# Midwifery Students' Experiences and Challenges in Transcultural Care: Insights into Implementation, Emotional Reactions, and Perceptions

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## Abstract

**Introduction:** Transcultural care has gained importance with the increase in migration worldwide. The aim of this study is to investigate and explain the feelings, thoughts and experiences of midwifery students towards transcultural midwifery approaches in health service provision.

**Methods:** The interviews were conducted between January 2024 and June 2024 with students studying in the Department of Midwifery at the Faculty of Health Sciences of a university. Qualitative research design was used in the study. Qualitative content analysis method steps were used in the interviews. Qualitative Research Reporting Standards (SRQR) were followed. The data were analyzed in the qualitative research software package ATLAS.ti 9. The data were analyzed in depth by interpreting and making inferences and codes were created.

**Results:** A total of 3 categories and 12 sub-categories were obtained from the interviews. Three categories were obtained: Implementation Difficulties, Emotional Reactions and Student Perceptions.

**Conclusion:** Midwifery students' experiences of transcultural midwifery approaches in health service provision showed various results. Students were excited by the opportunity to work with patients from different cultures and to learn

their perspectives. However, they may also be concerned that they do not have enough knowledge and skills or do not know how to care for a patient from a different culture. The main problem in this sense is the language barrier and lack of knowledge.

**Keywords:** Midwifery students, Transcultural care, Health Services, Qualitative study

## INTRODUCTION

Globalization and migration have led to increased cultural diversity in different societies around the world.[1] Turkey is the country with the largest refugee population in the world, hosting more than 3 million people from Syria and 300.000 people of different ethnicities since 2016.[2] The majority of the refugee population consists of women and children of reproductive age.[3] This population has many health problems related to migration.[4] Midwives have a fundamental responsibility to protect and improve the health of migrant women.

The prejudiced and negative approach of midwives and nurses who are not equipped to provide treatment and care to individuals, families or communities from different cultures negatively affects health care.[5] Turkey suggests that such negative attitudes make it difficult to comply with treatment, reduce the rate of utilization of health services, and negatively affect the physical and psychiatric health of refugees.[6]

Leininger's transcultural care theory is often tailor-made to fit the cultural values, beliefs and lifestyles of the individual, group or organization. Transcultural care theory endeavors to provide cognitively based, helpful, supportive and facilitative culturally compatible nursing care.[7] The aim of care is to comply with or have meaning and health outcomes that are beneficial for people with different or similar cultural backgrounds.[8] Transcultural care refers to holistic care to protect the health and well-being of individuals and to help them cope with barriers in the treatment process. A health professional who does not recognize the value and importance of culturally appropriate care cannot provide effective care.[9] The cultural competence of midwives is an important factor in improving and promoting maternal and child health.[10]

Midwives need to have sufficient knowledge of different cultural backgrounds and traditions to be able to provide culturally respectful care.[11] Therefore, midwifery students need to develop cultural awareness, knowledge and skills through an intercultural midwifery curriculum before graduation.[12] After graduation, midwives

are expected to be culturally competent global citizens, ready to provide health care services to people from diverse cultural backgrounds and ethnicities.[13] The International Confederation of Midwives (ICM) has emphasized the need to take women's cultural beliefs and norms into account in midwifery care in antenatal, birth and postnatal care.[14]

In the literature, although there are studies on transcultural care on nursing students, studies with midwifery students are limited. [13,15,16] Women and children constitute a large part of the migration that Turkey has received in recent years. Considering this situation, transcultural care is important in the field of midwifery. This study was conducted as qualitative research to investigate and explain the feelings, thoughts and experiences of midwifery students towards transcultural midwifery approaches in health service provision.

