HEALTHCARE PROVIDERS ON CULTURALLY SENSITIVE MATERNAL CARE

INVESTIGATING THE EXPERIENCES OF HEALTHCARE PROVIDERS IN DELIVERING MATERNITY CARE TO ETHNICALLY DIVERSE WOMEN: A SCOPING REVIEW

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LAY ABSTRACT

Women of different backgrounds who are pregnant or who have given birth sometimes like to practice certain cultural traditions during pregnancy and birth such as eating cultural foods, fasting, and having family involved. When healthcare providers do not know about these practices or do not have the time or resources to help women practice their cultural traditions, this can cause them and the women they care for to have conflicts. This can cause other problems which can lead to poor mental and physical health.

While there is a great amount of research on women's experiences with their health providers, there is not much research on healthcare providers' experiences with women. To address this, a scoping review was conducted to summarize research on healthcare providers' experiences in caring for women of diverse cultures, during and after pregnancy. This review can help bridge the gap between women's needs and healthcare providers' abilities in meeting them.

ABSTRACT

Background: Women across many ethnicities and backgrounds experience a lower quality of care compared to men, and have reported lower levels of patient satisfaction, and negative health outcomes. Women of various ethnic backgrounds often have health, cultural and religious needs during pregnancy that are not met by their care providers. While addressing patient needs is a priority, providers also face challenges in understanding, accommodating, and addressing women's needs due to limited understanding of their cultures and available resources in caring for diverse populations.

Objective: The purpose of this study is to describe and synthesize information from the literature regarding the perceptions and experiences of healthcare providers in delivering maternity care to ethnically diverse women.

Methods: A scoping review was conducted, and database searching occurred in Ovid Medline, Ovid Embase, Ovid Emcare and Web of Science. Primary studies and literature reviews in English were included if they discussed the perspectives of healthcare providers in delivering maternity care to either ethnically diverse women, immigrant women, or a specific ethnic group of women. No time restrictions were placed on articles. Thematic analysis was applied to analyze the data, and results were reported in tabular format.

Results: A total of 11 themes were generated across findings, namely, provider-patient communication difficulties, family involvement, lack of health and health system awareness, delays in care, limited time and resources, cultural conflicts, preference for a

female provider, creation of stereotypes, prejudice and superior thinking, motivation to help ethnically diverse women, and cultural sensitivity training.

Conclusion: Healthcare providers face challenges in addressing the needs of ethnically diverse women, due to resource and time limitations, lack of awareness of cultural norms, and lack of adequate cultural sensitivity training and education. Therefore, there is a need to increase the number of supports for providers as well as improve cultural sensitivity training in medical education.

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LIST OF ALL ABBREVIATIONS AND SYMBOLS

WHO – World Health Organization
HCP – Healthcare Provider
PCC – patient-centred care
WCC – woman-centred care
OBGYN – Obstetrician Gynecologist
OB – Obstetrician

DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration of academic achievement that this thesis has been written by Bismah Jameel and recognizes the guidance, contributions and support of Dr. Lydia Kapiriri and Dr. Olive Wahoush of McMaster University.

CHAPTER 1: OVERVIEW

In a report published in 2015, the World Health Organization (WHO) recommended the integration of "culturally appropriate skilled maternity care" services as part of its international mandate on health for all (WHO, 2015). The WHO also focuses on the importance of having "people-centred care" that prioritizes individual and cultural preferences in health service delivery (WHO, 2016). Numerous studies have suggested that poor patient health outcomes and low care satisfaction are linked to care that patients view as culturally insensitive (Filler et al, 2020; Bohren et al, 2014; Coast et al, 2014). This can lead to poor health-seeking behaviours, decreased uptake of health services, and delays in seeking care when needed (Ahmed et al, 2016; Wikberg & Bondas, 2010), which can exacerbate negative health outcomes (Larson et al, 2020)

Since then, research and implementation efforts have contributed to our understanding of providing culturally appropriate maternity care. A systematic review conducted by Jones et al. (2017) on the factors influencing the implementation of culturally appropriate maternity care interventions found that insensitive behaviour, poor patient-clinician interactions, discrimination, and negative attitudes towards patients of various cultures reduced the uptake of care in ethnically diverse populations (Jones et al, 2017). Delivering culturally appropriate care often stems from interacting with patients of diverse ethnicities that are sometimes not originally from the country they currently reside or receive care in. Within ethnic minority and ethnically diverse populations, women experience greater barriers and disparities compared to men (Gagliardi et al, 2019; Gerritsen & Deville, 2009), for various reasons relating to how women's health and health-seeking behaviours are culturally informed (Benza & Liamputtong, 2014). Women may have certain expectations for how their care will be delivered and when their expectations are not

met by providers, this can introduce tension and miscommunication that affect the patient-provider relationship (Suphanchaimat et al, 2015).

To understand ethnically diverse women's needs, research has looked at the experiences and perceptions of women from different ethnic groups with their healthcare providers (HCPs) and across different types and forms of health services. Immigrant and ethnically diverse women in several studies have highlighted the need to increase their providers' understanding of culturally appropriate care and accommodate personal, familial, and cultural needs (John et al, 2021; Gagliardi et al, 2020; Higginbottom et al 2014, Jomeen et al, 2013). For instance, women appreciate providers who consider their cultural and religious preferences alongside their biomedical needs (Higginbottom et al, 2014; Benza & Liamputtong, 2014). However, research has shown that physicians often do not know how, or do not feel comfortable in their ability to deliver culturally appropriate care (Gagliardi et al, 2020; Suphanchaimat et al, 2015). Similarly, HCPs also experience cultural dissonance that makes it challenging to effectively understand the needs of patients from different ethnicities (Bains et al, 2021). Factors such as language (Wikberg & Bondas, 2010), insufficient time and resources, and conflicting clinical guidelines impact health care providers' ability to treat ethnically diverse women (Gleddie et al, 2018). Despite the extensive research on ethnically diverse women's experiences and needs in maternity care, there is relatively less information on healthcare providers' experiences and perceptions in delivering culturally appropriate care to this population.

To improve the quality of care delivered to women in maternal settings, research on the experiences of providers that identifies their needs and the support they require for delivering

culturally sensitive maternity care should be synthesized. To ensure that care delivery is comprehensive and robust, there is a need to identify the barriers and enablers of maternal care delivery from the perspective of HCPs to supplement the existing research on ethnically diverse women's needs and experiences in maternity care. Simply exploring the perspectives of patients in healthcare delivery and satisfaction is not sufficient; moreover, there is a need to understand providers' capacities in meeting their patients' needs, since there is limited research on this topic. To address these issues, a scoping review was conducted on the experiences and perceptions of healthcare providers in delivering maternal health care to ethnically diverse women. The scoping review method is appropriate when addressing a research question for which there is limited research available. Since there is less research on the perspectives of healthcare providers compared to that of ethnically diverse women, conducting a scoping review would be an appropriate approach to take.

CHAPTER 2: BACKGROUND

2.1 Ethnicity and Healthcare

Two important factors that are often considered when exploring the health needs and outcomes of different groups are *race* and *ethnicity*. While these terms are often used synonymously, it is imperative to understand the differences between them to appropriately address health disparities. Race pertains to biological markers (Ford & Kelly, 2005). Ethnicity, in contrast, relates to common origin, language, cultural practices, and traditions (Ford & Kelly, 2005). Race includes phenotypic traits such as skin colour and tone (Ford & Kelly, 2005). While race is an important factor when looking at how different groups respond to disease, ethnicity may be more appropriate to consider when looking at the patient-provider relationship, since it includes cultural values, which can differ between patients and providers. These differences in cultural values and norms can create challenges in patient-provider interactions. Mir et al, (2013) conducted a Delphi study with researchers, practitioners, and policymakers on the need to include ethnicity in health services research. The authors concluded that health providers should include evidence on ethnicity within healthcare in their daily practice (Mir et al, 2013). Thus, exploring ethnicity in healthcare is a stepping-stone for addressing health disparities, and is warranted in our increasingly globalized world.

Individuals often migrate to a different country for various reasons such as new and better professional and educational opportunities compared to what they encountered in their home country. However, the stress of adjusting to a new country and way of life is associated with a decline in the physical and emotional well-being of newcomers (Thomson et al, 2015), and continues to decline over time due to structural barriers such as lack of access to health services,

differing expectations of healthcare, and underutilization of screening services (Newbold, 2005). Evidence suggests that within high-resource countries such as the UK, Canada, the US, and Australia, the overall health of foreign-born individuals is often lower compared to those born within the country (Veenstra 2011; Brach & Fraser, 2002), particularly as time passes. Cultural values, norms, and beliefs often inform the needs and behaviours of ethnic minorities in health contexts (Brown et al., 2016). Moreover, individuals who migrate to a country pass on their cultural norms and values to future generations, who may hold and carry these values with them even though they can assimilate well into the host country's society and culture. Furthermore, there is a need to adopt culturally appropriate health practices not only for recently migrated individuals but for their developing communities and second and third-generation immigrants.

A multitude of research has shown that health needs and preferences vary among patients of different ethnicities and cultures. The health needs of individuals are often based on the cultural traditions, values, and norms that they carry from their previous country. For example, studies have highlighted several health needs of ethnic minorities, however, the needs of ethnic minorities and immigrants tend to overlap within certain high-income nations such as Canada, the US, Sweden, the UK, and Germany (Higginbottom et al, 2019), all who accept a high quantity of immigrants each year (UN Migration, 2020). A study by Ahmed et al. (2015) found that the needs of immigrant patients continue to be unmet (Ahmed et al, 2015). The authors identified five prominent types of barriers that emerged for immigrant patients: cultural, communication, socio-economic status, healthcare system structure, and immigrant knowledge. Cultural barriers include patients not being forthcoming to straightforward questions, comparing the health system to their native country, and having different values surrounding privacy and

confidentiality. Communication barriers include providers feeling discomfort with interpreter-mediated conversations, patients not knowing English, and interpreters not accurately communicating patients' needs (Salavati et al, 2019). Additionally, ethnically diverse patients may be familiar with a power dynamic where the physician holds more power over the patient and does most of the talking during medical consultations. This creates challenges when patients are communicating with physicians who expect them to be straightforward about their health problems (Ahmed et al, 2016).

2.2 Cultural Sensitivity in Healthcare

Cultural sensitivity refers to "the ability to recognize, understand, and react appropriately to behaviours of persons who belong to a cultural or ethnic group that differs substantially from one's own" (Brooks et al, 2019). Cultural sensitivity can potentially improve the patient-provider relationship in the context of ethnically diverse patients. The patient-provider relationship plays a vital role in patient adherence to medication/treatment and overall satisfaction with care (Betancourt et al, 2013; Saha et al, 2011). Several different problems may arise from the dissonance between a patient and provider's cultural expectations including implicit or explicit discrimination, language barriers, conflicting patient-provider expectations of care delivery, and poor patient satisfaction (Degni et al, 2012). Additionally, cultural conflicts may result in missed diagnostic tests and screening, inappropriate drug interactions between pharmaceutical and naturopathic medications, and non-adherence to medication and prescriptions (Brach & Fraser, 2002). Furthermore, having culturally sensitive services in health organizations may be cost-effective as it will ensure the prevention of unnecessary testing, more accurate medical histories, and therefore, fewer resources spent on illnesses and treatments that could have been prevented

or were not necessary (Brach & Fraser, 2002). Moreover, patients often criticize the fact that HCPs do not give them enough time or show concern for their needs (Degni et al, 2012). Some patients may not realize that HCPs are often under stress from high cognitive load and time constraints (Whittal & Rosenberg, 2015). HCPs must be cognizant of the effect that cultural differences have on their relationships with patients. According to The Lancet's 2014 commission report on culture and health, neglecting the role of culture in health remains the greatest obstacle to achieving equitable health care worldwide (Lancet, 2014).

2.3 Culturally Sensitive Maternity Care

Pregnancy and childbirth are emotionally charged events that can incite feelings of fear and anxiety about the outcome and survival of both mother and child (Wikberg & Bondas, 2010). They also often hold significance in various cultures, since many cultural and religious values are tied with childbearing and childbirth (Preis et al, 2018). Women from high, middle- and low-income countries may experience less than optimal care during labour and delivery (Oladapo et al, 2018). The use of unnecessary interventions and over-medicalization of childbirth continues to be a concern in high- and middle-income maternal care settings, with a continuous focus on the biological components of maternity rather than overall health and wellbeing (WHO, 2009). Many women have reported undignified care during intrapartum care in high-income nations (Oladapo et al, 2018). Women genuinely want a positive care experience when delivering their infant, care that addresses their personal, psychological, and sociocultural needs (Oladapo et al, 2018). Over the course of the 20th century, there was a sudden shift towards the use of medical interventions during pregnancy and childbirth and having a one size fits all approach for all deliveries (Ferrer et al, 2016). The biomedical model has been criticized for treating childbirth as

a pathological process rather than a physiological one, with a high level of medications and interventions offered (Ferrer et al, 2016). In contrast, humanized childbirth, which emphasizes a woman-centric model of care, whereby the woman has a key role in decision making, and where her values and preferences are considered, has been encouraged globally over the past several decades (Ferrer et al, 2016). A study comparing models of childbirth found that the humanized model of care resulted in better obstetrical outcomes for women, and higher patient satisfaction compared to the biomedical model (Ferrer et al, 2016).

