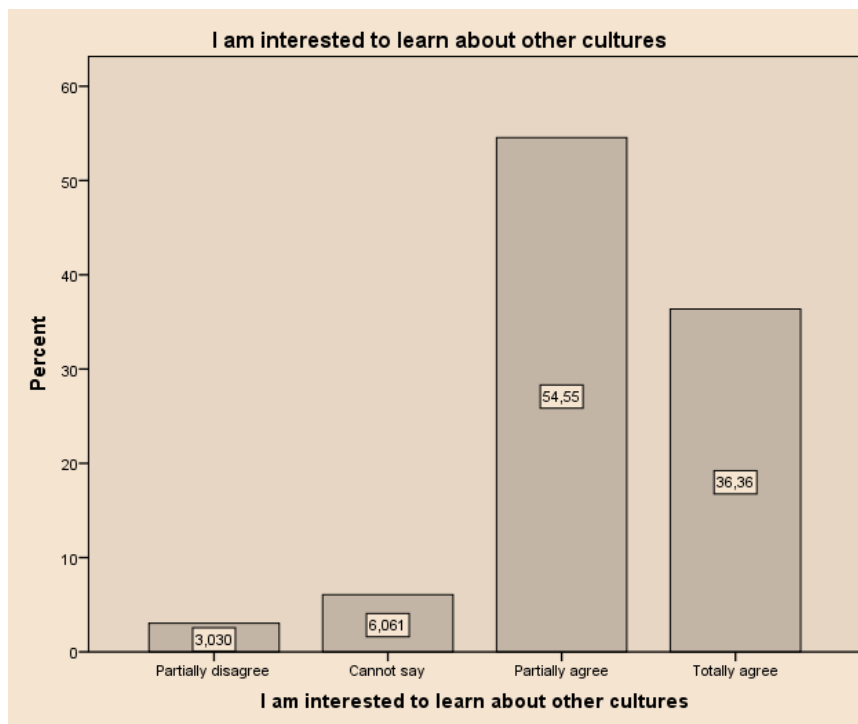
*“What they hope from us and what matters are taboos?”*

*“What am I allowed to talk about without insulting the client? How can I give the impression that for me it is allowed to talk about “forbidden” issues?”*

### Cultural desire

There were four questions in the questionnaire focusing on the cultural desire among the participants. According to the findings, most of the respondents seemed to have cultural desire.

Graph 3 illustrates that almost 90.9% (n=30) of the respondents expressed their interest towards learning about other cultures and none of them totally disagreed. Most of them 93.6 % (n=29) were willing to participate in the future if education in multicultural nursing was arranged at their workplaces. Only 6.5% (n=2) were not interested.

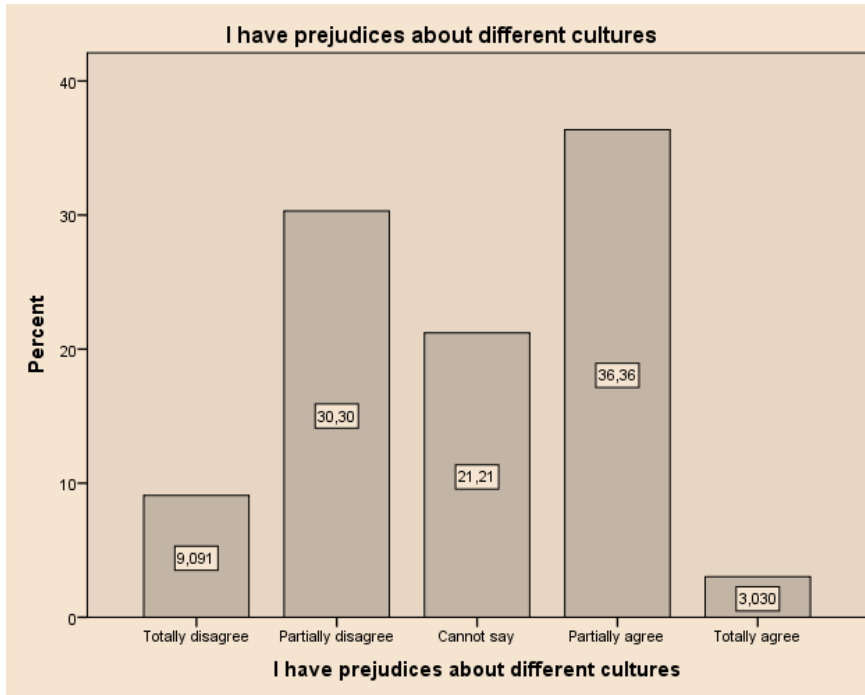


GRAPH 3. Own interest.

### Cultural awareness

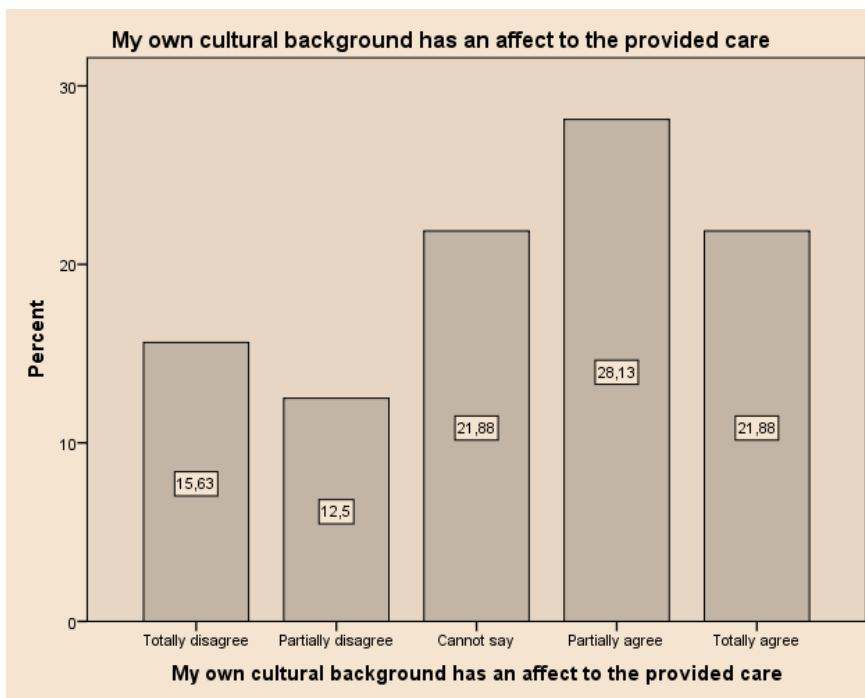
Two questions were formed to identify the cultural awareness of the respondents. The respondents were separated into two groups according to their answers. The amount of 39.4 % (n=13) partially or totally agreed that they have prejudices about different cultures.