## METHODS

### Research Design

This study used qualitative research design. (A constructivist qualitative research design was used for data collection). The research data were collected with a descriptive information form (5 questions) and a semi-structured interview form (11 open-ended questions) questioning the data related to socio-demographic questions such as age, socio-economic status, the process and experiences of caring for patients from different cultures. In data collection, individual interview technique was applied with a semi-structured interview form. In the interview, the data stated by the midwifery students were noted in detail on the interview form and recorded with a voice recorder. Methodologically, the data were explained according to the Standards for Qualitative Research Reporting (SRQR).[17]

### Sample and Participants

This study was conducted between January 2024 and June 2024 by conducting semi-structured face-to-face interviews with students studying at Ankara Medipol University, Faculty of Health Sciences, Department of Midwifery.

The study included 42 midwifery students aged between 19-34 years from different classes (Table 1.). The number of participants was determined according to the 'data saturation' principle valid in qualitative research.[18]

**Table 1. Interview questions**

| | |
|---|---|
| 1. | Can you tell us about your experiences in providing care to individuals from different cultures? |
| 2. | What difficulties have you encountered in providing care to individuals from different cultures? Explain. |
| 3. | How do you obtain cultural information? Explain. |
| 4. | How do you provide care to a patient from a different culture? Tell us about your experiences. |
| 5. | What are the women's health problems experienced by women who have to migrate from their countries for various reasons (war, epidemic, etc.) and encounter a different culture? Explain. |
| 6. | Have you encountered language problems in service provision? If so, how did you find a solution? |
| 7. | What were the roles of the women you served in different cultures? Describe. |
| 8. | How were the attitudes of the women you provided services to in different cultures towards family planning methods? Explain |
| 9. | How were women's approaches to labour and birth pain in different cultures? Describe. |
| 10. | How were women's approaches to breastfeeding and newborn feeding in different cultures? Describe. |
| 11. | Why are transcultural midwifery approaches necessary? Explain. |

## Data Collection

The data of the study were collected from the students who met the inclusion criteria and agreed to participate in the study. The data were collected by face-to-face interview technique in the educational institution. The inclusion criteria were students studying in the midwifery department, having clinical practice experience for at least three months, having provided health care services to patients in different cultures, having speaking skills and willing to participate in the study. The students who met the inclusion criteria were identified by a preliminary interview and

invited by e-mail with information about the study. After the participants gave informed consent, the dates and times of the interviews were planned. Interviews were conducted individually in quiet rooms. Semi-structured interview method was used to collect the data. The interviews were conducted over some general questions (Table 2.). The interview guide was created specifically for this study. The interview guide included open-ended questions that questioned the participants' feelings, thoughts and experiences of midwifery students towards transcultural midwifery approaches in health service delivery. The interviews lasted 942 minutes in total and 22 minutes on average.

**Ethics**

Ethics committee approval of the study was obtained from Ankara Medipol University Non-interventional research ethics committee with the decision numbered '162' dated 11.12.2023 and institutional permission was obtained from the relevant institution. Before the study data were collected, the purpose of the study and the questionnaires to be used were introduced to the students, they were informed that they would be voice recorded, and if they agreed to participate in the study, they were informed that they had the right to withdraw from the study at any time, that the data obtained would remain confidential and would not be used outside the scope of the research, and their verbal and written consent was obtained and their voluntary participation was ensured.

**Data Analysis**

The content analysis method developed by Graneheim and Lundman (2004) was used to analyze the interview data. The collected data were analyzed using Graneheim and Lundman's method through the following steps: Construction of the units of analysis, construction of codes of meaning, condensation, extracting codes, and categorization (subcategories, categories, and the core category).[19] Firstly, the audio recordings of the participants were transcribed and a raw data document of 86 pages was created. In this study, each interview was considered a unit of analysis. Afterward, the text was divided into meaning units. Each meaning unit consists of words, sentences, or paragraphs containing aspects related to each other through their content and