As part of an effort to improve maternal health worldwide and achieve the third Sustainable Development Goal (ensuring healthy lives and wellbeing for all), the WHO recommended the integration of individualized, woman-centred, respectful maternity care that is culturally sensitive (Oladapo et al, 2018; Jones et al, 2017). This shift in global maternal health care has moved beyond simply reducing morbidity and mortality to also ensuring overall positive health and wellbeing for mothers and children (Oladapo et al, 2018). Positive interactions between patients and providers include HCPs showing genuine empathy, compassion, and placing importance on the concerns that mothers raise (Mander & Miller, 2016). Good quality care is achieved when women are treated respectfully, value is given to their dignity and privacy, and attention is given not just to their cultural preferences but also to their personal preferences (Mander & Miller, 2016). Disrespectful communication, insensitive demeanour and unfriendliness from HCPs can be exacerbated by racial discrimination and prejudice (Jones et al, 2017). Healthcare providers sometimes display frustration at having to deal with patients who lack English speaking skills and have different cultural expectations for their care, which they find to be time-consuming and burdensome (Henderson et al, 2013; Wikberg & Bondas, 2010).

Additionally, good quality care involves complete informed consent to ensure that mothers are aware of why treatments are being provided to them and therefore increase the likelihood that they will be more willing to engage in treatment plans and follow up with care (Mander & Miller, 2016).

Several studies have focused on identifying the needs of ethnically diverse women. One of the most common challenges that arise relates to poor communication between health providers and ethnically diverse women, as noted by a qualitative study conducted in the United Kingdom and a meta-ethnography in Finland (John et al, 2021; Wikberg & Bondas, 2010). Women sometimes cannot comprehend the medical jargon used by professionals, feel that they speak too quickly for them to understand, and often misinterpret facial gestures and pictorial representations (Higginbottom et al, 2016). Some patients mention that health providers often rush and do not spend enough time explaining in detail the issue or treatment to the women (John et al, 2021; Gagliardi et al, 2020). Women also mentioned that consultations with physicians are usually short and that they are discharged from the hospital early (Higginbottom et al, 2019). A narrative synthesis conducted by Higginbottom et al. (2019) on ethnically diverse women's experiences with maternity care in the UK found that women feel confused regarding pregnancy and medical advice, which can be conflicting between the advice that healthcare providers provide with the medical advice that women were given in their home countries (Higginbottom et al, 2019). Women perceived an HCP as caring if they displayed kindness (John et al, 2021; Higginbottom et al, 2019; Wikberg & Bondas, 2010) were attentive, explained the details of treatment, and respected their family and cultural values (Wikberg & Bondas, 2010). On the other hand, women viewed uncaring HCPs as not being attentive, not being informative, and

being hostile (Wikberg & Bondas, 2010). Wikberg & Bondas (2010) found that women experienced problems when they could not exercise their cultural traditions and had to follow nurses' orders. While women appreciated HCPs who seriously consider their cultural and religious preferences alongside their biomedical needs, women reported that this was rare (Higginbottom et al, 2014; Benza & Liamputtong, 2014).

Issues relating to culture include being ashamed of discussing issues viewed as taboo in the community and leaving the hospital early to follow cultural traditions. Not having access to a female HCP is an issue mentioned by both patients and HCPs (Higginbottom et al, 2016; Wikberg & Bondas, 2010). Several other studies have mentioned patients desiring female HCPs, and that patients did not know where or whom to ask for this accommodation (Jones et al, 2017; Ahmed et al, 2016; Benza & Liamputtong, 2014; Wikberg & Bondas, 2010). Other studies have suggested that women may be more comfortable discussing their health issues with a female provider as opposed to a male, which they may find embarrassing to do (Gagliardi et al, 2020). A qualitative study with immigrant women in Canada found that some women did not appreciate providers' who did not give importance to privacy, in particular male providers who conducted physical examinations without the use of a curtain or barrier between the patient and other health staff (Gagliardi et al, 2020). This is the case for women of African descent (Anaman Torgbor et 2017), Muslim women, who come from a variety of different cultures (George et al, 2014), and women from Asian cultures (Seo & Li, 2018). Another example is when providers do not facilitate privacy during breastfeeding. Women of certain cultures do not feel comfortable breastfeeding openly in contrast to women of western countries (Riordan & Gill-Hopple, 2001).

A cultural disconnect between the values and norms of the host country and those of the home country is often an issue that arises as well. For instance, a Canadian study found that women from many cultures express that within health services, not much focus and support is placed on postnatal care, but more so is placed on prenatal and intrapartum care, whereas in many non-western countries, less importance is given to prenatal care, and more is given to postnatal care and recovery from childbirth (Higginbottom et al, 2016). Similarly, women expressed that they did not view pregnancy to be a disease or sickness that needed treatment, but rather a natural process, and therefore did not see the need to seek medical attention for it (Higginbottom et al, 2016). Women also express that they may not feel confident in making decisions regarding treatment, which physicians in western countries expect them to do (Ahmed et al, 2016). In many non-western countries, the norm is that the physician has the best insight into the right decision that the patient should take, and therefore is the primary decision-maker (Gagliardi et al, 2020).

Women from different ethnicities who feel dissatisfied with their care may become less likely to seek health care, and experience negative health outcomes compared to other women (Ahmed et al, 2016; Wikberg & Bondas, 2010). While addressing clinical aspects of maternity care is crucial, it is equally important to address the social aspects of care and improve care satisfaction. Therefore, improving the experiences of women in maternal healthcare settings can reduce maternal mortality by ensuring that patients are appropriately seeking and receiving timely care.

2.4 Cultural birthing Practices and Perceptions of Pregnancy

Cultural traditions and perceptions of pregnancy, birth, and infant care differ across cultures. It is imperative to be cognizant of the diversity that exists in cultural norms and values for patients of diverse ethnicities to ensure care delivery that is culturally appropriate and sensitive. Withers and colleagues conducted a scoping review that explored the birthing practices of women from Asian countries such as India, Pakistan, Nepal, Papa New Guinea, Bangladesh, Thailand, Myanmar, Singapore, China, Vietnam, and Lao PDR, Malaysia, Taiwan, Philippines, and Indonesia. They found that there was a belief of pregnancy as being a natural phenomenon that did not require much medical attention (Withers et al, 2018). Additionally, women of Japanese origin also believe in natural birth and thus, that there is no need for epidurals and interventions during birth (Behruzi et al, 2013).

Withers et al. (2018) found that women from the countries listed above focus on a specific diet, avoiding foods that were considered to create heat within the body, and thus likely to cause a miscarriage, such as beans, maize and sugar, and those that create coolness such as dairy and oranges as they are believed to possibly harm the fetus (Withers et al, 2018). In India, women drink ginger, lentils, and tea to facilitate birth, whereas in Laotian women drink blessed coconut water (Withers et al, 2018). Women also believed taking prenatal vitamins would cause the baby to grow large and thus create a difficult delivery (Withers et al, 2018). Chinese women had the perception that eating shrimp would create skin allergies (Withers et al, 2018). Additionally, women use traditional herbs as remedies (Ahmed et al, 2020; Withers et al, 2018) for things such as preventing nausea, induction of labour, placental delivery, and preventing uterine prolapse (Withers et al, 2018). Studies have also found that women from various

countries have certain ‘food taboos’. For instance, in countries such as Ghana, Bangladesh and Kenya, women avoid consuming eggs, and in Ghana women avoid recently butchered meat due to the belief that this will create a baby too large for an easy delivery (Iradukunda, 2019). While women may have certain food preferences and restrictions, these are not always supported by evidence, and therefore may lead to nutrient deficiencies during pregnancy. (Iradukunda, 2019).

Furthermore, women in Asian countries give birth in various positions, including kneeling, squatting, and sitting, as opposed to lying on the back which is typical in medical facilities (Withers et al, 2018). Women from countries such as Bangladesh, Papa New Guinea, and India practiced purification rituals to protect them from complications (Withers et al, 2018), and women from Pakistan tended to rely on amulets and holy water for spiritual protection against physical harm rather than seek medical attention for any issue (Withers et al, 2018). In different Asian societies, prenatal massage is given importance to help with healing and relaxation (Withers et al, 2018). Women from many cultures would like their family members present, and some prefer only their female relatives whereas others encourage the presence of the woman’s male partner (Withers et al, 2018).

The study also found a fear of obstetrical interventions, such as suturing, making incisions during birth, as well as the belief that an unhealed scar could interfere with daily activities or sexual relationships with spouses (Withers et al, 2018). Furthermore, Indian women were also reluctant to give birth in health facilities if they believed they would be hindered from practicing cultural traditions such as burying the placenta (Withers et al, 2018). Several communities within these countries held a widely adopted view that going to the hospital to give

birth or seek treatment during pregnancy indicated that one was “sick” or “ill” (Withers et al, 2018). Additionally, several cultures promote the use of heat therapy for postnatal recovery and to compensate for lost heat. Women avoid bathing after childbirth to prevent harm to bones and joints and reduce the likelihood of blood clots (Lamxay et al, 2011).

Similarly, women in Africa also use traditional herbs and medicines (Hastings-Tolsma et al, 2018), and have food taboos associated with pregnancy and maternal health (Lange-Balde & Amerson, 2018). They also place importance on mother figures (e.g., mother-in-law) in the family during birth (Lange-Balde & Amerson, 2018). Studies have found that women from African countries who live in high-income nations prefer to have more medical interventions, since they sometimes come from regions of the world where they had poor access to health services (Behruzi et al, 2013).

Many cultures practice confinement of women during pregnancy, as well as confinement massage (Abdullah et al, 2019). During confinement, there are certain nutritional restrictions and a specified diet for the pregnant woman (Abdullah et al, 2019). A practice known as “warming” is also present in countries such as Brunei, Cambodia, Laos, and Malaysia, where women are warmed following childbirth to restore lost heat escaped through the blood loss that occurs during childbirth. This is done through various methods such as lying on hotbeds, inhaling steam, or sitting on bricks with fires burning under (Muhammad Wafiuddin Wai’e et al, 2020). Women and families who are Muslim, regardless of their ethnicity or origin, perform a religious practice in which the call to prayer or *adhan*, is recited in a newborn baby’s ear shortly after birth (Hassan 2022).

To conclude, being open and willing to learn about the cultural practices and norms of women of different ethnicities can enable health providers to give the best support and tailor their communication to women's needs and preferences. Similarly, there may be instances where women's cultural knowledge of good health practices during pregnancy is not supported by medical evidence, and therefore providers can address this knowledge gap.

2.5 Relationships with Health Care Professionals

Within maternity care, there are several providers involved in care for women, including primary care physicians, midwives, nurses, obstetricians, and gynecologists. Each provider has a different role and can therefore also have a different relationship with ethnically diverse women. For instance, ethnically diverse women may not prefer to visit a midwife due to poor perceptions of midwives in their home countries or the fact that using midwifery care is less common or non-existent (Higginbottom et al, 2020). On the contrary, some view care by midwives to be very helpful, kind, and informative and thus have a positive perception of midwifery care (Higginbottom et al, 2020). Having open communication with midwives enabled women to discuss sensitive issues such as female genital mutilation/cutting (FGM/C) (Higginbottom et al, 2020). Having positive relationships with women is a goal that all healthcare providers should strive for, regardless of their role and level of interaction with women.

CHAPTER 3: RATIONALE

The cultural disconnect between HCPs and ethnically diverse women creates a strain on both groups and contributes to poor patient care delivery and satisfaction (Ahmed et al., 2016). Most studies to date on the challenges in providing culturally appropriate care have focused on the patient and patients' needs; however, there is less research on the perspectives and experiences of HCPs in the context of maternal care (Ahmed et al, 2016; Supranchaimat et al, 2015). HCPs also experience challenges and barriers when interacting with ethnically diverse women, which hinders them from adequately meeting their needs. For instance, some HCPs view ethnically diverse women as too demanding, and that they are not as independent as other women. Furthermore, some have said that women sometimes view the hospital as a hotel and expect too much from hospital staff (Higginbottom et al, 2016). Due to not wanting to see a male physician, some women have not sought proper medical care such as a pap smear (Higginbottom et al, 2016). Health providers may also find it challenging to meet the needs of their patients due to limited time, resources and lack of knowledge or awareness of women's cultural norms, practices, and values (Higginbottom et al, 2020). Several different challenges have been identified in the literature, including language and communication barriers, and different expectations of care. However, research continues to place a heavy focus on the patient, or the service user. Thus, there is a need to gain insight into the perspectives of the service provider to bridge the gap that exists and determine how care can be improved in a manner that meets the needs of both providers and patients.

To address the needs of health providers in providing maternal care to ethnically diverse women, the experiences of health care providers that are related to both individual (focused on providers' knowledge and ability) and external factors (time and resources) must be explored.

3.1 Thesis Objective

This thesis aims to describe and synthesize healthcare providers' experiences and determine the barriers, enablers and needs of providers for delivering culturally sensitive maternity care to ethnically diverse women.

3.2 Research Question

What are the experiences and perceptions of healthcare providers in delivering maternity care to ethnically diverse women, including barriers, enablers and healthcare providers' needs in delivering this care?

CHAPTER 4: METHODOLOGY AND METHODS

4.1 Design and Description of Methodology

Scoping reviews are conducted to synthesize and understand which types of research exist regarding a specific phenomenon and to map the "extent, range, and nature of research activity" (Arksey & O'Malley, 2005). Furthermore, scoping reviews can also be conducted to determine existing gaps in research, and to identify future steps for research or investigation that are needed (Arksey & O'Malley, 2005). They are useful when there is emerging or limited peer-reviewed information on the topic in question (Peters et al, 2015). Since the objective of this study is to identify what exists currently in the literature regarding the experiences of healthcare providers in delivering maternity care to ethnically diverse women, a scoping review was an appropriate approach. Arksey and O'Malley's approach to scoping reviews was used. The five stages of Arksey and O'Malley's approach include: identifying the research question, identifying relevant studies, study selection, charting the data, and collating, summarizing, and reporting results (Colquhoun et al, 2014; Arksey & O'Malley, 2005).