Same percentage totally or partially disagreed. Only 21.2% (n=7) could not state whether they have or not prejudices.



GRAPH 4. Prejudices

The effect of own cultural background to the provided care was totally or partially agreed with 50 % (n=16). Almost 30 % (n=9) totally or partially disagreed with that. No less than 21.9 % (n=7) could not state does it have effect or not.



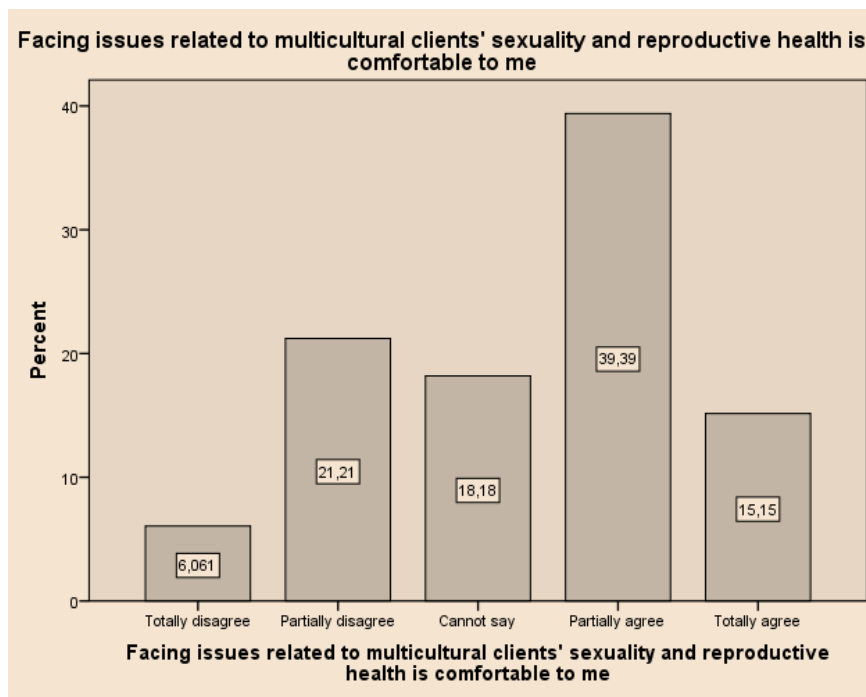
GRAPH 5. Cultural background

## Cultural skills

The cultural skills of the participants were investigated through six questions. Two of the questions were similar with the difference that another one focused only on the comfort ability of discussing issues related to sexuality and reproductive health and the other question was otherwise same but it was specified in facing these issues of multicultural clients'. There were differences in the answers.

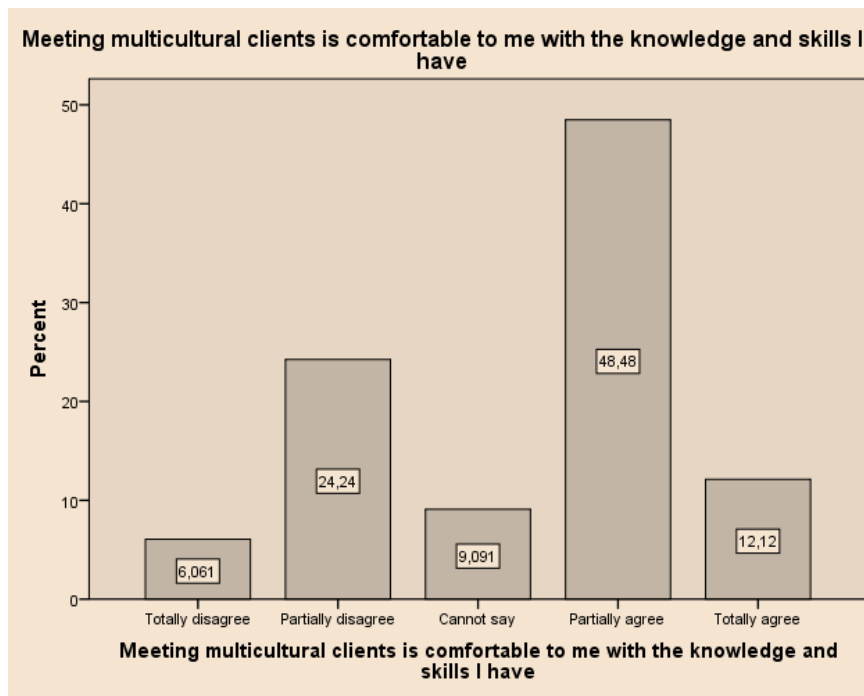
Almost 90 % (n=29) totally or partially agreed that they feel comfortable when discussing issues related to sexuality and reproductive health. None of them totally agreed and only 9.1% (n=3) partially disagreed.

In graph 6, that was focused on facing these issues of multicultural clients, the number reduced to 54.6 % of the participants who were totally or partially agreeing to the comfort ability to face multicultural clients in issues related to sexuality and reproductive health. Almost 30 % were partially or totally disagreeing.