context. In the next step, the meaning units were condensed, while still preserving the core. The condensed meaning units were then labeled with a code and subcategories were created. These codes were then sub-categorized according to their topics. The next step was to create categories that represent the core feature of qualitative content analysis. A category is a group of codes that are similar at a manifest level. The main category is a recurrent thread of underlying meaning running through codes and categories; it can be seen as an expression of the latent meaning of a text. [19] Although the analysis process was systematic, it was a back-and-forth movement between the whole and parts of the text. Sampling continued until the data were saturated and no new information was extracted The data were analyzed in the qualitative research software package ATLAS.ti 9 (Scientific Software Development GmbH, Berlin, Germany). The data were analyzed in depth through interpretation and inference and codes were generated. In total, 649 codes were identified. These subcategories formed the categories for the study objectives. During the analysis process, the whole data set required continuous review. All researchers discussed the analysis and in case of disagreement, a different opinion was taken and a consensus was reached.

## Rigor

The evaluation of the analyses provided a reflective perspective. Researchers from different disciplines such as Gynaecology and Obstetrics nursing and midwifery enrich the study. The first author was the main analyst of the study but did not participate in the interviews, which provided a more objective view of the data. Verifiability of the results was supported by using quotations to demonstrate the basis for the study findings. Reliability was supported by following Braun and Clarke's analysis evaluation process.[20] All authors were involved in a discussion about the interpretation of the data during the coding sessions, thus providing an audit trail to increase reliability. In addition, in order to verify the accuracy of the data analysis, some parts of the interview transcripts were sent to two Public Health Nursing experts and a social worker, along with the codes and categories, and their approval was obtained. The transferability of the research findings was strengthened through purposive sampling and in-depth interviews. In

addition, maximum diversity in sample was used to provide more comprehensive and complete information and direct quotations were also included.

This study qualitatively analyzed midwifery students' feelings, thoughts and experiences towards transcultural midwifery approaches in health service delivery, unlike most of the existing studies. The study may provide unique information to examine the feelings, thoughts and experiences of midwifery students who are in contact with patients from different cultures during clinical practice and to prepare the ground for interventions to solve their problems. The fact that some of the researchers conducting the study work in the institutions where the participants receive services, allowing them to observe the participants and establish close relationships with the participants can be shown as an advantage in terms of obtaining complete and accurate information.

## RESULTS

In this study, demographic information is presented in Table 2. The mean age of the participants was 24.07±1.12, the majority of them were single, their income was less than their expenses, and the longest-lived region was the Central Anatolia region. All participants provided healthcare services to individuals from different cultures and reported that they did not receive training to improve healthcare service delivery to different cultures.

**Table 2. Demographic Characteristics Information**

| Variables | Dimensions | Frequency | Percentage |
|---|---|---|---|
| Age (year) [24.07±1.12]* | 20-21 | 5 | 11.75 |
| | 22-23 | 23 | 54.75 |
| | 24-25 | 10 | 23.75 |
| | 26 and above | 4 | 9.75 |
| Income | Less than expenses | 26 | 61.90 |
| | Equal to expenses | 13 | 30.95 |
| | More than expenses | 3 | 7.15 |

| | | | |
|---|---|---|---|
| Marial Status | Equal to expenses | 5 | 15.62 |
| | More than expenses | 1 | 3.12 |
| Region where you have lived the longest | Black Sea | 2 | 4.75 |
| | Mediterranean | 8 | 19.05 |
| | Eastern Anatolia | 2 | 4.75 |
| | Aegean | 3 | 7.15 |
| | Marmara | 3 | 7.15 |
| | Central Anatolia | 21 | 50 |
| | Southeast Anatolia | 3 | 7.15 |
| Have you participated in the provision of healthcare services to individuals from different cultures before? | Yes | 42 | 100 |
| | No | 0 | 0 |
| Have you received training to improve health service delivery to individuals from different cultures? | Yes | 0 | 0 |
| | No | 42 | 100 |

*Mean±SD

The data analyzed resulted in 3 main categories and 12 sub-categories (Table 3.). Midwifery students' experiences of transcultural midwifery approaches in health service delivery were categorized as follows: Implementation Challenges, Emotional Reactions, Student Perceptions. The sub-categories of each category are presented in Table 3.