4.2 Identifying the Research Question

The research question is "What are the experiences and perceptions of healthcare providers in delivering maternity care to ethnically diverse women, including barriers, enablers and healthcare providers' needs in delivering this care?"

The term experience can be deemed broad and general, however, I will include any articles that mention terms that relate to or contribute to experiences, such as perspectives, opinions, beliefs, attitudes, and views. I have chosen to focus on the terms ethnically diverse within the research question, rather than immigrant, since the term immigrant tends to place

individuals of different ethnic backgrounds into one homogenous group. As a result, there is less attention paid to the nuanced differences between various ethnic groups and their health care needs. Furthermore, there may even be differences *within* ethnic groups regarding cultural and individual needs and preferences, which has not received sufficient research attention. Ethnic populations comprise immigrants and individuals whose grandparents or family members were immigrants at a certain point in time. Individuals who immigrate tend to hold onto their culture to a certain degree over the course of several generations (Beharry & Crozier, 2008). By focusing on immigrants collectively, the diverse needs of communities are being missed, such as ethnic and sub-ethnic groups, as well as second and third-generation immigrants. Evidence suggests that immigrants of certain ethnicities experience challenges concerning interacting with health care providers (HCPs), however, these differences may not necessarily be the result of migration, but *cultural differences*. Cultural differences may result in strained interactions between HCPs and patients when one or both cannot understand the other. There is a need to leverage tools, research and frameworks that might promote cultural sensitivity in health care settings and alleviate gaps between patient preferences and HCPs' styles of interaction. I recognize that not all literature will use the term "ethnically diverse" or "ethnic minority" to define foreign-born individuals, and therefore, I will include studies that also use terms such as immigrant, minority group, and migrants.

4.3 Identifying Relevant studies

An exploratory search was performed on Medline using terms such as intrapartum care, labour and delivery, postpartum care, childbirth, midwi*, maternal health services, emigrant, migrant, inequity, and patient-provider relations. A small sample of articles was screened to

identify other relevant terms for the search strategy. A more comprehensive search strategy was created with assistance from an information scientist at the McMaster Health Sciences Library. Multiple iterations of the search strategy were developed to ensure that relevant research was retrieved.

Searches occurred in the following databases: Ovid Medline, Ovid Embase, Ovid Emcare, and Web of Science. These databases were chosen due to their content on clinical as well as social aspects of care. No time restraints were placed on articles to capture the most breadth of articles; however, only articles in English were included. A comprehensive search strategy was created with assistance from an information scientist from the McMaster Health Sciences Library and used to run searches. The most recent search was conducted on December 12, 2021. The results of database searching were imported into the review management software Covidence (Covidence Review Management Software, 2021). The search strategy used in Ovid Medline can be found in Appendix A. The search strategy contained terms related to different aspects of maternity care, such as midwifery, obstetrics, maternal and child health, and pregnancy. Terms related to foreign-born individuals were also used, such as immigrant, emigrant, ethnic minority, ethnic group, and minority group. While the focus of this study is on ethnic minorities, terms such as immigrant or emigrant were also used, as these also encompass ethnic minorities, and studies on immigrants tend to focus on cultural needs and preferences. Research primarily uses “immigrant” and related terms to understand cultural barriers, challenges, and experiences of non-western individuals. Ethnic groups consist of both recent immigrants, second, and third-generation immigrants and more who eventually begin to assimilate to the host country’s culture but hold onto aspects of their own culture. For instance,

individuals from China have resided in various western countries for several generations (Guo & DeVoretz, 2006). Terms relating to the patient-provider relationship were also used, such as cultural sensitivity, cultural safety, and patient-centred care.

4.4 Study Selection

Title, abstract and full-text screening of relevant articles was independently done by one reviewer via Covidence. Any reasons for exclusion during full-text screening were noted on Covidence. Results of all searches were reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)-SCR for reporting scoping reviews (Tricco et al, 2016). The PRISMA-SCR is more useful for scoping reviews which aim to answer broader questions compared to systematic reviews (Tricco et al, 2016). While screening with verification is the gold standard, recent evidence shows that there are diminishing returns on screening with verification when researchers are very familiar with the topic and have published similar work in the past (Waffenschmidt et al, 2019). In such cases, single screening has been shown to be equivalent to double screening.

4.5 Inclusion and Exclusion

Inclusion and Exclusion criteria are outlined according to the PICO framework (population, intervention, comparator, outcome), in Table 1 below.

Table 1

PICO Framework

Population	• Publications that mention ethnically diverse women of any ethnic background or race, of reproductive age (above adolescence), immigrant, or migrant women • Healthcare providers that delivered maternity care services in the article, including but not limited to, primary care physicians, nurses, nurse-midwives, obstetric nurses, obstetricians and or gynecologists, midwives • Publications in English from countries including Canada, the United States, Australia, New Zealand, the UK, and the European Economic Area. Focusing on these countries would allow for an appropriate comparison since they are all high-income countries that all implement the western biomedical model of maternity care. Previous research on women's health and health service delivery has also used this approach when determining countries for eligible studies (Christy et al, 2021)
Intervention or Issue	• Publications using the term maternity care, or any term related to maternity care, including the following: prenatal, intrapartum/antenatal, labour and/or delivery, childbirth, postnatal care (including infant feeding and infant care), abortion care midwifery care, reproductive health care • Publications on the topic from any country if they are a literature review
Comparison / Study Designs	• N/ A
Outcomes	• Outcomes from eligible studies may include experiences, opinions, attitudes, beliefs, views, and interactions that healthcare providers have regarding their interactions with ethnically diverse or immigrant women
Exclusion	• Publications not in English • Publications focused on refugee/asylum-seeking populations • Publications on contraception or contraceptive counseling • Publications focused solely on the perspectives of patients/clients, with no mention of provider perspectives • Publications on reproductive health services not directly related to pregnancy such as family planning, HIV, treatment for STIs/STDs, fertility treatment, etc. • Editorials, commentaries, abstracts, protocols

4.6 Charting and Collating Data

Study characteristics such as author, year, title, type of study, objectives, methods, type of healthcare provider, type of ethnically diverse population, country of study, whether the article was about an intervention, and relevant findings about health care provider experiences were extracted. Data extraction was recorded in an excel spreadsheet. Relevant qualitative information from articles was extracted for findings, specifically on perceptions, experiences, views, attitudes, beliefs, and opinions of healthcare providers.

4.7 Reporting and Summarizing Results

Data analysis involved describing the characteristics of included studies and identifying similarities, differences, and patterns between findings of different articles. Findings related to healthcare providers' experiences, including perceptions, experiences, views, beliefs, attitudes, and opinions of health providers, were displayed in tabular format in the final manuscript. Specifically, thematic analysis, which aims to understand meaning from data (Braun & Clarke, 2012), was used. An inductive approach was used, whereby the themes generated were aligned with words authors used within articles (Braun & Clarke, 2012). Existing gaps in the research were also identified. Potential gaps that were identified included the need for more research on specific ethnic minorities, healthcare providers, within specific maternal healthcare contexts and certain types of care. Data analysis also made note of any concepts that involve addressing patients' needs and preferences such as patient/person-centred care, cultural sensitivity, cultural humility, and cultural safety, and how these concepts were discussed within relevant articles.

4.8 Quality Appraisal

Evidence suggests that quality appraisal is not appropriate for all scoping reviews, since the purpose of scoping reviews is to determine the breadth of available research, regardless of the quality of studies (Tricco et al, 2016). As included studies used a range of methodologies and methods, a formal quality appraisal was impractical and not conducted.

CHAPTER 5: RESULTS

A total of 20,994 hits were retrieved from database searching, and 8,129 duplicates were removed, which left 12,815 articles to be included for the title and abstract screening. Out of these articles, 12 665 were deemed to be irrelevant based on the inclusion criteria, which left 140 for full-text screening. Out of these, 32 were included in the final review, as outlined in Figure 1, the PRISMA diagram, located in Appendix B.

5.1 Descriptive Characteristics

A total of 32 studies were included in this review. From these studies, (2) were from Canada, (4) were from the United States, (5) were from Australia, (2) from Norway, (6) from Sweden (7) from the United Kingdom, (1) from Spain, (1) from Singapore (1) was from Finland, (1) from Iceland, (1) from Ireland, and (1) from the Netherlands. All 32 studies included were primary studies, of which 29(90.6%) were qualitative studies, 2(6.3%) were mixed methods designs and 1(3.1%) was a literature review. In terms of data collection methods, 23(71.9%) employed semi-structured interviews only, 3(9.4%) used focused groups only, 4(12.5%) used both semi-structured interviews and focus groups, 1(3.1%) used semi-structured interview and survey, and 1(3.1%) was a qualitative meta-synthesis. Types of healthcare providers and types of maternity care that were discussed in studies are listed in Table 3 in Appendix D.

In terms of the ethnic group of ethnically diverse women, 14(43.8%) focused on ethnically diverse women in general, 4(12.5%) mentioned Somali women, 4(12.5%) discussed Black women, 2(6.3%) discussed Pakistani women, and 2(6.3%) discussed Latina women, 2(3.1%) included indigenous women, 2(6.3%) included Asian women, 1(3.1%) included Micronesian women, 1(3.1%) discussed Bangladeshi women, 1(3.1%) discussed Indian women

1(3.1%) mentioned Marshallese women, 1(3.1%) mentioned South Asian women, and 1(3.1%) mentioned culturally and linguistically diverse women (CALD). Of the total studies, 20(62.5%) looked at more than one ethnicity of women, whereas 12(37.5%) focused on only one ethnic group. The findings of this review represent the perspectives of providers towards patients who were both legally classified immigrants and others who may have been citizens of the host country but were born in a different country.

5.2 Findings

From the findings, 11 themes were generated, namely, provider-patient communication difficulties, family involvement, lack of health and health system awareness, delays in care, limited time/resources, preference for a female provider, cultural conflicts, creation of stereotypes, prejudice and superior thinking, motivation to help ethnically diverse women, and cultural sensitivity training and education. A round of pilot coding occurred where five articles were reviewed and the findings from these were used to generate a coding schema. The coding schema was modified and formed into a coding table, to which new themes were added. Findings are summarized in Table 4 in Appendix E.

5.2.1 Provider-Patient Communication Difficulties

The theme of patient communication difficulties was related to challenges in conveying information to and receiving information from patients. This included the use of different cultural norms with regards to the extent of speaking, verbal expressions, tone and body language, and passivity versus expression between patient and provider.

One challenge mentioned by midwives and OBs included that some languages do not have specific words for medical terms, which makes the conversation about anatomy and physiology difficult with ethnically diverse women (Ayers et al, 2018; Hughson et al, 2018). Needing to be careful in communication without offending the patient, (Hassan et al, 2020; Ahrne et al, 2019; Lyons et al, 2008) was also mentioned. For instance, midwives and nurses mentioned that they needed to tread carefully when expressing their medical opinions to avoid coming off as patronizing or judgemental to patients (Hassan 2020; Ahrne et al, 2019). Additionally, OBs feared appearing racist and therefore had to be careful when using certain language (Lyons et al, 2008).

Another challenge that appeared included not being able to gauge a woman's emotional needs or understanding of information, either due to patients asking minimal questions, as noted by midwives, OBs, and nurses (Delafield et al, 2020; Ahrne et al, 2019; Ayers et al, 2018), or providers having difficulty in deciphering non-verbal expressions (Shorey et al, 2021; Ayers et al, 2018; Cioffi, 2003), which varied between women of different ethnicities. To elaborate, some women from certain ethnicities such as Arabian women were very expressive during childbirth whereas Chinese women were not, which made it difficult to determine their needs for pain relief and support (Cioffi, 2003). Furthermore, one study found that certain groups present a form of stoicism, which makes it difficult to understand how they can be supported (Shorey et al, 2021). Additionally, providers also noted that some women refrained from discussing certain topics such as their mental health (e.g., past traumatic events) (Byrskog et al, 2015), sexual and reproductive health (Mengesha et al, 2018) and were "shy" and "timid" (Bandyopadhyay, 2021). Studies found that providers mentioned that they often do not obtain complete medical histories

from ethnic patients (Shorey et al, 2021; Ahrne et al, 2019; Lyons et al, 2008); due to women not providing enough information or if they have poor language skills and cannot fill out important documentation and forms.

In several studies, providers mentioned a few enabling factors, including being able to speak in the same language as the patient or having access to providers who could speak the same language (Chitongo et al, 2021; Hassan et al, 2020; Byrskog et al, 2015; Cioffi, 2003). Providers stated that using telephone interpretation services as opposed to in-person services was more useful, as it protected a woman's confidentiality (Ahrne et al, 2019; Lyberg et al, 2012). Providers also mentioned using non-verbal communication such as sign language, drawings, pictograms, and non-verbal cues to communicate with ethnic patients (Shorey et al, 2021; Aquino et al, 2015).

The theme of communication difficulties also highlighted issues with interpretation services. This included the accessibility of interpreters and inadequate skills for translation. Studies mentioned the use of formal interpreters, as well as family members being used as interpreters during consultations.