GRAPH 6. Facing multicultural clients' issues in sexuality and reproductive health

As many as 60.6% (n=20) of the participants experienced themselves totally or partially comfortable to meet multicultural clients with the knowledge and skills they have. One third of participants 30.3 % (n=10) partially or totally disagreed with that.



GRAPH 8. Cultural skills

The ability of the participants to offer same quality of care to all clients despite their cultural backgrounds was divided into two opposite groups of almost the same size. Graph 9 illustrated that 40.6% (n=13) totally or partially disagreed with their ability to offer same quality of care and 37.5 % (n=12) totally or partially agreed. The rest of respondents (n=7) could not say. Fortunately, the amount of 72.7% (n=24) of the participants knew were to get help for the interpretation to aid multicultural encounters. Only 15.2% (n=5) do not have the knowledge.





GRAPH 9. Quality of care

**Sources of information in multicultural client’s sexuality and reproductive health**

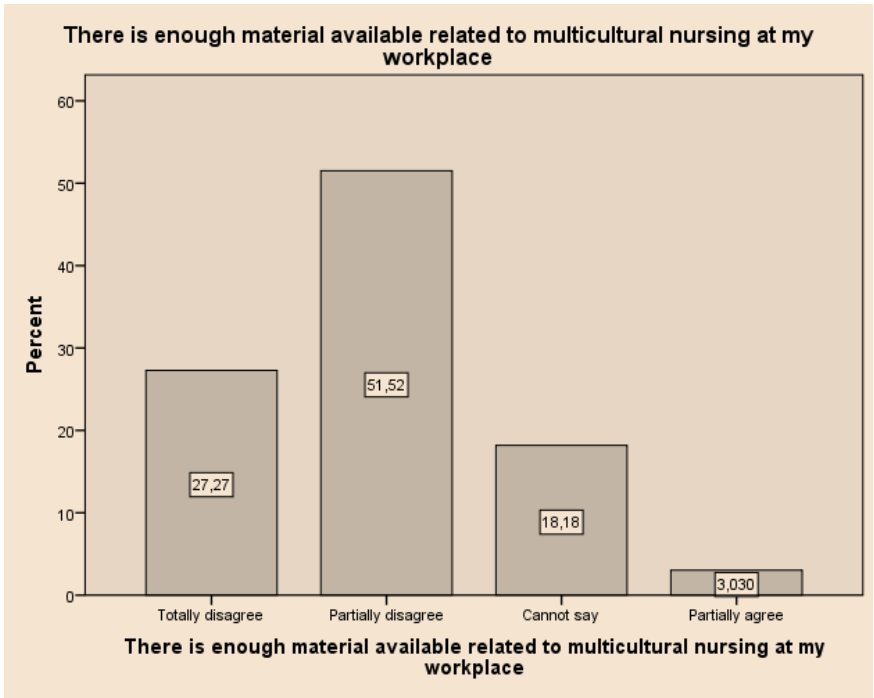
Table 6 shows that the participants have previously gained their information in multicultural clients sexuality and reproductive health mostly from education (24.1%), patients/clients (21.8%) and colleagues (19.5 %). Other sources were from Internet and Magazines.

TABLE 6. Previous sources of information

Previous information sources	Responses		Percent of Cases
	N	Percent	
Internet	11	12,6%	36,7%
Colleagues	17	19,5%	56,7%
Literature	10	11,5%	33,3%
Education	21	24,1%	70,0%
Patients/Clients	19	21,8%	63,3%
Magazines	9	10,3%	30,0%
Total	87	100,0%	290,0%

Almost 70% (n=23) of the participants know where to search for more information if necessary. They were asked to specify the information source that they would use. Most of the answers mentioned the Internet and some considered to search from the literature as well. The respondents would like to gain more information mostly from education, Internet and researches in the future. Literature was less preferred information source. Only 5.2% were not interested to get information at all. Almost 40 % (n=13) stated that their employer had organized education related to multicultural nursing and sexuality.

GRAPH 10 illustrates the lack of adequate material considering multicultural nursing care in several units. No one totally agreed of having adequate material available related to multicultural nursing at workplace and only 3% (n=1) partially agreed. Even 78.8% (n=26) totally or partially disagreed of having sufficient materials while 18.2 % (n=6) could not mention.



GRAPH 10. Sufficiency of material

## **DISCUSSION**

### **Discussion of the findings**

The purpose of this study was to describe nurses' experiences when facing multicultural clients in sexual and reproductive health care. The goal of the study was to gain information for the development of the nursing practice and education in multicultural nursing. Nurses were tried to be encouraged to talk about these issues by conducting this study. The aim was to aid them to become more aware of multicultural nursing and their own level of cultural competence. Respondents in this study had encounters with multicultural clients quite frequently and these situations had offered some challenges to the nursing care.

Tuokko (2007) revealed that cultural competence of nurses and counseling of the clients was experienced to be inadequate because of language problems. The results in the study were similar with the findings of this thesis. Language barrier is causing real difficulties for implementation of nursing care together with the difficulty caused by sensitive issues related to sexuality and reproductive health. Language and communication issues were considered to be the greatest concerns hindering the counseling. Moreover, Dogan, Tschudin, Hot and Özkan (2009) and (Häkkinen 2009) have had similar findings.

Language issues were tried to overcome with the support of interpreters. Many of the participants reported of their experiences with interpreters. There was found to be challenges. However, the importance of interpretation was admitted when there was no common language with the client. This was found also by Hanssen (2004).

Hoye & Severinsson (2008) have found factors causing distress among nurses in multicultural nursing. Gender issues and communication challenges were revealed in their study. Respondents in this thesis had encountered also challenges related to gender roles and communication. Dominant role of men was experienced by many nurses. It affected to self-determination of their clients. In addition, Lukkarinen (2001) had found experiences indicating the dominant role of men to be problematic if a woman with no language skills has to communicate through her husband's interpretation.

The study results revealed that it is more time-consuming to counsel clients speaking in foreign language and having counseling with the help of interpreter. It was found that counseling with foreigners is sometimes inadequate due to language issues. A study carried out by Häkkinen (2009) supported this result. Hence, it was noticed that explaining issues during counseling and preparation for the meeting needs more attention.