**Table 3. Categories, Sub-Categories, and Examples of Codes**

| **Categories** | **Sub-categories** | **Code examples** |
|---|---|---|
| Implementation Challenges | Communication Challenges | Communication anxieties, difficulties of having a different language, inadequacies in expression, etc. |
| | Cultural Differences | Inadequate knowledge about the beliefs, values and health perceptions of different cultures, etc. |

| | | |
|---|---|---|
| | Language Barriers | Inability to communicate effectively with patients or family members, having to rely on interpreters, etc. |
| | Misunderstanding | Misunderstanding due to cultural, educational differences, etc. |
| | Cultural Awareness | Being unaware of one's own cultural prejudices, perspectives, not having enough knowledge about the beliefs, values and traditions of different cultures, etc. |
| Emotional Reaction | Empathy | Understanding the perspectives of patients from different cultures and empathising with them |
| | Stress | Observation of emotional reactions such as restlessness, tension, convulsions, sweating and difficulty in focussing |
| | Prejudice | Consciously or unconsciously avoiding service provision to individuals from different cultures, fear of not being able to support them. |
| | Curious | The desire to get to know culturally different people and their cultures, the desire to acquire new knowledge, the desire to have a different experience, etc. |
| | Uncertainty | Caring for a patient with an unknown culture, emotional reactions caused by uncertainty, etc. |
| Student Perceptions | Lack of Information | Inadequate knowledge content on transcultural midwifery approaches, not |

| | | |
|---|---|---|
| | | having enough clinical experience with patients from different cultures, etc. |
| | Gender | Gender perceptions in different cultures, etc. |

**Theme 1: Implementation Challenges**

Midwifery students face various difficulties in putting transcultural midwifery approaches into practice. These difficulties are a prerequisite for inadequacy in service provision, but also affect the job satisfaction that students need in clinical practice. The implementation challenges faced by midwifery students for transcultural midwifery approaches in health service delivery can be counted as Communication difficulties, Cultural differences, Language Barriers, Misunderstanding, Cultural Awareness.

Communication Difficulties: Communication concerns were expressed as the difficulties of having a different language and inadequacies in expression.

"*Even though I don't have many opportunities to meet individuals from different cultures, Syria, which is the culture and actually the country, is the one I encounter most frequently. A woman speaking Arabic was admitted with mastitis when I was working in the oncology department and she was 23 weeks pregnant. The first thing we guessed from mastitis was that she had a baby at home who was at the age of breastfeeding, but she had stopped breastfeeding because she was pregnant and her milk ducts were blocked. Despite being 23 weeks pregnant, we were facing a mother who hadn't had any tests done. We couldn't understand what we were trying to explain, but we couldn't understand what she was saying either. In fact, we had no choice but to wait with our hands tied until the interpreter arrived. After that day, I realized more and more that a midwife and a health professional should improve themselves in different languages. And sign language came to my mind. Therefore, I thought it would be right for all health personnel, including me, to learn sign language while they were still in school". (Interviewee 18)*

*"I often had difficult experiences, because we did not use a common language and we did not always have access to an interpreter, so we had to communicate. Sometimes we were playing a wordless theatre. Since I didn't want to say breathe in and out, I was explaining it to him by animating it. Sometimes I communicated by using technology. We understood by opening the translation and speaking in turn. When you look at the result, you can somehow understand and communicate, but the process can be challenging. And apart from communication, there are different practices brought about by cultural differences. Sometimes it is like the wrong interventions applied to a newborn baby. Again, even if we explain the right way and try to reach the result, changing the stereotyped norms does not happen in an instant". (Interviewee 1)*

*Communication was difficult. We had difficulty getting along as a team. She was looking at the obstetrics department with fearful eyes from the moment she was admitted to the delivery room. She had a very difficult time expressing herself and experienced stress because she could not understand us. This situation was very clear even in blood pressure values. First of all, she was complaining because we had problems with language. I asked her to communicate with a friend who speaks Arabic. I had my friend explain the care I would give. The woman's fear decreased a little". (Interviewee 27)*

Cultural Differences; Having insufficient knowledge about the beliefs, values and health perceptions of different cultures, etc.