Interpretation not being available in the language spoken by the patient was noted as an issue, both with in-person interpretation (Decker et al, 2021; Ayers et al, 2018; Hughson 2018; Cioffi, 2003) and printed materials such as leaflets (Shorey et al, 2021). A lack of qualified interpreters also made it difficult for providers to interact with patients, as they wondered if the message would pass on to the woman properly and whether the interpreter was doing their job

effectively (Shorey et al, 2021; Hughson et al, 2018; Degni et al, 2012; Ng & Newbold, 2011). More specifically, many providers found having to use family members as interpreters to be concerning (Shorey et al, 2021; Delafield et al, 2020; Hassan et al, 2020; Otero-Garcia et al, 2013; Degni et al, 2012; Lyons et al, 2008), particularly due to issues with confidentiality, such as family members using information from consultation against the patient outside of the clinical setting, family members becoming decision-makers and "taking over" consultations, and family members themselves not being able to communicate properly (Delafield et al, 2020). Studies also discussed the problem of having the women's children serve as interpreters, who would not communicate as effectively as adults and did not know medical terms (Otero-Garcia, 2013; Degni, 2012).

> *"The worse cases are the use of kids as interpreters in meetings with the patients. To preserve their privacy, many women prefer to bring their kids to be interpreters in the examination. Using children as interpreters is as well worse as using non-medical interpreters, because in both situations, the physician patient's miscommunication and misinterpretations of the medical instructions might have great consequences. While medical interpreters or translators must be educated for medical interpreter career, they must speak fluently the language of the physician and that of the patient and must have an in-depth knowledge of medical terminology."*

Included studies highlighted providers' concerns that knowledge of medical terms was lacking with interpreters or interpretation applications/services (Oscarsson & Stevenson-Ågren, 2020; Akhavan, 2012; Ng & Newbold, 2011), which providers found frustrating (Degni et al, 2012). Having poor interpretation could also lead to mistrust (Akhavan, 2012), misunderstanding and miscommunication (Shorey, 2012), as well as losing nuances of information in conversation (Byrskog et al, 2015). A few studies highlighted the challenge of using male interpreters during consultations particularly because most women felt uncomfortable discussing female health

issues in the presence of a male and thus tended to withhold information from the provider (Shorey et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Ayers et al, 2018; Lyons et al, 2008).

Studies also mentioned that interpreters were sometimes inaccessible, and this was a barrier as interpreters are limited in number already (Delafield et al, 2020), and are not always able to come when needed, such as in emergencies or on when providers are on call (Cioffi, 2003). Sometimes interpreters are late or miss appointments (Lyberg et al, 2012). Interpretation services also created logistical issues such as extended time of consultations (Bains et al, 2021; Aquino et al, 2015; Byrskog et al, 2015), or having to rush consultations (Chitongo et al, 2021). Providers also stated that using telephone interpretation services as opposed to in-person services was more useful as it protected a woman's confidentiality (Ahrne et al, 2019; Lyberg et al, 2012).

5.2.2 Family Involvement

The theme of family involvement included the presence of many family members and their involvement in decision-making for women. The heavy involvement of family was a common change that providers had to adjust to and caused them to reflect on their cultural values of patients' independence and autonomy and be open to more collectivist ideas of family support and authority figures (husbands and mothers-in-law).

Studies from Norway, the UK, Finland, and the US mentioned the involvement of family causes issues during appointments and consultations. The theme of family involvement included articles mentioning family being present during consultations, and family speaking on behalf of

women. Some midwives found that when women brought their mother-in-law to the consultation, she would appear to dominate the conversation (Goodwin et al, 2017), which could negatively impact the relationship between client and provider. This could be because of the inability of providers to discuss confidential or private information in the presence of family (Larsson et al, 2016; Degni et al, 2012). Some providers such as midwives found it surprising and unsettling to see so many family members present with women in the delivery room (Bains et al, 2021; Ayers et al, 2018).

> *"And then because family is so involved, I think in the labor process, you know from my western mind, I think there's goods and bads to that. In one sense you have this incredible family support for this experience, and you have all your moms and your aunties and your sisters, and everybody's there just rooting for you for this amazing experience, which is wonderful. But at the same time, decisions around what to do during labor seem to be not the woman's own decisions, but whatever the family discusses and decides. And from my mind, and us in western culture, we feel like "Well, she should decide, it's her decision." But it seems to me that that's sort of a cultural normalcy"*

Articles that discussed family involvement emphasized that family members often became decision-makers for women or spoke on their behalf (Delafield et al, 2020; Hassan et al, 2020; Oscarsson & Stevenson-Ågren, 2020; Goodwin et al, 2017; McFadden et al, 2013 et al 2013; Otero-Garcia et al, 2013; Degni et al, 2012). Furthermore, some women allowed family members to speak for them during appointments, (Hassan et al, 2020) did not attend prenatal classes without their husband's approval or make decisions about treatment without his approval, as noted by studies conducted in Spain and Finland (Otero-Garcia et al, 2013; Degni et al, 2012). Husbands also tended to speak on behalf of their wives who would appear shy (Hassan et al, 2020).

"It does annoy me when the men interfere because then I think it is very difficult to find out [what] women actually feel like … when you have the man saying 'no, you are not doing this to my wife"

Within included studies, some providers mentioned that some women preferred to have their family members serve as interpreters during consultations, and providers did not feel comfortable with this since the family would often take over the consultation and start answering questions on behalf of the patient (Oscarsson & Stevenson-Ågren, 2020). In these situations, providers felt that women lacked the independence to make their own decisions and questioned whether a decision was truly made by the woman's free choice without pressure or influence from her family or in-laws (Delafield et al, 2020).

At the same time however, providers also recognized the important role that family could have in improving the relationship between patient and provider, as well as further understanding the cultural norms of the patient (Shorey et al, 2021). Therefore, in situations where patients were from a culture where male partners are not actively involved in the birthing process, providers made sure to involve the male partners as they acknowledged how familial bonds and support could improve the woman's experience (Shorey et al, 2021).

5.2.3 Lack of Health and Health System Awareness

The theme of lack of health and health system awareness related to women having limited knowledge of their own reproductive anatomy and physiology as well as how to navigate the healthcare system and how it operates.

Many studies stated that providers mentioned that women often lacked basic knowledge of female reproductive anatomy and physiology, including menstruation, pregnancy, and childbirth (Shorey et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Larsson et al, 2016; Lyberg et al, 2012), and sometimes providers had to explain to women in detail about their own bodies. Providers stated that ethnically diverse women were sometimes ignorant of how the health system of the host country operated (Bains et al, 2021, Simonardottir et al, 2021; Ahrne et al, 2019; Larsson et al, 2016; Boerleider et al, 2013). Providers within a few studies from the United States and the Netherlands found that women often also did not know what options were available to them, such as treatment options for perinatal depression (Ituralde et al, 2021) and home vs hospital birth (Boerleider et al, 2013). Providers speculated that having a lack of knowledge of the health system could be the causing factor in cultural dissonance and differing expectations of care (Boerleider et al, 2013). Midwives in a study conducted in Sweden believed it was the patients' responsibility to learn about the healthcare system and be familiar with the language, rather than help being provided to them (Akhavan, 2012).

5.2.4 Delays in care

The theme of delays in care referred to delays that arose as a result of women inadequately attending and following up with appointments. Furthermore, delays in care also resulted from beginning to seek care during the third trimester of pregnancy.

From the literature, providers mentioned that caring for ethnically diverse women could be time-consuming (Bandyopadhyay, 2021; Larsson et al, 2016) since they are already limited on time, and it can be difficult to understand their cultural needs in such a short time. It was also

difficult if patients did not show up to appointments on time, or missed them altogether (Bains et al, 2021; Shorey et al, 2021; Ayers, et al, 2018; Larsson et al, 2016; Otero-Garcia et al, 2013; Lyberg et al, 2012). Studies found that reasons for missing appointments included a lack of transportation or women having to rely on a spouse/partner to bring them to the appointment (Bains et al, 2021; Ayers, et al, 2018; Hughson et al, 2018). Additionally, some ethnic women were from cultures where there is no concept of booking appointments and they arrive at the health facility and wait to be called in (Goodwin et al, 2017).

Delays in care also occurred from women seeking care late in pregnancy which was mentioned by several studies (Ayers et al, 2018; Degni et al, 2012; Otero-Garcia et al, 2013; Lyons et al, 2008). Coming for a first appointment late during pregnancy made things stressful for providers who then had to quickly book tests and scans to ensure that the pregnancy was healthy, which meant they needed more time for appointments to learn about the pregnancy (Ayers et al, 2018). Some providers noted that some women did not show up to the clinic until very close to delivery (Degni et al, 2012; Lyons et al, 2008).

5.2.5 Limited Time and Resources

The theme of limited time and resources related to providers not being able to understand the health and emotional needs of women in the time frame of consultations. Providers also felt that working with ethnically diverse patients increased their workload in terms of time commitment, resources used and emotional and mental exhaustion.

Within included studies, several providers mentioned that they lacked sufficient time to adequately meet and understand patients' needs during consultations (Bandyopadhyay 2021; Larsson et al, 2016; Aquino et al, 2015; Akhavan, 2012). Furthermore, appointment times were usually fixed and could not be changed, and appointments with interpreters would take more time than was allotted (Hughson et al, 2018). Having delays in care such as missing appointments also made things difficult for providers, who were already short on time (Shorey et al, 2021). Some providers recognized a need for more time and resources to be able to better meet women's needs (Larsson et al, 2016). Some studies mentioned that even with interpreters present, there is not enough time to understand needs (Aquino et al, 2015), and often the amount of time required is doubled (Hughson et al, 2018). Many providers also faced difficulty when patients requested a female physician to carry out delivery, especially when a female physician was not available (Aquino et al, 2015; Lyons et al, 2008).

Providers within included studies felt that working with ethnically diverse women and migrant women often made their work more demanding and exhausting (Boerleider et al, 2013; Essen et al, 2011; Lyons et al, 2008) Reasons for this increased workload included language barriers (Chitongo et al, 2021; Boerleider et al, 2013; Lyons et al, 2008), women having insufficient knowledge of female health or the health system (Lyons et al, 2008) delays in care seeking (Ng & Newbold, 2011), and preferring to not have any form of pain medication during labour:

> *'The culture is that they are not into epidurals, only a few of them [ethnically diverse women] have epidurals. So it sounds really bad, but it is true when you have a full labour ward and you have two women, one with an epidural and the other one without the epidural, you spend more time with the woman with no epidural. The other one is happy*

> *there, smiling, talking. You have a student who is looking after her or if you haven't anybody you have a quick look ''Are you OK?'' and you go back to the woman that is shouting and breathing and pushing"*

Additionally, one study from the UK mentioned that some women tended to refuse to have C-sections in cases where they were needed, which would create an intense pressure environment for staff, who did not know what else to do (Essen et al, 2011). Additionally, some providers expressed that ethnic women are "too demanding" as they expected providers to take on tasks that were generally outside of their professional roles. For instance, women expected providers to book appointments for them or become babysitters (Ayers et al, 2018), or expected them to perform administrative tasks (Goodwin et al, 2017). Some women would also start demanding tests and interventions when they were not needed (Lyons, 2008).

5.2.6 Preference for a Female Provider

This theme presented the tension with male providers that arose when women expressed a preference, or even demanded a female provider to deliver their baby. Additionally, having the demand for a female provider when none was available could result in negative health outcomes.

A study conducted in Finland found that when women requested a female provider, this caused male providers to feel insulted and embarrassed by the situation (Degni et al, 2012).

> *"I have been in this medical profession for several years already, and no woman has ever refused my services because I am a man. I felt insulted and humiliated when the nurse told me that a patient said she does not want to come to the examination because I am a man. Her attitude was a shock to me, but there was nothing to be done about it, so I accepted it. As time passed, changes have taken place and now the same woman and others have started to come to me to be physically and gynaecologically examined. I must say that the changes have also become possible because of the nurses and midwives' good contacts and communication with these women."*

Women needing female providers stemmed from the discomfort of discussing female health issues such as sexual and reproductive health or menstruation with male staff (Degni et al, 2012). This however, could make it difficult for male providers to obtain gynecological history and decide what the best course of action to take is (Degni et al, 2012).

Within studies, providers found that it was difficult to provide care when the need for a female provider could potentially lead to negative health outcomes or adversely impact emergencies (Shorey et al, 2021). There were instances where patients would completely refuse to undergo a certain procedure or have their child delivered by a male provider (Degni et al, 2012; Ng & Newbold, 2011).

> *"Somali women should understand that if they are going to live in Finland, they have to accept medical services provided by male physicians because, there are more male gynaecologists in our Finnish hospitals and clinics than females" (F1).*

5.2.7 Cultural Conflicts

The theme of cultural conflicts included conflicting advice between patient's family and provider, different opinions of health between patient and provider, differing expectations of care, non-compliance to advice, and not feeling the need to seek maternity care services.