Appointment with interpreter is obviously easier in clinics where patients have a scheduled time. Utilizing interpreter services was more difficult in delivery ward because the need is usually sudden. Interpreters need to be reserved beforehand. Some participants felt unsure if the clients receive the information correctly. These challenges were found also by Koskimies & Mutikainen (2008).

Even though this research had its' focus on sexuality and reproductive health the issues related to communication were raised because of their importance. Communication is remarkable tool for nurses to use in their daily work to provide care. A communication difficulty challenges the quality of given care. Issues may be handled superficially without adequate communication. Clients can be taken care of routinely but their right for self-determination cannot be respected without sufficient communication. Understanding of client's wishes is important to reach patient-centered care.

Nurses' need for information was evaluated by utilizing Campinha-Bacote's Model of Cultural Competence. Therefore, the challenging issues were discovered according to the Model. Cultural knowledge is the educational base of different cultures and most of the participants felt that they have adequate information. Still, it was surprising that almost the same amount felt that they need more education in issues related to sexuality and reproductive health.

Cultural awareness was based on the respondents' ability to recognize their own attitudes and cultural background. The question was inquired about prejudices against other cultures. Answers were quite equally distributed between agreement and disagreement. The sensitive nature of the question may have effected to the responses. It is natural to have prejudices but it may not be easy to recognize or admit of having them. Häkkinen (2009) stated that being aware of attitudes towards cultures and their effect on provided nursing care shows higher level of cultural awareness. If the health care worker is not

aware of the starting point for him/herself, he/she might not recognize the cultural differences or may think that they do not matter in providing care.

Cultural desire is a person's genuine interest towards different cultures and almost all of the participants expressed their interest. It is the most important factor in development of one's cultural competence because the interest grows inside someone and it cannot be enhanced by education. Furthermore, in a study by Dogan, Tschudin, Hot and Özkan (2009) the desire to deepen the cultural knowledge was described by participants.

Cultural skill is the ability to take into consideration the client's culture when assessing, planning and implementing nursing care. Respondents were divided into two opposite groups in their evaluation of cultural skills. Over half of them still felt comfortable to encounter multicultural clients with their existing skills.

Most of the participants had gained their knowledge in sexuality and reproductive health of multicultural clients through education and it was also the most preferred source for future. Less than half had experiences of employer organizing education in this field. Maier-Lorentz (2008) stated that health care facilities should be responsible for increasing the cultural competence among staff members by organizing education.

Research results in this research were similar compared to previous studies in this field and there was no new information. The advantage of the results is to offer information to the development of multicultural nursing on a local level as the results indicate the situation in Kokkola Health Care Services. Health care facilities, nurses and nursing students can benefit from the results.

### **Discussion of the method**

Research method was combining qualitative and quantitative methods. The combination of these was found to be demanding by the researcher. Nevertheless, has given new knowledge to the researcher. Method triangulation supported the validity of the results as similar findings were obtained from open and close-ended questions.

The purpose was to describe nurses' experiences and it would have been carried out more deeply by using interviews instead of a questionnaire. It would have enhanced by inquiring correct questions to guide the discussion to right direction. The limitation of the questionnaire was that answers to open-ended questions were short in many cases. On the other hand, the findings acquired from the quantitative analysis supported the results achieved through content analysis.

Research data is considered adequate if same topics start to occur in different answers. (Hirsijärvi et al. 2004.) The data for this research was not as broad as aimed but more data was not possible to collect in these circumstances. Still, there were many repetitions in the data among different participants but it also included answers that arose only in individual papers. As for quantitative research, there were quite a small amount of participants to obtain statistically significant results.

Questionnaire was developed by the researcher and it was modified in many steps. Questions were formed according to research problems and previous literature. Developing a valid questionnaire is demanding and time-consuming task. The process of developing questionnaire required more time than estimated. One limitation of the questionnaire was its broadness. It was considered to be time-consuming by the participants to fill it and it may have effected on the response rate.

Besides that, partial response was limiting the study. Only some of the questions were answered and others left blank. Piloting was carried out carefully to minimize this risk. Understandable questions were detected and changes performed before the actual data collection. The questionnaires had to be distributed again to non-respondents because the aimed percentage was not achieved after the first round. (Gerrish & Lacey 2006.)

### **Ethical considerations**

The permission to carry out the research was applied from the target organizations before conducting the study (APPENDICES 6-9).

Ethical values in nursing research includes respecting participants, gaining consent, and maintaining confidentiality. These issues have to be taken into consideration during

planning and conducting the research. There should be no harm caused to participants in any step of the research (Gerrisch & Lacey 2006.)

The target group was informed about the voluntary participation to the study and its' anonymity in the accompanying letter (APPENDIX 5) that was attached to the questionnaire. It included information about the research to enable the participants to choose whether they want to participate or not. Confidentiality has been guaranteed by the researcher being the only person who handled the filled questionnaires and they have been kept carefully in a safe place.

Sexuality and issues related to reproduction are sensitive topics in all cultures and difficult in discussing them. Communication and language issues gave their own pressure on discussing these delicate matters with clients. The sensitive character of the study may affect a response rate (Gerrisch & Lacey 2006). Edwards et al. (2002) stated that questionnaires with sensitive subject are less likely to be responded.

### **Proposal for further studies**

There were several studies already carried out related to multicultural nursing and cultural competence. The demand for research in multicultural nursing was stated in previous studies. It would be beneficial to obtain the clients' perception about offered care to allow their voice and wishes heard.