*"We say that the pregnant woman has given birth too many times and that the body is now very tired and we want her tubes to be tied, especially most of these pregnant women are Syrian, but pregnant women say that they do not want this situation, the reason is that their husbands marry someone else, that is, they tell us unhappily that there will be consequences such as the case of kuma or divorce. We tell them that they should take some time off so that the body can recover. However, they do not accept it due to cultural differences". (Interviewee 30)*

*"Once I went to the baby and mother in the postnatal ward to provide breastfeeding counselling and active sucking. But the state of the baby surprised me very much, they had drawn kohl on both eyes of the baby, in fact, doing this to the newborn causes eye infection. Although I explained this many times, they were doing it because they wanted the baby to have black eyebrows and eyes according to their culture. Eventually we deleted it, of course. It is really difficult to communicate with Syrian patients and explain the procedure to them. I also experienced a lot of companion problems, while the woman wanted her husband to be with her, her mother-in-law argued that it was a shame, according to their culture, she could not see the woman until her husband went home, it was considered shameful, and this caused the woman to hesitate even while taking anamnesis to give care.". (Interviewee 42)*

Language Barriers; not being able to communicate effectively with patients or family members, having to rely on interpreters, etc.

*"For refugees, since I know some Arabic, when I work with refugee pregnant women, we can understand each other. However, in the field, I witnessed that refugee pregnant women were treated more harshly during labour and this made me sad. A woman who feels lonely because we don't know her language feels bad, so I support her by touching her shoulder and holding her hand, even if I don't understand her language". (Interviewee 19)*

*"Since he does not speak our language, he can't speak, there is a communication problem, they can't take care of it because there are few staff and a lot of work in the hospital. Once there was a Syrian woman in the pediatric emergency. Her baby was tachycardic and she was signaling us to eat. We thought it was the baby and said no. Then she tried to say some other things, but I didn't understand, so I used Google translate. However, the woman had been there with her hungry baby since last night. She couldn't reach anyone on the phone, she couldn't communicate with anyone, she waited hungry. I was really upset, I immediately told the midwives and nurses and we gave the mother something to eat". (Interviewee 10)*

*"I was hesitant while providing care to people from different cultures. We could not communicate because I could not understand them and they could not understand me. When I could not communicate, I had difficulty in helping the individual in front of me because I could not understand what the problem was". (Interviewee 36)*

Misunderstanding; Being misunderstood due to differences such as cultural, educational differences, etc.

*"First of all, I had difficulty in communicating. They did not want to receive care because we could not communicate. Because they could not understand how to give care or they misunderstood and made wrong applications". (Interviewee 41)*

*"Communication was really very difficult. I met a lot of 'young' girls in terms of age. There were girls who were 16 years old and had their second baby. Especially when I remembered myself at that age, I found it strange and even sad (don't misunderstand, this is never a condemnation, but bringing a person into the world requires great sacrifice and responsibility). Vaginal examinations, touching and going home from the hospital without any care and services. Although we explained to these people what was needed or how we could help them, their lack of understanding, misperception and prejudice prevented us from providing direct care". (Interviewee 16)*

Cultural Awareness: Being unaware of one's own cultural prejudices, perspectives, not having enough knowledge about the beliefs, values and traditions of different cultures, etc.