Providers in studies conducted in Norway, the United States, the United Kingdom, and Sweden expressed that difficult situations occurred when health advice was given to women from their families that conflicted with that given by their health providers (Bains et al, 2021;

Oscarsson & Stevenson-Ågren, 2020; Ayers et al, 2018; Hughson et al, 2018; Goodwin et al, 2017; Akhavan, 2012). Advice given by certain family members such as mothers-in-law tended to conflict with medical advice (Goodwin et al, 2017). Examples of where health advice differed include women's families wanting to wash the baby right after birth, whereas midwives would advise against this to prevent the baby from getting cold (Aquino et al, 2015). Another example included family advising women to remain inactive and less mobile during and after pregnancy, whereas midwives would encourage women to exercise (Bains et al, 2021). Family members would also bring unhealthy food for women after birth, such as carbonated drinks and oily foods for women after birth, which providers would disagree with (Ayers et al, 2018). Differing opinions on health also manifested outside seeking and taking advice. Providers sometimes disagreed with cultural and religious traditions such as placing honey in a newborn's mouth after birth, and fasting whilst pregnant (Goodwin et al, 2017). Some providers found it challenging to provide medical suggestions when women did not inform them that they were fasting (Hassan et al, 2020). Additionally, providers found it challenging to "get women moving" since South Asian women avoided much movement during pregnancy (Bandyopadhyay, 2021). While providers often disagreed with health advice or traditions practiced by family members, they found that they became more accepting of these traditions once they had more time to understand the family and patient's culture (Goodwin et al, 2017).

Included studies from the United Kingdom and one study from Sweden found that some patients did not comply with medical advice, which would cause frustration on the part of providers (Ahrne et al, 2019; Goodwin et al, 2017; McFadden et al, 2013 et al, 2013; Essen et al, 2011). For instance, midwives would advise women to go outside to get fresh air and get sunlight

to increase their vitamin D levels, however, most women remained inside and immobile (Goodwin et al, 2017). Some often ate too much or too little of what they were told by providers (Lyberg et al, 2012). Sometimes patients would claim that they would follow the advice in front of providers but then go home and follow their family's advice (Goodwin et al, 2017). Providers from a study conducted in the United Kingdom found that providers felt helpless in giving advice when they knew that family members such as grandmothers had a stronger influence on infant feeding than providers (McFadden et al, 2013).

The literature found that providers and patients had differing expectations of care, such as patients wanting to see specific care providers. For instance, some women preferred to be seen by midwives (Ng &Newbold, 2011), while many preferred to be seen by physicians such as obstetricians (Shorey et al, 2021; Ng & Newbold, 2011). This was due to the perception of obstetricians as having more training and therefore a higher standard of care compared to nurses and midwives (Ng & Newbold, 2011), and many women were not confident or knowledgeable about the qualifications and role of midwives (Goodwin et al, 2017). Women were often unsure and surprised when care was delivered by midwives (Boerleider, 2013). In certain countries, midwives are not qualified professionals and serve as women in the community who attend to births (Ng & Newbold, 2011). A Canadian study found that some women also held the same attitude towards nurses as well (Ng & Newbold, 2011). Similarly, the notion of interdisciplinary teams was foreign to ethnic women, who desired to be seen by obstetricians, thus rejecting care from any other care provider (Ng & Newbold, 2011).

Differing expectations of care also were present when both providers and patients expected the other party to take initiative in certain situations. For example, providers often expected patients to bring an interpreter with them to the appointment, whereas patients expected that a translator would be provided for them (Ng & Newbold, 2011). Another example of this included when providers expected patients to express if they had any cultural preferences, when in fact patients did not openly express these preferences and expected that providers would investigate this themselves (Ng & Newbold, 2011). Furthermore, patients were not as open in expressing their preferences and providers did not realize that this is something they should seek information about, given the limited time of consultations (Ng & Newbold, 2011). Similarly, providers expressed frustration when women would not be mobile and expect the providers to take care of the baby instead of taking care of the baby themselves (McFadden et al, 2013).

"What I suspect is that if an immigrant woman had certain particular cultural birthing desires, she probably wouldn't have the gumption to share them with you because she would suspect that you would say either, 'No', or that you might think they were silly."

Providers in Sweden also had to spend quite a bit of time explaining the reasoning for certain aspects of the patients 'care, which sometimes led to patients feeling dissatisfied if the care clashed with what they were accustomed to in their home country (Oscarsson & Stevenson-Ågren, 2020). A lack of knowledge of the healthcare system also led to cultural clashes and expectations in care (Shorey et al, 2021). Some women expected a high frequency and number of medical tests, whereas others did not want much treatment or medical care at all during pregnancy (Shorey et al, 2021). Some providers expressed a desire to be more educated

regarding different cultures and traditions, however, most, often did not want to accommodate those traditions (Simonardottir et al, 2021). Furthermore, one study found that Asian and Latina women were not forthcoming with regards to perinatal depression due to stigma, the need for privacy, not prioritizing their depression, and viewing it as a "white woman's disease" (Ituralde et al, 2021).

Many women also do not seek medical care during pregnancy, much to the dismay of providers. Some ethnic women believe there is no need to seek care as they do not view pregnancy as a sickness that needs treatment (Goodwin et al, 2017; Otero-Garcia et al, 2013). Others do not think that seeking care will make any difference as everything in their view, is up to God's will. Some view prayer as the only way to recover (Chitongo et al, 2021), whereas others give complete refusal for certain procedures such as cesarean section, responding that everything is up to God's will (Essen et al, 2011). In included studies, providers felt that women should be willing to compromise in situations where their health may be at risk (Shorey, 2021).

5.2.8 Creation of Stereotypes

The theme of creation of stereotypes referred to stereotypes that propagated amongst providers both willingly and unwillingly, as well as unconscious biases that were formed towards patients.

Several studies mentioned that providers often had stereotypes of the ethnic women they interacted with. For example, a notable stereotype of black women was that they were strong and could manage pain well or did not need pain relief since they viewed childbirth to be a

completely natural process (Ahrne et al, 2019; Puthussery et al, 2008). Some providers view patients as being passive, particularly in instances where they do not speak much (Simonardottir et al, 2021). Similarly, South Asian women were expected to have a lower pain tolerance (Puthussery et al, 2008). Other stereotypes of women from certain ethnicities such as Micronesian women were that they do not know English, do not space out their children well, come to seek care immediately after landing and are non-compliant (Delafield et al, 2020). Additionally, some providers mentioned that they view these women to come with many diseases, making them less inclined to care for the patients (Delafield et al, 2020).

In addition to describing stereotypes, providers also expressed that they recognized that they had unconscious biases towards certain patients and could not help but create a stereotype based on the limited knowledge they had of a certain group (Delafield et al, 2020).

> *"I think that it's a challenge for a lot of the staff, nursing and residents included . . . to try to not group all Micronesians together, and I try to be very conscientious about what I say about patients. And a lot of times I feel like . . . we get very jaded, and we see a certain name or we see a certain ethnicity and we start assuming things that will happen, or start assuming things about the patient even before we've met the patient. And I try to be very conscientious about that, but I'm sure that subconsciously, sometimes I assume things about patients that are not true"*

5.2.9 Prejudice and Superior Thinking

Some studies found that providers rationalized their refusal or lack of acceptance of certain cultural practices based on their view of western values as being superior (Simonardottir et al, 2021; Hickey et al, 2019). For instance, in Iceland, providers felt that certain cultural practices did not align well with gender equality, and thus outright rejected them, such as having to ensure a female provider would deliver a baby or care for a woman in her pregnancy

(Simonardottir et al, 2021). A study on indigenous women and providers found that some providers dismissed cultural practices, claiming that they were "confusing" (Hickey et al, 2019).

5.2.10 Motivation to help Ethnically Diverse women

Despite the numerous challenges providers expressed in caring for ethnically diverse women, some mentioned that they were willing to help women of different backgrounds. This was in the form of taking steps to improve their relationship with women through kind demeanour and approaches to understanding the women's culture.

It was apparent in the included literature that most providers who discussed forming and keeping a relationship with women included midwives and nurses. Many stressed the importance of establishing a sound relationship with women (Goodwin et al, 2017; Oster et al, 2016; Degni et al, 2012; Cioffi, 2003), and being empathic and respectful (Cioffi, 2003). Some mentioned strategies they used in fostering a caring relationship, such as assessing a woman's understanding of pregnancy and childbirth from the beginning to determine how much information they needed (Oscarsson & Stevenson-Ågren, 2020). A study from Canada found that providers attached meaning to forming relationships, which were done by, "treating them like a friend", "acknowledging their victories", "being open and honest", "being non-judgemental", "using a lot of humour", "building rapport, "focusing on the positives" and "asking open-ended questions" (Oster et al, 2016).

> *"I think the biggest thing is just trying to create that relationship with the moms. I know they are hesitant accessing health care. They may have had poor or bad experiences with*

other nurses… We don't know that patient's story. That's probably the first thing you could do is ask them. Not about why they're there at their appointment, but to try to talk to them and create a conversation. Ask them about who they are, about their family, and really try to get to know them… Really just being open to whatever they bring to us and talk about that first."

Midwives within studies mentioned the importance of listening to and understanding women, which could lead to establishing a good relationship (Chitongo et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Akhavan, 2012). Additionally, understanding and facilitating women's choices was also important. For instance, some women from various cultures give birth in different positions, and providers mentioned that they were happy to facilitate this (Akhavan, 2012).

"It is important to let the immigrant woman herself say what she needs and that the midwives then follow up on these needs and try to make the meeting a positive experience"

The topic of trust was also brought up in several studies (Shorey et al, 2021; Oster et al, 2016; Akhavan, 2012; Degni et al, 2012; Edge, 2010), and that this could result in healthier pregnancies (Oster et al, 2016). However, providers also noted that there were obstacles in establishing trust, such as fear from immigration authorities, as well as distrust in the healthcare system (e.g., conduction of X-rays for recently immigrated pregnant women) (Akhavan, 2012).

Providers also found it important to tailor the care to meet women's needs. This could be in the form of tailored plans and providing support outside of medical care, such as with housing (Aquino et al, 2015). Additionally, paying attention to the woman, and being mindful of certain values (e.g., modesty and privacy while breastfeeding, doing prayers during labour) was mentioned to be important in meeting women's needs (Hassan et al, 2020). Moreover, providers felt a sense of commitment to providing equitable care, regardless of their clients' or patients' ethnic background or immigration status (Chitongo et al, 2021; Aquino et al, 2015; Akhavan, 2012), and did not wish to promote policies that reduced access to care, such as out of pocket expenses for women without immigration status.

Some providers also took the initiative to adapt their communication style to accommodate ethnically diverse women. For instance, some decided to learn new words in their patient's language to help ease the communication (Ayers et al, 2018; Hughson et al, 2018; Byrskog et al, 2015; Cioffi, 2003). Another approach that providers took was easing their way into intimate topics such as sexual health and reassuring women that they are asking such questions to help them get better (Mengesha et al, 2018).

> *"Generally, no one likes talking about that area of their health. So, the way I do it is prepare them first, that I would like to ask them these questions, and give them a benefit to answering those questions for themselves. So for example, I ask this for your health. I want to make sure you're all right. There is a positive in it for them."*

Furthermore, when discussing perinatal depression, providers avoided the use of stigmatizing words such as mental health, and rather, focused on discussing feelings, emotions, and physiology (Ituralde et al, 2021). Providers made efforts to reduce loneliness and social isolation amongst ethnic women by organizing weekly activities or group meetings to meet other women of similar ethnicities (Shorey et al, 2021). Some providers verbalized that they felt it was their responsibility to learn more about different women's cultures (Akhavan, 2012). Providers also mentioned that they found working with ethnically diverse women to be meaningful (Lyons et al, 2008).

5.2.11 Cultural Sensitivity Training and Education

The theme of cultural sensitivity training and education related to providers lacking formal education or learning on cultural sensitivity and/or cultural practices, working with ethnically diverse patients, and their expressed desire to have more education in this area.

A very common idea that emerged was that providers felt unequipped and unprepared to care for ethnically diverse women (Ituralde et al, 2021; Hassan et al, 2020; Oscarsson & Stevenson-Ågren, 2020; Mengesha et al, 2018; Oster et al, 2016; Akhavan, 2012;). Several stated that they lacked cultural understanding and knowledge of different birthing traditions and practices, and this was mentioned regarding Somali women (Byrskog et al, 2015), Caribbean culture (Edge, 2010), and indigenous women's health (Oster et al, 2016). Midwives expressed that their knowledge was lacking and that they wanted to learn more (Oscarsson & Stevenson-Ågren, 2020). Some also mentioned that they did not know where to seek this knowledge (Oster et al, 2016). Midwives and other health providers highlighted the need for additional training

(Shorey et al, 2021; Ituralde et al, 2021; Akhavan, 2012) in areas such as cultural diversity or sensitivity (Akhavan, 2012), and a focus on migrant health instead of simply indigenous health (Mengesha et al, 2018). Some providers mentioned that education should be given in the form of university courses (Hassan et al, 2020; Mengesha et al, 2018). On the contrary, other providers did not want to learn more about ethnic women in the form of further training (as this might increase their workload), but rather, wanted increased opportunities to engage with ethnic women and their communities to learn through experience, as well as opportunities to reflect on their experiences with other healthcare providers through group discussion (Hassan et al, 2020). Some mentioned learning about both cultural differences and approaches to take when interacting with diverse populations (Hassan et al, 2020). Others mentioned the opportunity for interdisciplinary collaboration and working with different organizations to ensure holistic care (Shorey et al, 2021).

CHAPTER 6: DISCUSSION

6.1 Review of Findings

This scoping review aimed to describe and synthesize the experiences of HCPs in delivering maternity care to ethnically diverse women. The included literature had studies that discussed both immigrant women and women of diverse ethnicities. This review found 11 themes, out of which 10 were barriers and 1 was an enabler. The barriers were categorized as *logistical* (communication difficulties; limited time and resources; delays in care, and preference for female providers), and *cultural* (cultural conflicts; family involvement; lack of health and health system awareness; the creation of stereotypes, prejudice and superior thinking; and lack of cultural sensitivity education and training). The only enabler pertained to HCPs' motivation to help ethnic women and improve relationships.