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APPENDIX 1

<ul style="list-style-type: none"> <li>-Own language skills are on the average level</li> <li>-Own English skills are good</li> <li>-Language skills of clients varies</li> <li>-Many of the clients cannot speak English</li> </ul>	<p>Language skills</p>	<p>Communication skills</p>	<p>Experiences in language skills &amp; communication with multicultural clients</p>
<ul style="list-style-type: none"> <li>-Facial expressions, gestures, sign language are used to aid communication</li> <li>-Explaining with hands is used if no words</li> <li>-Non-verbal communication and gestures are used</li> <li>-Touch, eye-contact, smile</li> </ul>	<p>Non-verbal communication</p>		
<ul style="list-style-type: none"> <li>-Communication is challenging if no common language</li> <li>-No common language</li> <li>-Common language can be English or Finnish</li> </ul>	<p>Common language</p>		
<ul style="list-style-type: none"> <li>-Female interpreters</li> <li>-Gender matters (breastfeeding/delivery)</li> <li>-Husband acts as an interpreter for his wife</li> </ul>	<p>Gender roles</p>	<p>Cultural skills</p>	
<ul style="list-style-type: none"> <li>-No common concepts</li> </ul>	<p>Cultural differences</p>		
<ul style="list-style-type: none"> <li>-Basic information can be offered but emotional issues are often left behind</li> <li>-Clients are not always understood</li> <li>-Cannot be sure if the client gets information correctly via interpreter</li> <li>-Misunderstandings - &gt;confusion</li> </ul>	<p>Evaluation of communication</p>	<p>Quality of care</p>	
<ul style="list-style-type: none"> <li>-Interpreter has to be ordered if there is no common language</li> <li>-Interpretation on the phone</li> <li>-Using interpreter is challenging</li> <li>-Good experiences with interpreters</li> <li>-Phone interpretation is time-consuming</li> </ul>	<p>Interpretation</p>		

APPENDIX 2

<ul style="list-style-type: none"> <li>-Man is the head of the family</li> <li>-Man does the decisions</li> <li>-Man does not accept male doctors to examine his wife</li> <li>-Man does not approve the use of contraceptives</li> </ul>	<p>Gender roles</p>	<p>Culture</p>	<p>Experiences related to sexuality and reproductive health of multicultural clients</p>
<ul style="list-style-type: none"> <li>- Man cannot be present in the delivery</li> <li>- Man cannot see woman in examinations and delivery</li> <li>-No cultural differences in deliveries</li> <li>-Behavior in deliveries is not different</li> </ul>	<p>Delivery customs</p>		
<ul style="list-style-type: none"> <li>-Religion does not approve the use of contraceptives</li> </ul>	<p>The role of the religion</p>		
<ul style="list-style-type: none"> <li>-Women feel ashamed if they have to undress</li> <li>-Women feel ashamed to talk about intimate matters</li> <li>-Women want to cover their bodies during delivery and breastfeeding</li> <li>-Women do not want to undress</li> </ul>	<p>Decency</p>	<p>Client</p>	
<ul style="list-style-type: none"> <li>-After delivery women want to stay in bed longer</li> <li>-Loud expression of pain during delivery</li> </ul>	<p>Behavior of the client</p>		
<ul style="list-style-type: none"> <li>-Sexuality is a difficult issue that clients do not want to talk about</li> <li>-Women do not want to talk about sexuality related issues</li> </ul>	<p>Sensitive character of sexuality</p>		
<ul style="list-style-type: none"> <li>-Pregnancy is as a normal part of life</li> <li>-Pregnancy is a taboo</li> </ul>	<p>Clients' views of pregnancy</p>		
<ul style="list-style-type: none"> <li>-Not enough knowledge about cultures</li> <li>-Sexuality is different; there is no intercourse during pregnancy</li> </ul>	<p>Cultural knowledge of the nurses</p>	<p>Nurse</p>	
<ul style="list-style-type: none"> <li>-Ignorance of the staff to inform multicultural clients</li> <li>-Language and communication is problematic</li> <li>-No material in different languages</li> </ul>	<p>Equality of care</p>		

## Questionnaire

### Background information

Tick the appropriate answer

#### Age

16-20

36-45

20-25

46-55

26-35

56+

#### Education

Registered nurse

Midwife

Public health nurse

Other

#### Work experience

Less than 1 years

1-5 years

6-10 years

11-15 years

Over 16 years

#### Workplace

Hospital

Antenatal clinic

**Experiences in facing multicultural client's sexuality**

1. I have experiences of facing multicultural clients in my work.

- Yes      No

(If you answered no, you do not need to continue.)

2. I meet clients from different cultures

- a.  Daily
- b.  Weekly
- c.  Monthly
- d.  Rarely
- e.  Never

3. Explain freely what you understand with the word sexuality

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4. Explain freely what you understand with the word multicultural client

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5. Explain freely about your experiences in parts a-e:

- a. Experiences related to language skills and communication (e.g. use of interpreter, own/client's language skills, non-verbal communication, cultural specialties in communication)

etc.) \_\_\_\_\_  
\_\_\_\_\_  
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b. Experiences of clients from different religious groups: \_\_\_\_\_

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c. Experiences of gender roles and the effect of them on the interaction between nurse and client:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_







j.  Beliefs related to health/sickness

k.  Differences in non-verbal communication

l. Other? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. I have adequate knowledge about my clients' cultures

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

9. I need more education in facing issues related to sexuality and reproductive health of multicultural clients

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

10. In which areas the education and information is especially needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. I am interested to learn about different cultures

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

12. I have prejudices about different cultures

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

13. Discussing issues related to sexuality and reproductive health is comfortable to me.

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

14. Facing multicultural client's issues related to sexuality and reproductive health in nursing work is comfortable to me

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree

15. I feel comfortable when meeting clients from another cultures with the knowledge and skills that I have

- a.  Totally agree

- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

16. I am able to offer the same quality of care to all clients despite their cultural background

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

17. I do not feel comfortable meeting clients from a different culture with matters related to sexuality with the knowledge and skills that I have.

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

Why?

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18. I would like to educate myself in multicultural nursing

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

19. How would you like to get more information in the following ways: (you can tick as many options as you wish)

- a.  Education
- b.  Researches
- c.  Books
- d.  Internet
- e.  Other: \_\_\_\_\_
- f.  Not interested to get information

20. My own cultural background affects the care provided

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

21. I know where to get help for interpretation if needed

yes                      no

a. Where?