*"When I was doing my internship at the hospital, a woman who was about to give birth and I did not know where she was from asked me for water. I asked the midwives, and they said no water could be given. But the woman was practically begging me. Although she was older than me, she was saying 'sister water'. I wet a cotton ball with water and wiped her lips. Then she thanked me in her imperfect Turkish. Time progressed and the moment of birth approached. One of the midwife sisters said: 'look, this lady has been circumcised'. When I saw her, I was very surprised. The woman only listened to me and understood me, I told her that she*

*had to push when the contraction came. When the contraction came, the woman said 'elem came'. That day I learnt that the word elem corresponds to labour in their language. After that, I started to ask the woman, 'Did labour come?' Then the birth was completed. Time passed. She wanted to wrap her baby tightly in a cloth, so I asked her why. She said 'the baby will get cold'. I told her that it was enough to cover her baby in such a way that the baby would not get cold and that it was wrong and harmful to wrap it tightly. According to their culture, the baby is wrapped tightly enough to immobilize it. I was astonished when I heard it". (Interviewee 28)*

*"In fact, we try to provide the same care to individuals from different cultures. However, it can sometimes disturb the patient in terms of religion or there are many times when we cannot get along in terms of language. In this case, we try to meet the patient at a common point". (Interviewee 39)*

**Theme 2: Emotional Reactions**

Midwifery students' various emotional reactions were identified when addressing their experiences of transcultural midwifery approaches in health service delivery. These responses can be influenced by various factors such as the student's individual experiences, cultural background, educational level and clinical environment. They may be excited by the opportunity to work with patients from different cultures and learn about their perspectives, or they may be concerned that they do not have enough knowledge and skills or do not know how best to care for a patient from a different culture. Empathy, stress, prejudice, curiosity and uncertainty are among the experiences of midwifery students towards transcultural midwifery approaches in healthcare delivery.

Empathy; efforts to understand the perspectives of patients from different cultures and to empathies with them

*"Firstly, I was very anxious, I was very afraid of giving wrong information or offending and upsetting them. Then I adapted myself to those individuals, but I did it without giving up my own essence. I tried to learn their language, but I failed. I*

*tried to understand them and their feelings and put myself in their shoes. It was a nice experience for me to see different lives, different cultures, to perceive them and to try to learn". (Interviewee 5)*

*"The other person felt helpless because he was looking at me with eyes full of fear and I felt very lonely because he couldn't understand what to do, putting myself in his place. Due to language and cultural differences, they had difficulty in understanding what we wanted to explain and what they should do. Syrian and Afghan individuals were very careful about privacy. When we realised this, we paid as much attention as possible". (Interviewee 38)*

Stress; Observation of emotional reactions such as restlessness, tension, contraction, sweating and difficulty in focusing

*"I have given antenatal, labour and postnatal care to women from different communities in Turkey or from different parts of the world. I have understood this from their posture, the way they dress, the way they speak, their language or their cultural approach to babies. I had a lot of difficulty in communicating. Before I was going to perform vaginal palpation on a foreign patient, of course, I tried to explain the procedure as much as I could. I tried to explain that this was important for the baby, but she never allowed the touch and started shouting by closing her legs. As a student, I was in a difficult situation there, I was stressed, stressed, I thought I made a wrong application. I felt the need to express myself and explain". (Interviewee 3)*

*"When I encounter individuals with whom we have cultural differences as a health professional, I have seen that they continue to do what is in their own culture, even if I explain what is medically beneficial for the mother and baby or for a woman who is about to enter menopause to protect, maintain and improve her health. For example, a woman going through menopause drinking litres of boiled onion juice, giving the baby fennel to drink to prevent gas, brewing cumin and giving it to drink. The cultural differences and traditional practices of the patient profile that I am in*

*charge of caring for and the decline and deterioration in their health have increased my fear and stress". (Interviewee 37)*

*Prejudice; Conscious or unconscious avoidance of service provision to individuals from different cultures, fear of not being able to support.*

*"I learn cultural information by asking questions and chatting with the pregnant woman when I enter her room to take care of her. I try to understand what their culture is like, what they care about and what is right for them. I do not want to prejudge the pregnant woman even if our cultures clash at some points. I do not speak in a judgemental way and I listen to what they tell me. I try to convey something from my own culture on some of the issues they ask me to help them with. I want to explain the truths they know wrong in a way that they will not try to be prejudiced. Sometimes I research their culture on the internet". (Interviewee 8) "We have problems especially in terms of communication and speech. They oppose the maintenance and applications that need to be done. Their lack of knowledge was high and their education level was low". (Interviewee 24)*

Curious; The desire to get to know culturally different people and their cultures, the desire to acquire new knowledge, the desire to have a different experience, etc.