While HCPs in included studies mentioned logistical and cultural barriers, this review found that collectively, cultural barriers were more salient and were reported to have a greater impact on improving HCP-patient relationships. This finding suggests that addressing cultural barriers such as different expectations of care may improve the HCP-woman relationship and reduce logistical barriers. For example, by taking time to understand patient expectations and needs (i.e., addressing different expectations in care), HCPs may require less time in future medical consultations (i.e., addressing limited time and resources). Similarly, HCPs who implement cultural safety and culturally sensitive care may increase patient trust, which may increase patients' willingness to attend appointments and follow medical advice (i.e., delays in care).

The findings suggest that within included studies, many HCPs expected ethnically diverse women and migrant women to behave according to the societal norms of their host country. However, it is impractical for HCPs to expect that all individuals from various ethnicities will behave according to the cultural norms and etiquettes of the dominant society. Rather, HCPs may benefit from acknowledging the challenges in providing care to ethnically diverse women and the cultural values that may influence their behaviour. There is also a need to equip HCPs with the knowledge, skills, and resources to care for ethnically diverse patients in a manner that meets patients' needs and emphasizes compassion and cultural sensitivity.

In the following sections, I will compare the findings of this review with extant literature, particularly the literature on women's experiences in maternity care. I will use concepts such as cultural safety, cultural humility, and woman-centred care to emphasize how models of care can or should be integrated to provide care that is appropriate and meets the diverse needs of ethnically diverse women, including immigrants. I will also recommend a paradigm shift from cultural competency to cultural sensitivity. Finally, I will identify some implications of this research for practice and policy and list the limitations of this study.

6.2 Factors that promote strong HCP-women Relationships

The findings of this review found that establishing relationships through creating rapport, giving women choice, listening to their needs, and tailoring care was present in HCPs' perspectives. These approaches are consistent with similar research on improving HCP-women relationships within women's health and obstetrical care. Studies from Canada have highlighted the need for establishing a positive relationship with ethnically diverse women (Filler et al,

2020a) through shared decision-making during medical consultations (Filler et al, 2020a; Nyhof et al, 2020), engaging in active listening and bi-directional information exchange (Nyhof et al, 2020). Creating a relationship grounded in trust, and tailoring care to meet women's needs was also mentioned as being important for improving the HCP-woman relationship (Dong et al, 2022). The findings of this review suggest that HCP's willingness to provide care for ethnically diverse women is grounded in concepts that aim to improve HCP-women relationships such as cultural safety and humility, patient/person-centred care, and woman-centred care. The findings of this review also emphasize a greater need to integrate such concepts within clinical practice.

6.3 Patient and Woman-Centred Care

Patient-centred care is care that is "compassionate, empathetic, and responsive to the needs, values, and expressed preferences of each patient" (Baker, 2001). A study on clinicians' perspectives on implementing patient-centred care for ethnically diverse women included seeking permission from women before touching them, using a relaxed posture, and a non-judgemental tone (Filler et al, 2020b). Similarly, woman-centred care involves allowing women to define their individual and cultural needs, giving women autonomy in decision making and ensuring continuity of care (Fontein-Kuipers et al, 2008). Woman-centred care can be defined as care that "focuses on the woman's unique needs, expectations and aspirations; recognizes her right to self-determination in terms of choice, control and continuity of care, and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations (Davis et al, 2021). The concept of woman-centred care comes from patient-centred care but has been framed to be more appropriate for women's health and maternity care (Fontein-Kuipers et al, 2018).

The concept of woman-centred care is heavily prevalent within midwifery practice (Fontein-Kuipers et al, 2018). There are intuitive reasons why Woman-Centred care is more relevant for midwifery compared to obstetrical care. For example, midwifery care involves a one-on-one relationship with midwives and clients, including care for all parts of pregnancy including birth and postnatal care, for up to 6 weeks after birth, with visits to the woman's home. Midwifery care also incorporates emotional and psychological support (ten Hoope-Bender et al, 2014). In contrast, obstetrical care normally involves less time with the obstetrician and less one-on-one interaction compared with midwives. The difference in clinical care between midwives, nurses and obstetricians was critical to consider for my findings since midwives generally have more time and opportunity to build a relationship with patients compared to physicians, which may mean that midwives may have more opportunity to learn and address the diverse needs of ethnically diverse women. However, the findings of this study reported challenges for midwives in achieving woman-centred care such as their care being rejected by ethnically diverse women who view non-physician care as sub-standard (Ng & Newbold, 2011). Fostering trust in midwives, nurses, and other non-physician HCPs may address these barriers, and ultimately improve both outcomes and experiences of care. In the next section, I will discuss strategies and approaches that can integrate woman-centred models of care.

6.4 Integrating Woman-Centered Models of Care

Despite the challenges experienced by midwives and nurses in this review, there is potential to improve and further integrate woman-centred care in clinical practice. This can be done by implementing models such as midwifery-led continuity of care models and Centering Pregnancy, which are grounded in the principles of woman-centred care. Some studies suggest

that midwifery-led continuity of care models, where the midwife is at the forefront of care for low-risk pregnancies, improve patient satisfaction and health outcomes (i.e., decreased cesarean sections, induced labour, and instrument-based deliveries) compared to obstetrical-led care (Sandall et al, 2016). Improving the use and practice of midwifery-led continuity of care models can reduce the medicalization of childbirth and increase patient satisfaction (ten-Hoop-Bender, 2014). Despite the beneficial outcomes of models of midwifery-led care, it continues to be undervalued in middle- and low-income nations (Filby et al, 2016), where many ethnically diverse women originate from. Furthermore, this is often due to unregulated midwifery practice, which has a much lower standard of care compared to that in high-income nations (Michel-Schuldt et al, 2020). Thus, providers need to reframe the perception of midwifery that women carry from their home countries. Moreover, there is potential to change the perceptions of midwifery amongst various populations. Interprofessional collaboration with different maternal health HCPs can increase the visibility and acceptance of midwifery care (Reszel et al, 2018).

A novel maternity care model in the Netherlands and the United States called Centering Pregnancy involves group learning led by a midwife, obstetrician, and co-facilitator, which contrasts with the traditional model of one midwife per client (Rijnders et al, 2018). Within the Centering Pregnancy model, group learning occurs across prenatal care and involves education and peer support (Rijnders et al, 2018). The model has resulted in improved psychosocial outcomes, decreased premature birth, and has been an effective approach for delivering maternity care for vulnerable groups such as ethnically diverse women (Rijnders et al, 2018). A study from the United States on the experiences of underserved women (including ethnic minorities) with the Centering pregnancy model found that women rated their care as 9 out of 10

(Liu et al, 2016). The Centering Pregnancy model is an example of how woman-centred models can improve the experience and outcomes of care for ethnically diverse women in different maternity settings. However, there is a need for further research on how to increase the awareness and acceptance of midwifery care in culturally diverse populations.

Since ethnically diverse women do not tend to seek midwifery care, it might be useful to integrate woman-centred care in healthcare settings such as primary healthcare facilities and obstetrical care departments within hospitals. Additionally, there is a need to advocate for midwifery-led care within primary health settings so that there is more awareness of midwifery, which can lead to ethnically diverse women changing their perceptions of midwifery care.

6.5 Cultural Sensitivity Training

One prominent barrier found in this review was the lack of cultural education and training for HCPs. While HCPs expressed the desire to learn more about the cultures and practices of their patients, they mentioned that they did not have access to the knowledge or resources to treat patients of diverse backgrounds. While some HCPs wanted to have this knowledge in the form of university courses, others preferred hands-on learning experiences with ethnically diverse patient groups such as indigenous women.

The findings of this review noted that some HCPs expressed a need for training and courses on different ethnic groups to increase their knowledge and cultural competency. Cultural competency relates to “understanding the importance of social and cultural influences on patients’ health beliefs and behaviours; considering how these factors interact at multiple levels

of the health care delivery system" (Betancourt et al, 2003). Cultural competency interventions may include workshops and training for health professionals and culturally modified education programs for patients (Truong et al, 2014). Among the interventions used to increase cultural competency, most studies have focused on HCP knowledge of individual cultures, and few research studies have assessed the effectiveness of such interventions regarding patient health outcomes and experiences (Truong et al, 2014).

Despite the widespread use of cultural competency in medical education, cultural competency has been viewed as a rigid and limited way to treat ethnic patients (Curtis et al, 2019). Claiming that HCPs can be "competent" in-cultural values, norms and practices implies something achievable – perhaps easily through seminars and courses – and that it is as simple as ticking off an item on a checklist (Curtis et al, 2019). On the other hand, HCPs who lack knowledge of different cultures may be labelled as "incompetent" (Abe, 2020). As a strategy to increase cultural competency, cultural profiles of specific ethnic groups have been formulated and kept as a resource in healthcare settings; however, this has led to a surface-level understanding of communities that have diverse needs and preferences, which contain an immense amount of diversity within and between them (Grewal et al, 2008). Furthermore, using cultural competency can lead to stereotyping of ethnic patients; where they are framed as the root of the challenges in patient-HCP interactions (Curtis et al, 2019). Previous studies on cultural competency training have found such training ineffective (Jowsey, 2019; Handtke et al, 2019). For example, a scoping review by Deliz and colleagues on the types of cultural training in medical education found that most articles in their study included education about specific ethnic populations rather than cultural diversity in general (Deliz et al, 2019). Most of these studies

were published in the United States, Canada, Australia, Romania, Germany, New Zealand, and Russia (Deliz et al, 2019). Findings from Deliz and colleagues indicate that although cultural competency has been criticized for being impractical and ineffective, many training initiatives still adopt this approach for medical education.

Within the literature of the present scoping review, HCPs stated the need for *cultural sensitivity* training rather than cultural competency training because the latter might cause further stereotyping, segregation, and prejudice (Shorey, 2021). This idea is supported by research that suggests that cultural competency, which mostly involves learning about different cultural customs, is insufficient for meeting HCPs' needs for treating ethnically diverse women, and cultural sensitivity or safety may be more effective and appropriate (Curtis et al, 2019; Jowsey et al, 2019).

HCP's willingness to create, foster, and maintain a positive relationship with ethnically diverse women is the first step in cultivating culturally sensitive care. Practicing concepts such as cultural humility and safety may be useful for grounding HCP interactions with diverse populations. Cultural safety refers to the support of patients in a manner where they do not feel inferior to the provider and where their culture is respected and embraced (Parisa et al, 2016). Cultural humility is defined as "a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals" (Foronda et al, 2016). Cultural humility and safety involve continuous reflection by HCPs that aim to harmonize power imbalance between them and their patients (Abe, 2019). These concepts require HCPs to be reflexive in their assumptions, biases, and privilege by examining how these

elements can impact their relationship with patients (Curtis et al, 2019; Grewal et al, 2008). Reflexivity involves questioning one's view of the environment and adapting ways of viewing or knowing based on novel perspectives or information (Liberati et al, 2015). The reflexivity of HCPs should focus on nurturing a relationship that embraces, appreciates, and understands cultural values and beliefs. It is important to first acknowledge and reflect on one's own culture and beliefs, and how these might influence the perception of other beliefs and is vital in establishing culturally sensitive and respectful communication (Brooks et al, 2019). Grounding maternity care in cultural humility and safety can address the cultural barriers that women face when receiving maternity care found in this review, such as stereotyping, superior thinking, and prejudice.

Studies have proposed different models for cultural sensitivity training and interventions; however, no training models to date focus on cultural sensitivity for women or in the context of maternity care. The findings of this review suggest that rather than focusing on specific details of pregnancy customs and traditions of different cultures, cultural sensitivity training for maternity care may include aspects of culture that apply to women of many different cultures, such as expressing a preference for female HCPs, expressing shyness when discussing sexual and reproductive health, having cultural practices during and after birth, involving family members in consultations and decision making, acknowledging the role of religion during pregnancy and childbirth, recognizing women's need for modesty and privacy during consultations and/or during and after birth, and understanding different perceptions of pregnancy and birth. Furthermore, understanding and respecting certain cultural values such as distanced gender interactions between men and women and the need for modesty, accommodating aspects of

religion and culture such as prayer, and customs performed on the newborn can increase a woman's level of comfort within the clinical setting. Taking the time to understand these customs will allow providers to change their perceptions of what is considered harmful to the infant's and mother's health and adapt their approaches in clinical practice to tailor care for diverse women. In addition to learning about the needs of women of different cultures, it is important to also train health professionals in communication styles with different ethnic groups. This includes making the family familiar with the hospital environment and healthcare system to prevent any uncertainties, doubts, or fears about treatment (Brooks et al, 2019). Furthermore, providers should take the initiative and ask about cultural and religious preferences upfront, communicate these to other providers and demonstrate that they consider the individual and family's cultural needs as their priority (Brooks et al, 2019). Providers should also motivate patients and family members to be involved in decision-making to whatever extent they feel comfortable (Brooks et al, 2019).