\_\_\_\_\_  
\_\_\_\_\_

22. My employer has organized education concerning multicultural nursing and sexuality.

yes                      no

23. I have participated in education about multicultural nursing and sexuality.

yes                      no

a. If                      yes,                      who                      arranged                      the  
education \_\_\_\_\_

\_\_\_\_\_



yes

no

28. There is enough material available for me at the workplace about the multicultural nursing.

- a.  Totally agree
- b.  Agree
- c.  Cannot say
- d.  Disagree
- e.  Totally disagree

Thank You for Your answers!



## Kyselylomake

### Taustatiedot

Rastita sopiva vaihtoehto

#### Ikä

16-20

36-45

20-25

46-55

26-35

56+

#### Koulutus

Sairaanhoidtaja

Kätilö

Terveystenhoitaja

Muu

#### Työkokemus

Alle 1 vuotta

1-5 vuotta

6-10 vuotta

11-15 vuotta

Yli 16 vuotta

#### Työpaikka

Sairaala

Neuvola

## Kokemuksia monikulttuuristen asiakkaiden seksuaalisuuden kohtaamisesta

1. Minulla on kokemuksia monikulttuuristen asiakkaiden kohtaamisesta työssäni.

Kyllä      Ei

(Mikäli vastasit ei, sinun tarvitse jatkaa kysymyksiin vastaamista.)

2. Kohtaan työssäni eri kulttuureista tulevia asiakkaita

- a.  Päivittäin
- b.  Viikottain
- c.  Kuukausittain
- d.  Harvemmin
- e.  En koskaan

3. Selitä omin sanoin käsite seksuaalisuus

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4. Selitä omin sanoin käsite monikulttuurinen asiakas

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5. Kerro vapaasti omista kokemuksistasi kohdissa a-e:

- a. Kokemuksia liittyen kielitaitoon ja kommunikaatioon (esim. tulkin käyttö, oma/asiakkaasi kielitaito, sanaton kommunikointi, kulttuurien erityispiirteet

kommunikaatiossa

jne.): \_\_\_\_\_  
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b. Kokemuksia asiakkaista, jotka kuuluvat eri uskonnolliseen ryhmään: \_\_\_\_\_

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c. Kokemuksia sukupuolirooleista eri kulttuureissa ja niiden vaikutuksesta hoitajan ja asiakkaan väliseen vuorovaikutussuhteeseen:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





j.  Terveysteen/sairauteen  
liittyvät uskomukset

k.  Sanattoman viestinnän  
merkityserot

l. Muu,  
mikä? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Minulla on riittävästi tietoa asiakkaideni kulttuureista

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

9. Tarvitsen lisää koulutusta monikulttuuristen asiakkaiden seksuaalisuuteen ja  
lisääntymisterveyteen liittyvien kysymysten kohtaamiseen

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

10. Millaisilla aihealueilla tietoa ja koulutusta mielestäsi erityisesti tarvitaan

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Olen kiinnostunut oppimaan vieraista kulttuureista

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

12. Minulla on ennakkokäsityksiä erilaisista kulttuureista

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

13. Seksuaalisuuteen ja lisääntymisterveyteen liittyvistä asioista keskusteleminen on helppoa/luontevaa minulle.

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

14. Monikulttuuristen asiakkaiden seksuaalisuuteen ja lisääntymisterveyteen liittyvien kysymysten kohtaaminen on helppoa/luontevaa minulle.

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

15. Minusta on luontevaa tavata asiakkaita eri kulttuureista näillä tiedoilla ja taidoilla joita minulla on.

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

16. Pystyn tarjoamaan samantasoista hoitoa kaikille asiakkaille heidän kulttuuritaustastaan riippumatta.

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

17. Minusta ei ole luontevaa tavata eri kulttuureista tulevia asiakkaita seksuaalisuuteen ja lisääntymisterveyteen liittyvissä asioissa näillä tiedoilla ja taidoilla joita minulla on.

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

Miksi?

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18. Haluaisin kouluttaa itseäni monikulttuuriseen hoitotyöhön.



- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

19. Haluaisin saada lisää tietoa seuraavalla/seuraavilla tavoilla: (Voit rastittaa useamman kuin yhden vaihtoehdon)

- a.  Koulutuksista
- b.  Tutkimuksista
- c.  Kirjoista
- d.  Internetistä
- e.  Jostain muualta: \_\_\_\_\_
- f.  En ole kiinnostunut saamaan lisää tietoa

20. Oma kulttuuritaustani vaikuttaa tarjoamaani hoitoon

- a.  Täysin samaa mieltä
- b.  Jokseenkin samaa mieltä
- c.  En osaa sanoa
- d.  Jokseenkin eri mieltä
- e.  Täysin eri mieltä

21. Tiedän mistä saan apua tulkkaukseen tarvittaessa.

- kyllä                       ei

Mikäli vastasit 'kyllä', vastaa myös kohtaan a. Muutoin siirry kysymykseen 21.

b. Mistä?

\_\_\_\_\_

\_\_\_\_\_

22. Työnantajani on järjestänyt koulutusta liittyen monikulttuuriseen hoitotyöhön ja seksuaalisuuteen.

- kyllä                       ei

23. Olen osallistunut koulutukseen monikulttuurisesta hoitotyöstä ja seksuaalisuudesta.

kyllä                       ei

b. Jos vastasit kyllä, kenen järjestämä koulutus  
oli? \_\_\_\_\_

\_\_\_\_\_

24. Millaista tietoa tarvitaan eri kulttuurista tulevan asiakkaan seksuaalisuuteen ja lisääntymisterveyteen liittyvien kysymysten kohtaamiseen?