*"It is very exciting to get to know a new culture while providing service to our patients. Wondering about the behaviours we see from different cultures, researching on the internet, asking patients increases our knowledge". (Interviewee 32)*

*"I understand the pregnant women who come to the hospital by chatting with them and then I get information by asking or researching the things I am curious about. I learn new cultures through the communication I establish with the patients in the department where I am in practice". (Interviewee 31)*

*Uncertainty: Caring for a patient with an unknown culture, emotional reactions caused by uncertainty, etc.*

*"There was a particularly urgent case. The woman's water broke, her patency was almost complete and everything progressed very quickly. But the problem with me was that we could not communicate with the woman at all, we could not express ourselves, we could not manage that moment. At that moment, only uncertainty prevailed. The whole team was so tense until the baby was born". (Interviewee 6)*

*"Certainly interpreters are requested, but sometimes they do not arrive on time. In situations where rapid intervention is required, uncertainty and waiting is too long. It can be painful and exhausting for the patient". (Interviewee 14)*

**Theme 3: Student Perceptions**

Midwifery students reported that they lacked theoretical and clinical knowledge and experience about transcultural midwifery approaches in health service delivery and that they had not had enough clinical experience with patients from different cultures before. Lack of knowledge and gender are among the experiences of midwifery students regarding transcultural midwifery approaches in health service provision.

*Lack of knowledge; Insufficient knowledge content for transcultural midwifery approaches, not having enough clinical experience with patients from different cultures, etc.*

*"Although we have clinical knowledge and experience, we cannot reflect this to patient groups from different cultures. We do not know what to do and how to behave in cross-cultural service provision. We learn by experimenting". (Interviewee 37)*

*"Especially during my summer internship, I learnt that caring for patients from different cultures requires a completely different competence. We were not trained for these, I felt my deficiencies so much. This was not only in us, but also in the midwives and nurses of the graduated years. This deficiency should be eliminated in our culturally rich country". (Interviewee 11)*

*Gender; Gender perceptions in different cultures, etc.*

*"Since they are not fully adapted to where they live, they do not know where the health centres or hospitals are located. Women's health, unfortunately, women are a little bit withdrawn and hesitant when it comes to health. Due to their culture, they do not apply to health centres or hospital-style health institutions unless necessary, or they go with their mothers-in-law". (Interviewee 36)*

*"The majority of women do not know the concept of family planning. They do not know how to protect themselves. They were always saying that my husband wants to have children. People of different cultures especially do not know these issues. Their only duty is to give birth. There is also the fear that if she does not want to give birth, she will be imposed on. Even if we try to explain, it seems impossible to change the knowledge that exists in their culture". (Interviewee 20)*

## DISCUSSION

Transcultural care awareness should be laid at the undergraduate education level of the midwifery profession. This study was conducted to determine the feelings, thoughts and experiences of midwifery students towards transcultural midwifery care in health service delivery. As a result of the study, midwifery students stated that they had difficulty in communicating while providing care, had insufficient knowledge about the beliefs, values and norms of different cultures, and were not aware of their own cultural perspectives. Midwifery students were found to experience emotions such as empathy, stress, prejudice, curiosity and uncertainty in health service provision. In addition, it was determined that students lacked theoretical/clinical knowledge of transcultural midwifery approaches and did not have a good command of gender perceptions in different cultures.