6.6 Implications for Policy and Practice

HCPs in western nations such as Canada, the US, Australia, New Zealand, and the European Economic Area, require support within their workplaces and organizations to better support patients of diverse cultures. Structural changes are necessary for increasing resources and support for HCPs. The findings of this scoping review suggest focusing on cultural sensitivity as the goal within all healthcare settings that provide maternal healthcare. This can be achieved through programs and employee training. Studies have suggested that human resources can play a role by changing their policies to include employee training on cultural sensitivity and patient/woman-centred care (Castillo et al, 2011). Such training has been effective in Switzerland

(Handtke et al, 2019). In Canada, there have been cultural ambassador programs which involve individuals being highly trained in cultural sensitivity and liaisons between providers and patients (Handtke et al, 2019). Furthermore, increasing the quantity and accessibility of professional, female language interpreters can improve patient-HCP encounters for women who do not prefer to discuss female health issues in the presence of male language interpreters. Moreover, having professionals working in interdisciplinary teams may provide a greater opportunity to provide holistic care since some team members may have more cultural awareness or knowledge and can assist others in the team (Brooks et al, 2019). Having connections with communities, such as cultural and religious organizations and women's health advocacy groups may provide information about different cultures (for HCPs) and how the health system operates (for patients). Increasing collaboration between healthcare services and cultural groups or patient partners can improve awareness of cultural needs and approaches to take when encountering diverse populations within health services, as recommended by the WHO (WHO, 2015). Increasing resources can potentially reduce the logistical barriers that HCPs face, such as language difficulties, difficulties with interpreters, and limited time and resources. Increasing the type, quality, and quantity of support for HCPs can make consultations go more smoothly, reduce delays and logistical issues in treatment, decrease frustration on the part of HCPs, and increase patient satisfaction and health outcomes for women.

6.7 Future Research Priorities

Based on the search conducted, most publications included in this review were from the perspectives of midwives, which presents a need to conduct further research on the perspectives, barriers/enablers and needs of other maternity providers such as OBGYNs, since the role, setting

and care delivery of OBGYNs and midwives differ considerably. Furthermore, there were several studies focused specifically on Somali women, a few on Pakistani women, and some on Indian/Bangladeshi women. Therefore, it might be pragmatic to conduct research on providers' experiences with women from Asian or East Asian countries, as well as other countries in Africa. Further research on healthcare providers' perspectives on cultural sensitivity education within medical curricula and the work environment of providers is needed, as well as how well cultural sensitivity has been embedded within healthcare settings.

6.8 Study Strengths

This scoping review has several strengths. Firstly, it synthesizes research on different healthcare providers' experiences which indicate that the barriers that are sometimes present with ethnically diverse women are experienced by different types of providers, and therefore, similar implementation efforts can be made to address these challenges for various professionals and in various settings. Secondly, this review also highlights barriers that are logistical as well as cultural in nature. Logistical barriers are often the result of limited time and resources, and these are often exacerbated by cultural dissonance and vice versa. Therefore, by increasing the number of resources and supports for providers, logistical barriers can be addressed and more time and effort can be placed into understanding patients' cultural needs. Similarly, by emphasizing open dialogue regarding cultural and personal needs with patients, future logistical barriers such as patients not coming to their appointments or using more time than needed can be addressed.

6.9 Limitations

This study has two limitations. First, while this study analyzed international literature of western nations on HCP challenges in providing maternity care to ethnically diverse women, a primary qualitative study through interviews might offer a deeper and more relevant understanding of the needs of health staff in certain contexts. However, due to the covid-19 pandemic, HCPs became increasingly busy with covid-19 related work, and health organization and hospital priorities shifted towards covid-19, making it difficult for providers to allocate time towards research. Another limitation is that while this scoping review offers broad findings from the international literature, it is difficult to provide recommendations for providers within specific countries because of differences in health system structure and social norms. Therefore, while the results of this study may offer a starting point, it is important to research strategies that can achieve cultural sensitivity in clinical practice within countries and in specific contexts.

CHAPTER 7: CONCLUSION

This study aimed to describe and synthesize the experiences and perspectives of HCPs in delivering maternity care to ethnically diverse women. A total of 32 studies were included in this review. From the findings, 11 themes were generated, which were: communication difficulties, family involvement, delays in care, lack of health and health system awareness, limited time and resources, preference for female providers, cultural conflicts, creation of stereotypes, prejudice and superior thinking, lack of cultural sensitivity and training, and motivation to help ethnically diverse women. The findings suggest that there are several common challenges that providers experience with women from various ethnic backgrounds. Thus, it might be useful to explore strategies to involve collaboration between ethnically diverse women and health service providers in creating tailored maternity care programs and services in a manner that is suitable given providers' resources and time. This review also found that while woman-centred models may be better implemented within midwifery practice, cultural sensitivity training may be useful for other HCPs such as OBGYNs and general physicians, who may not have the time to properly learn the needs of women. Nonetheless, cultural sensitivity training should be given to all healthcare providers as standard practice, however, should be tailored for maternal healthcare. To conclude, there may be a need for research in investigating providers' conceptualization and practice of concepts such as patient-centred care, woman-centred care, cultural sensitivity, safety, and humility.

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APPENDICES

Appendix A

Search strategy (used in OVID MEDLINE)

Type of Care Search

1. midwi*.tw,kf,kw.
2. obstetric*.tw,kf,kw.
3. gynaecolog*.tw,kf,kw.
4. gynecolog*.tw,kf,kw.
5. maternity.tw,kf,kw.
6. maternal health*.tw,kf,kw.
7. reproductive health*.tw,kf,kw.
8. maternal health services.tw,kf,kw.
9. "maternal and child health".mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
10. pregnan*.tw,kf,kw.
11. Parturition/
12. Delivery, Obstetric/

Patient Population Search

13. Ethnic Groups/ or Minority Groups/
14. ethnic minorit*.tw,kf,kw.

15. minority group*.tw,kf,kw.
16. immigrant*.tw,kf,kw.
17. emigrant*.tw,kf,kw.

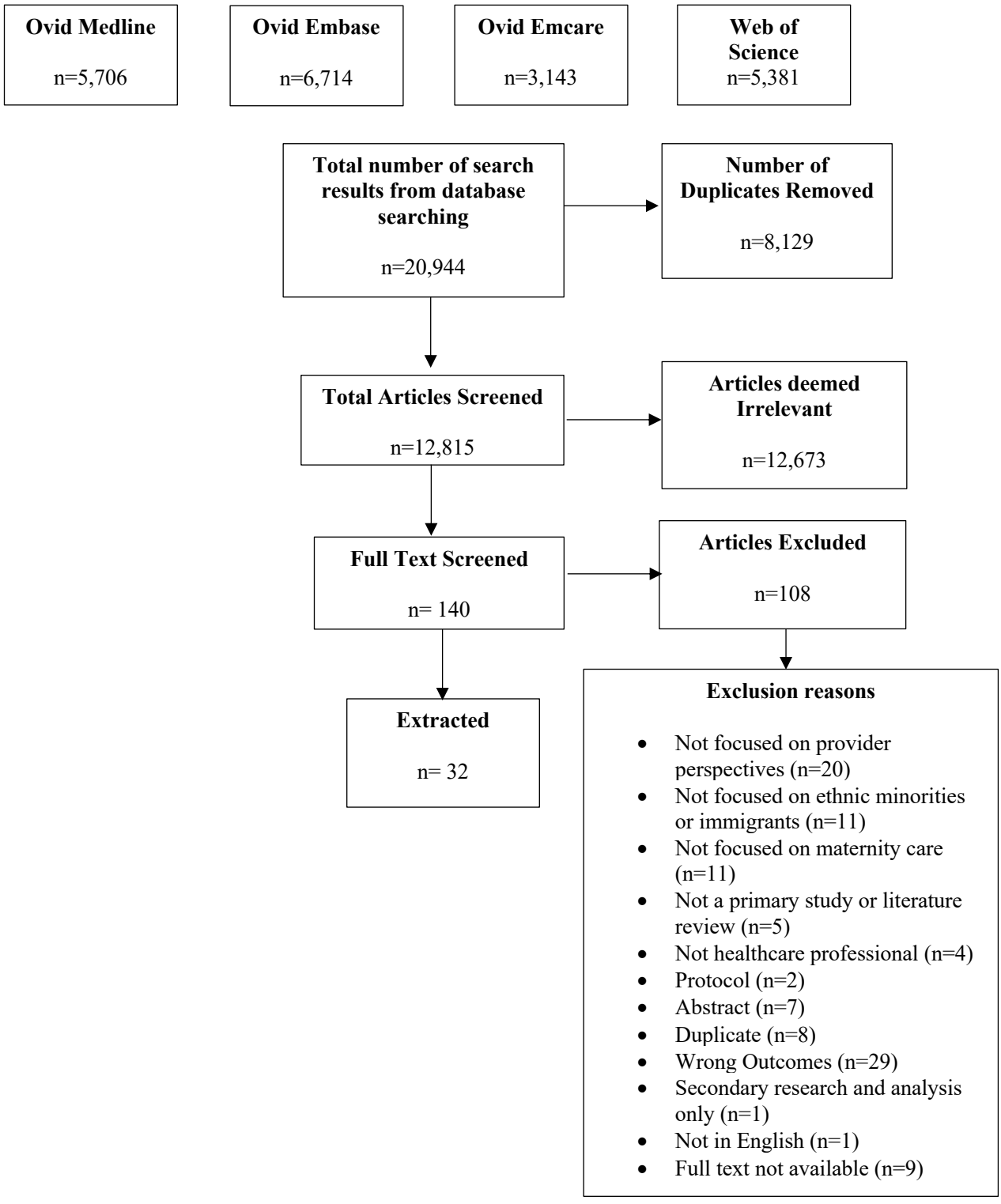
Cultural Sensitivity Search

18. cultural* diversit*.tw,kf,kw.
19. cultural* sensitivit*.tw,kf,kw.
20. cultural* competen*.tw,kf,kw.
21. cultural* aware*.tw,kf,kw.
22. minority population*.tw,kf,kw.

Appendix B

Figure 1

PRISMA Diagram



Appendix C

Table 2

Methodological Characteristics

Author year	Methodology, Approach	Data Collection Methods	Number and Type of Participants	Ethnic Group
Ahrne et al, 2019	Qualitative, thematic analysis	Focus groups	7 midwives	Somali
Akhavan, 2012	Qualitative, not specified	Semi-structured interviews	10 midwives	Migrant women in general
Aquino et al, 2015	Qualitative, thematic analysis	Semi-structured interviews	20 midwives	Black and ethnic minority
Ayers et al, 2018	Qualitative, phenomenology	Semi-structured interviews, focus groups	13 nurses, 3 OBGYN	Marshallese women
Bains et al, 2021	Mixed-methods, thematic analysis	Semi-structured interviews	7 midwives	Migrant women in general
Bandyopadhyay, 2021	Qualitative, ethnography	Semi-structured interviews	8 nurses, 6 OBGYN, 4 dieticians, 3 endocrinologists	South Asian immigrant women
Boerleider et al, 2013	Qualitative, not specified	Semi-structured interviews, focus groups	21 midwives	Migrant women in general
Byrskog et al, 2015	Qualitative, thematic analysis	Semi-structured interviews	17 midwives	Somali
Chitongo et al, 2021	Qualitative, thematic analysis	Semi-structured interviews	20 midwives	Migrant women in general
Cioffi, 2003	Qualitative, interpretive description	Semi-structured interviews	23 nurses, 12 midwives	Migrant women in general
Decker et al, 2021	Qualitative, thematic analysis	Semi-structured interviews, focus groups	15 nurses and medical assistants	Latina
Degni et al, 2012	Qualitative, qualitative description	Semi-structured interviews, focus groups	10 OBGYNs, 7 nurses, 8 midwives	Somali
Delafield et al, 2020	Qualitative, framework analysis	Semi-structured interviews	13 OBGYNs	Micronesian
Edge, 2010	Qualitative, framework analysis	Semi-structured interviews, focus groups	27 midwives, 5 health visitors, 2 hospital physicians, 3 third sector employees	Black and ethnic minority
Essen et al, 2011	Qualitative, anthropological analysis	Semi-structured interviews	62 OBGYNs	Somali
Larsson et al, 2016	Qualitative, thematic analysis	Semi-structured interviews	10 midwives, 3 physicians	Migrant women in general

Goodwin 2017	Qualitative, ethnography	Semi-structured interviews	11 midwives	Pakistani
Hassan et al, 2021	Qualitative, thematic analysis	Semi-structured interviews	7 midwives, 2 nurses, 2 support workers, 1 sonographer	Muslim
Hickey et al, 2019	Qualitative, participatory action	Semi-structured interviews	13 service delivery staff, 8 managers	Indigenous – Aboriginal and Torres Strait Islander women
Hughson et al, 2018	Qualitative, case study	Semi-structured interviews	7 midwives, 5 OBGYNs, 5 physiotherapists, 1 social worker, 1 occupational therapist	Culturally and linguistically diverse women
Ituralde et al, 2021	Qualitative, not specified	Semi-structured interviews	6 OBGYNs, 1 primary care physician	Asian, Black, Latina
Lyberg et al, 2012	Qualitative, content analysis	Focus groups	5 midwives, 1 nurse	Migrant women in general
Lyons et al, 2008	Qualitative, grounded theory	Semi-structured interviews and focus groups	15 OBGYNs, nurses and midwives	Migrant women in general
McFadden 2013	Qualitative, not specified	Semi-structured interviews	4 practitioners	Bangladeshi
Mengesha 2018	Mixed-methods, thematic analysis	Semi-structured interviews, survey	36 nurses, 24 nurses, 13 health promotion officers, 6 allied health professionals	Migrant women in general
Ng & Newbold, 2011	Qualitative, grounded theory	Semi-structured interviews	midwives, nurses, OBGYNs, social workers	Migrant women in general
Oscarsson & Stevenson-Agren 2020	Qualitative, content analysis	Focus groups	16 midwives	Migrant women in general
Oster et al, 2016	Qualitative, ethnography	Semi-structured interviews	12 health care providers (nurses, physicians, dieticians, mental health therapists)	Indigenous
Otero-Garcia et al, 2013	Qualitative, ethnography	Semi-structured interviews, observation	midwives	Migrant women in general
Puthussery et al, 2008	Qualitative, grounded theory	Semi-structured interviews	30 professionals	Black African, Black Caribbean, Indian, Pakistan, Irish