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## Tiedon lähteet

25. Olen saanut tämänhetkisen tietoni monikulttuurisen asiakkaan seksuaalisuuden kohtaamisesta ja lisääntymisterveydestä seuraavasta/seuraavista lähteistä:

- a.  Internetistä
- b.  Työkavereilta
- c.  Kirjoista
- d.  Koulutuksesta
- e.  Potilailta/Asiakkailta
- f.  Lehdistä
- g.  Muualta mistä: \_\_\_\_\_

26. Tiedän mistä voin tarvittaessa etsiä lisää tietoa.

kyllä  ei

a. Jos vastasit kyllä, tarkentaisitko

mistä? \_\_\_\_\_

27. Jos työpaikallani järjestettäisiin koulutusta monikulttuurisesta hoitotyöstä, olisin kiinnostunut osallistumaan.

kyllä  ei

28. Työpaikallani on riittävästi materiaalia saatavilla liittyen monikulttuuriseen hoitotyöhön.

a.  Täysin samaa mieltä

b.  Jokseenkin samaa mieltä

c.  En osaa sanoa

d.  Jokseenkin eri mieltä

e.  Täysin eri mieltä

Kiitos vastauksestasi!

Hei!

Olen viimeisen vuoden terveydenhoitajaopiskelija Keski-Pohjanmaan ammattikorkeakoulun englanninkieliseltä linjalta. Teen opinnäytetyötä hoitajien kokemuksista eri kulttuuritaustaisten asiakkaiden/potilaiden seksuaalisuuden kohtaamisesta neuvoloissa, äitiys- ja naistentautien poliklinikoilla sekä synnytys- ja naistentautien osastolla.

Opinnäytetyön tarkoituksena on kuvailla hoitajien kokemuksia eri kulttuuritaustaisten (esim. vähemmistökulttuurit, romanit, maahanmuuttajat, muut ulkomaalaiset ryhmät jne.) asiakkaiden/potilaiden seksuaalisuuteen ja lisääntymisterveyteen liittyvien kysymysten kohtaamisesta, sekä selvittää millaista tietoa hoitajat tarvitsevat työhönsä ja mistä he tuon tiedon hankkivat. Tutkimuksen tavoitteena on kerätä tietoa monikulttuurisen hoitotyön ja koulutuksen kehittämiseen.

Tutkimusaineisto kerätään oheisella kyselylomakkeella. Kyselyyn vastaaminen on vapaaehtoista ja kaikki vastaukset käsitellään luottamuksellisesti. Vastaaminen suoritetaan nimettömänä.

Kyselylomake sisältää avoimia ja suljettuja kysymyksiä. Mikäli avoimiin kysymyksiin varattu vastaustila ei riitä, voitte jatkaa vastaustanne paperin kääntöpuolelle. Muistakaa tällöin merkitä kysymyksen numero vastauksen eteen.

Palautathan kyselyn 10.10.2011 mennessä.

Kiitos vastauksestasi!

Ystävällisin terveisin,

Outi Kattilakoski

## APPENDIX 6

Hi!

I am 4th year public health nursing student from Central Ostrobothnia University of Applied Sciences. I am doing my thesis about nurses' experiences in facing multicultural clients' sexuality in antenatal and family planning clinics, maternity and gynecological polyclinics and gynecological and delivery wards.

The aim of the thesis is to describe nurses' experiences of multicultural clients' (minorities, immigrants, other groups of foreigners etc.) in issues related to sexuality and reproductive health. Another aim is to find out the nurses' need of information to carry out their duties and the sources they use to get the information. The goal of the research is to gain material for the development of the nursing education and practice.

Research data is collected via an accompanied questionnaire. Participation is voluntary and all of the responds will be handled with confidentiality. Questionnaires are filled-in anonymously.

The questionnaire includes open and close-ended questions. In case of extra space needed for open questions, feel free to use the other side of the paper. Then remember to mark the number of the question before your answer.

Return by 10th of October 2011.

Thank You for Your participation!

Sincerely,

Outi Kattilakoski

**TUTKIMUSLUPA-ANOMUS**

Organisaatio, jolle anomus osoitetaan Kokkolan terveyskeskus,  
neuvolat

Vastuhenkilö organisaatiossa Satu Lohilahti

Tutkimusluvun anoja(t) Outi Kattilakoski

Osoite \_\_\_\_\_

Puhelin \_\_\_\_\_

Sähköpostiosoite \_\_\_\_\_

Tutkimuksen nimi Nurses' experiences of multicultural clients  
in sexual and reproductive health care in Kokkola.

Tutkimuksen tarkoitus Kuvailta hoitohenkilökunnan kokemuksia  
eri kulttuuritaustaisten asiakkaiden kohtaamisesta.

Tutkimuksen kohderyhmä Äitiys- ja perhesuunnittelu-neuvoloiden  
hoitajat

Aineiston keruun arvioitu ajankohta Lokaku 2011

Tutkimusmenetelmä Kvalitatiivinen ja kvantitatiivinen  
kysely tutkimus

Tutkimussuunnitelma hyväksytty 19 / 12 20 10

Tutkimuksen ohjaaja Anita Hollanti

Lupa myönnetään

paikka \_\_\_\_\_ aika \_\_\_\_\_ / \_\_\_\_\_ 20 \_\_\_\_\_

anomuksen mukaisesti  muutosehdotuksin  hylätty

Luvanmyöntäjän allekirjoitus \_\_\_\_\_

**LIITTEET**  Tutkimussuunnitelma  
 Kysely/haastattelulomake  
 Muut liitteet, mitkä \_\_\_\_\_

**KOKKOLAN KAUPUNKI**  
 Terveyspalvelut

 Viranhaltija ja virka-asema  
 Tikkakoski-Alvarez Hannele  
 Hoitotyön johtaja

**VIRANHALTIJAPÄÄTÖS**  
 Yleinen päätös

1

 Päivämäärä / pykälä  
 12.09.2011 / § 13  
 13

Asia	<b>Kattilakoski Outi, tutkimusluvan myöntäminen</b>	
Päätös ja sen perustelut	Hyväksytään  Outi Kattilakoskelle myönnetään tutkimuslupa aiheesta: Nurses experiences of multicultural clients in sexual and reproductive care in Kokkola. Tutkimuksen kuvaa hoitohenkilökunta kokemuksia eri kulttuuritaustaisten ta-siakkaiden seksuaalisuuden kohtaamisessa. Tutkimus on kyselytutkimus ja kohderyhmänä on Kokkolan terveyskeskuksen neuvoloiden terveydenhoita-jat	
Allekirjoitus	 Hoitotyön johtaja Tikkakoski-Alvarez Hannele	
Oikaisuvaatimus- oi-keus	Päätökseen tyytymätön voi tehdä kirjallisen oikaisuvaatimuksen. Oikaisuvaatimuksen saa tehdä se, johon päätös on kohdistettu tai jonka oikeuteen, velvollisuuteen tai etuun päätös välittömästi vaikuttaa (asianomainen) sekä kunnan jäsen.	
Oikaisuvaatimus- viranomainen	Sosiaali- ja terveyslautakunta	
Oikaisuvaatimusaika ja sen alkaminen	Oikaisuvaatimus on tehtävä 14 päivän kuluessa päätöksen tiedoksisaannista. Kunnan jäsenten katsotaan saaneen päätöksestä tiedon kun pöytäkirja on asetettu yleisesti nähtäväksi. Asianosaisen katsotaan saaneen päätöksestä tiedon, jollei muuta näytetä, seitsemän päivän kuluttua kirjeen lähettämisestä, saantitodistuksen osoittamana aika-na tai erilliseen tiedoksisaantitodistukseen merkittynä aikana.	
Oikaisuvaatimuksen sisältö ja toimittami-nen	Oikaisuvaatimuksesta on käytävä ilmi vaatimus perusteluineen ja se on tekijän allekirjoitettava. Oikaisuvaatimus on toimitettava oikaisuvaatimusviranomaiselle ennen oikaisuvaatimusajan päättymistä.	
Päätöksen nähtäväksi asettaminen	Päivämäärä	
Tiedoksianto asianosaiselle	<input type="checkbox"/> Lähetetty tiedoksi kirjeellä Annettu postin kuljetettavaksi, pvm / tiedoksiantaja	Asianosainen _____
	<input type="checkbox"/> Luovutettu asianosaiselle Paikka, pvm	Asianosainen _____
	Tiedoksiantajan allekirjoitus ja virka-asema	Vastaanottajan allekirjoitus
	<input type="checkbox"/> Muulla tavoin, miten	
Lisätietoja		
Liitteet		
Sisäinen jakelu		

 Postiosoite / Postadress:  
 PL 43 / PB 43  
 67101 KOKKOLA / KARLEBY

 Käyntiosoite / Besöksadress:  
 Kaupungintalo / Stadshuset  
 Kauppatori 5 / Salutorget 5

 Puhelin / Telefon:  
 (06) 828 9111  
 Fax: (06) 8289 389

 S-posti / E-post:  
 etunimi.sukunimi@kokkola.fi  
 fomamn.etermamn@kokkola.fi

 Internet:  
 www.kokkola.fi

**KESKI-POHJANMAAN SAIRAANHOITOPIIRI  
TUTKIMUSLUPA-ANOMUS**

Hakijan nimi Outi Kattilakoski

Hakijan nimi

Osoite

Puhelin

Tutkimuksen ohjaajan nimi ja yhteystiedot

Anita Hollanti [anita.hollanti@cou.fi](mailto:anita.hollanti@cou.fi)

Tutkimuksen nimi

NURSES EXPERIENCES OF MULTICULTURAL CLIENTS IN SEXUAL AND  
REPRODUCTIVE HEALTH CARE IN KOKKOLA

Tutkimuksen tarkoitus

Tutkimuksen tarkoituksena on kuvaila hoitohenkilökunnan kokemuksia eri kulttuuritaustaisten asiakkaiden seksuaalisuuden kohtaamisesta.

Tutkimuksen tavoitteet

Tutkimuksen tavoitteena on kerätä tietoa monikulttuurisen hoitotyön ja koulutuksen kehittämiseen.

Tutkimustehtävät

Hoitajien kokemuksia monikulttuuristen asiakkaiden seksuaalisuuteen liittyvistä kysymyksistä.  
Hoitajien tarvitsema tieto monikulttuuristen asiakkaiden kohtaamisessa.  
Hoitajien käyttämät tietolähteet monikulttuuristen asiakkaiden seksuaalisuudesta.

Aineistonkeruu ja analyysi

Tutkimusaineisto kerätään oheisella kyselylomakkeella. Lomake sisältää avoimia ja suljettuja kysymyksiä. Avoimet kysymykset analysoidaan sisällönanalysillä ja suljetut SPSS- ohjelmalla.

Paikka Ruotsalo Päiväys 4.9.2011

*Outi Kattilakoski*

Hakijan allekirjoitus:

Hakijan allekirjoitus

Liitteet

- 1)  Tutkimussuunnitelma
- 2)  Kysely/haastattelulomake



KESKI-POHJANMAAN ERIKOISSAIRAANHOITO- JA VIRANHALTIJAPÄÄTÖS  
PERUSPALVELUKUNTAYHTYMÄ

Tutkimuslupapäätös  
Hallintoylihoitaja

14.09.2011

16 §

**ASIA**

Kattilakoski Outi, NURSES EXPERIENCES OF MULTICULTURAL  
CLIENTS IN SEXUAL AND REPRODUCTIVE HEALTH CARE IN  
KOKKOLA, Keski-Pohjanmaan ammattikorkeakoulun  
englanninkielinen linja

**PÄÄTÖS**

Tutkimuslupa-anomus hyväksytään. .

**ESITYKSEN TEKIJÄ**

**PÄÄTÖKSEN TEKIJÄ**

  
Pirjo-Liisa Hautala-Jylhä  
Hallintoylihoitaja