Shorey et al, 2021	Systematic review, qualitative-meta synthesis	Not applicable	Healthcare providers	Migrant women in general
Simonardottir et al, 2021	Qualitative, thematic analysis	Semi-structured interviews	16 health care providers	Migrant women in general

Appendix D

Table 3

Study Characteristics

Characteristic of Study	No of Studies (%)
Care provider	
Single care provider	17(53.1%)
Multiple Care providers	15(46.9%)
Type of Care provider	
OBGYNs	8(25%)
Nurses	7(21.9%)
Midwives	16(50%)
Primary Physicians	3(9.4%)
Dieticians	1(6.25%)
Endocrinologist	3(9.4%)
Type of Maternity Care	
Maternity care in general	8(25%)
general reproductive care	3(9.4%)
Prenatal	6(18.8%)
Antenatal	3(9.4%)
Perinatal	3(9.4%)
Postnatal care	2(6.3%)
Intrapartum Care	2(6.3%)
Primary Maternity care	1(3.1%)
Abortion care	1(3.1%)
Gestational diabetes mellitus	1(3.1%)
Breastfeeding support	1(3.1%)
No specify a type of maternity care	1(3.1%)

Appendix E

Table 4

Findings Summary Table

Theme	Findings	References
Provider-Patient Communication difficulties	Language barriers make encounters difficult	McFadden et al, 2013; Degni et al, 2012
	Speaking in same language is easier to communicate	Chitongo et al, 2021; Hassan et al, 2020; Byrskog et al, 2015; Cioffi, 2003
	Providers often need interpretation services	Delafield et al, 2020
	Physicians use less complex medical documents to help patients understand	Delafield et al, 2020
	Providers need to be careful to not offend patient, appear judgmental or racist	Hassan et al, 2020; Ahrne et al, 2019; Lyons et al, 2008
	Difficult to have discussion when language of patient does not have words for medical terms	Ayers et al, 2018
	Difficult to read facial expressions of women and understanding pain tolerance	Ayers et al, 2018
	Some patients exhibit stoicism which makes it difficult to understand pain and support	Shorey et al, 2021
	Patients do not ask many questions leaving provider questioning needs or feeling that patient is uninterested	Ahrne et al, 2019; Ayers et al, 2018
	Providers sometimes must ask direct questions to get information out of patient	Delafield et al, 2020
	Patients are shy to discuss sexual/reproductive and mental health	Mengesha et al, 2018; Byrskog et al, 2015; Lyberg et al, 2012
	Patients are timid and do not speak much	Bandyopadhyay, 2021
	Providers unable to get complete or accurate medical histories due to reserved nature of patients as well as language barriers (verbal and written medical histories)	Shorey et al, 2021; Ahrne et al, 2019; Lyons et al, 2008

	Providers prefer telephone interpretation since this protect women's anonymity	Ahrne et al, 2019; Lyberg et al, 2012
Provider-Patient Communication difficulties	Lack of qualified interpreters were available	Hughson, et al 2018
	Patients' partners or children sometimes must act as interpreters	Otero-Garcia et al, 2013; Degni et al, 2012
	Relying on family members to be interpreters can be problematic	Shorey et al, 2021; Hassan et al, 2020; Degni et al, 2012; Lyons et al, 2008
	Providers were skeptical about the legality and degree of confidentially that would be present with family members	Lyons et al, 2008
	Interpreters often did not know medical terms or were not professionally trained for interpreter services	Lyons et al, 2008; Delafield et al, 2020; Degni et al, 2012; Lyons et al, 2008; Akhavan et al, 2012; Degni et al, 2012
	Exact word for word translation would not be possible without medical terms being translated	Ng & Newbold, 2011
	Digital interpretation applications do not know medical terms and so it can be difficult to use these	Oscarsson& Stevenson-Ågren, 2020; Akhavan, 2012; Ng & Newbold, 2011; Lyons et al, 2008
	Non-professional translators could use information of woman against her outside the clinical setting	Ng & Newbold, 2011
	Losing nuances of conversation with interpretation	Byrskog, et al 2015
	Interpreters can be a physical barrier between provider and patient	Aquino et al, 2015
	Interpreters may be late to or miss appointments	Lyberg et al, 2012
	Interpreters may be inaccessible, since some cannot be available for on call or emergency situations	Cioffi, 2003
	Misinterpretation can lead to mistrust and miscommunication	Shorey et al, 2021
	Male interpreter was not preferred since patients feel shy to discuss female health in the presence of a male interpreter	Shorey et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Ayers et al, 2018; Lyons et al, 2008

	Consultations would be extended with interpreters or providers would need to allot more time for consultations with ethnically diverse women	Bains et al, 2021; Byrskog et al, 2015
Family involvement	Some women preferred to have family speak on their behalf	Goodwin et al, 2017
	Mothers in law or husbands would dominate conversations	Goodwin et al, 2017
	Family would start to make decisions on behalf of patients, or would have a strong influence over mothers' decisions, or start to answer questions themselves in consultation	Hassan et al, 2020; Oscarsson & Stevenson-Ågren, 2020; McFadden et al, 2013; Otero-Garcia et al, 2013
	Providers questioned the agency or independence of women and whether decisions were truly that of the patient	Delafield et al, 2020
	Prescence of family members would sometimes create a barrier between women and providers; Providers found it difficult to ask sensitive questions in the presence of family	Aquino et al, 2015; Degni et al, 2012
	Providers found it difficult to have many family members present in the birthing room	Bains et al, 2021; Ayers et al, 2018
	Providers found it difficult to ask sensitive questions in the presence of family members	Degni et al, 2012
Lack of Health and Health System Awareness	Patients lacked awareness and knowledge about female reproductive health	Shorey et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Larsson et al, 2016; Lyberg et al, 2012
	Less knowledge regarding the host country's healthcare system (e.g., home vs hospital birth, treatment options, not having too many medical tests, etc.)	Boerlieder et al, 2013
	Lack of knowledge of healthcare system could lead to cultural conflicts	Shorey et al, 2021
Delays in Care	Patients sometimes were late to appointments or missed them	Ayers et al, 2018; Boerleider et al, 2013
	Patients showed up unexpectedly for an appointment	Ayers et al, 2018; Lyberg et al, 2012
	Women not able to come to appointments due to transportation issues	Bains et al, 2021; Hughson et al, 2018

	Patients sometimes presented late in their pregnancy (after 20 weeks), or right before delivery	Otero-Garcia, 2013; Degni et al, 2012; Lyons et al, 2008
Limited time and resources	Added workload due to language barriers, less knowledge of healthcare system and not wanting anesthesia during childbirth	Chitongo et al, 2021; Boerleider et al, 2013; Lyons et al, 2008
	Midwives felt that they had to take on additional roles such as "cleaning lady"	Boerleider et al, 2013
	Some ethnic women viewed midwives to be in an administrative role and would make requests to fill out documentation, which would create more work and stress for midwives	Goodwin et al, 2017
	Some women expected providers to book appointments for them and expected providers to act as babysitters	Ayers et al, 2018
	There was increased workload for providers when women showed up late in pregnancy (from having to quickly book tests)	Ng & Newbold, 2011
	Providers felt that they were limited on time to adequately meet patients' needs and deliver patient centered care	Bandyopadhyay, 2021; Decker et al, 2021; Larsson et al, 2016; Aquino et al, 2015; Akhavan, 2012; Degni et al, 2012
	When patients missed appointments, this created further constraints for providing care	Shorey et al, 2021
	Some patients request female providers, but these are not always available	Hassan et al, 2020; Ayers et al, 2018; Lyons et al, 2008
	Need for culturally diverse staff	Ituralde et al, 2021; Akhavan, 2012
Preference for female providers	Some ethnic patients preferred to have a female physician carry out delivery of their child	Ng & Newbold, 2011
	Some patients would not compromise in wanting a female physician and would refuse care if provided by a male	Shorey et al, 2021; Ng & Newbold, 2011
	Providers would feel helpless in situations where patients rejected care in emergency situations or if C-section is needed	Shorey et al, 2021; Ng & Newbold, 2011
	Preference for a female provider could sometimes create tensions with male providers and staff	Degni et al, 2012; Ng & Newbold, 2011

Cultural conflicts	Health advice given by providers would conflict with that given by family members	Bains et al, 2021; Hughson et al, 2018; Goodwin et al, 2017
	Cultural values and medical advice sometimes clashed (e.g., giving baby bath after birth, putting honey in baby's mouth, fasting during pregnancy)	Goodwin et al, 2017
	Family members sometimes brought in unhealthy food for patient after birth	Hassan et al, 2020; Ayers et al, 2018
	Differing expectations regarding who takes initiative in care (e.g., providers expecting patients to bring a translator vs patients expecting to be provided with one)	Ng & Newbold, 2011
	Some women wanted multiple medical tests/scans, and some did not want any form of intervention during pregnancy, which would conflict with care practices	Shorey et al, 2021; Simonardottir et al, 2021
	Providers found it frustrating when women would not comply with medical advice, which led providers to view patients as uncooperative, or felt that giving advice was useless	Ahrne et al, 2019; Goodwin et al, 2017; Lyberg et al, 2012; Essen et al, 2011
	Some patients desired to be cared by specific providers (e.g., obstetricians) or did not view midwifery or nursing care to be of high standard or quality and would therefore prefer obstetricians	Shorey et al, 2021; Simonardottir et al, 2021; Goodwin et al, 2017; Boerlieder et al, 2013; Ng & Newbold, 2011
	Some women did not seek care as they though that trust in God would be enough for them	Chitongo et al, 2021; Goodwin et al, 2017; Essen et al, 2011
	Not seeking maternity care as some patients viewed pregnancy as natural and not an illness that needed treatment	Goodwin et al, 2017; Otero-Garcia, 2013
Prejudice and superior thinking	Stereotypes of Black women (e.g., strong and can withstand pain, so less need for pain relief)	Chitongo et al, 2021; Ahrne et al, 2019; Puthussery et al, 2008
	Stereotypes of south Asian women (low pain tolerance)	Puthussery et al, 2008
	Stereotypes of women as being passive and expecting staff to take care of their babies	Simonardottir et al, 2021; McFadden et al, 2013

	Stereotypes of Micronesian women are that they come with diseases	Delafield et al, 2020
	Some providers found it difficult to accept certain practices since they conflicted with western values	Simonardottir et al, 2021; Oster et al, 2016
	Providers recognized that they may have sub-conscious biases against certain ethnicities	Simonardottir et al, 2021
Motivation to help ethnically diverse women	Providers felt a sense of commitment to help ethnically diverse women	Aquino et al, 2015; Degni et al, 2012; Akhavan, 2012
	Providers found working with ethnically diverse women meaningful	Lyons et al, 2008
	Providers sometimes became involved in creating social activities to reduce isolation	Shorey et al, 2021
	Providers did not want to promote policies that reduced access to care	Chitongo et al, 2021
	Some providers felt a desire to learn more about their patients' cultures	Degni et al, 2012
	Providers mentioned approaches to improving care such as: forming a relationship (e.g., creating rapport)	Oster et al, 2016
	establishing trust (e.g., listening to women and getting to know them)	Shorey, 2021; Chitongo et al, 2021; Oscarsson & Stevenson-Ågren, 2020; Oster et al, 2016; Byrskog et al, 2015; Akhavan, 2012; Degni et al, 2012; Edge, 2010
	giving women choice (e.g., being open to different approaches to birth)	Akhavan, 2012
	tailoring care to their needs (e.g., tailored plans)	Hassan et al, 2020; Oscarsson & Stevenson-Ågren, 2020; Aquino et al, 2015; Byrskog et al, 2015
	Adapting style of communication (e.g., preparing women about conversation beforehand, using less stigmatizing language)	Mengesha et al, 2018; Byrskog et al, 2015
	adapting their communication styles for different patients (learning words from patient's language)	Ayers et al, 2018; Hughson et al, 2018; Byrskog et al, 2015; Akhavan et al, 2012; Cioffi et al, 2003
	Providers felt that they lacked cultural awareness and understanding of different ethnic	Mengesha, 2018; Oster et al, 2016; Byrskog, 2015; Edge et al, 2010

Cultural Sensitivity training and education	groups and often did not know where to seek this knowledge	
	Lack of training in medical education to prepare providers for working with diverse patients, and informal training in the form of presentations, manuals and documents was ineffective	Oster et al, 2016
	Providers such as midwives were motivated to learn more	Akhavan, 2012
	Providers felt that more training was needed for providing equitable care, as more focus on indigenous health compared to ethnic minority health	Mengesha et al, 2018; Akhavan, 2012
	Providers wanted training in the form online self-learning, workshops, and courses	Mengesha et al, 2018
	Some providers expressed that interprofessional and interdisciplinary collaboration should be encouraged to improve care for diverse patient groups	Shorey et al, 2021
	Certain providers expressed a preference for learning opportunities to engage with patients to learn rather than formal training	Hassan et al, 2020; Oster et al, 2016
	Providers also mentioned that training should be done in a manner that enables continuous self-reflection on the part of providers	Hassan et al, 2020