Migrants are at higher risk of maternal and neonatal morbidity and mortality than local women in the region of origin.[21] Midwives are unable to provide effective care to migrant women due to the language barrier, limited patient-carer trust, misunderstandings and cultural differences.[22] This situation constitutes an obstacle in the provision of health care services, even with sufficient knowledge and experience.

The most important and primary barrier in transcultural health services is language. Due to the language barrier, it is seen that the needs cannot be met because of communication breakdowns and lack of knowledge of cultural expectations.[23] In this study, midwifery students expressed that they had difficulty in expressing themselves and understanding women while providing transcultural care. As a result, it was also determined that they experienced misunderstandings, could not understand cultural beliefs and values, and had insufficient knowledge about the health perceptions of different cultures.

In Switzerland, in a study evaluating the care provided by midwives working in antenatal care clinics to migrant women, it was reported that midwives experienced communication difficulties, that the expectation of care was different due to cultural differences and that midwives had difficulty in working.[22] Another study conducted in the United Kingdom on midwives caring for ethnic minority groups with high-risk pregnancies found that communication was among the barriers to care.[24] In Turkey, another study conducted to identify the difficulties experienced by nurses and midwives working in obstetrics clinics while providing care to refugee mothers showed similar results.[25] The results of this study are in parallel with the studies in the literature. Language barrier is one of the most common and most important challenges in transcultural care. Having facilitators for language barriers (rapid interpreter support, incentives for staff with language training, etc.) can improve health service delivery in the desired direction.

Health professionals have difficulties in coping with the traumas experienced by women as well as cultural and language barriers while providing care to women from different cultures.[26] For example, a significant number of migrant/refugee women experience anxiety, depression and trauma-related symptoms due to the difficulties they have experienced.[27] No study has been found to examine the emotions felt by midwifery students caring for traumatized women. In this study, it was determined that midwifery students experienced various emotional reactions such as empathy, stress, prejudice, curiosity and uncertainty because of caring for women from different cultures. In a study conducted in Switzerland to examine the

difficulties encountered by professionals providing reproductive health services to women seeking asylum, it was reported that health professionals felt the same emotions as women experiencing trauma.[28] A qualitative study of Irish midwives found that working with traumatized women elicited feelings of empathy, compassion and powerlessness. It was also reported that midwives experienced feelings of sadness, worry and anxiety for the women they cared for.[29] In a study conducted on nursing students in Turkey, it was reported that students felt hopelessness, sadness and anger.[30] Health professionals' experiences of working with migrants can shape their perceptions and attitudes towards transcultural care.[31] Emotions experienced by health professionals while providing care affect the professional-patient relationship and cause clinical outcomes to be affected.[32] Therefore, in addition to the need for clinical support for midwives caring for traumatized women, it is important to include trauma-related educational content for midwifery students at the undergraduate level.

Transcultural care provision is complex for health professionals and students due to different interpretations of personal and organizational factors.[33] The main aim of transcultural care is to individualize care by addressing the physical, psychological, emotional, spiritual and social needs of patients as well as developing the knowledge and skills required to provide culturally diverse care.[34] Students need to have cultural competence to develop their transcultural professional practice. Training on cultural competence should be provided at the undergraduate education level. In this study, it was found that midwifery students lacked knowledge about how to provide transcultural midwifery care. In the literature, no study measuring students' knowledge about transcultural care was found. Considering that the foundations of transcultural care should be laid at the undergraduate education level, measuring the knowledge levels of students and developing educational interventions for this will shed light on future studies.

Transcultural care should be understood and skillful by all members of the healthcare team. The training and foundation of transcultural care is laid at the undergraduate level. For this reason, issues related to transcultural care skills should

be addressed in a broad framework in education programmed. Transcultural service provision contents for practice in clinical trainings will also be initiatives to improve equality in health service provision.

## CONCLUSIONS

Midwifery students' experiences with transcultural midwifery approaches in health service provision reveal a complex mix of excitement and apprehension. While students appreciate the opportunity to engage with diverse cultural perspectives and expand their understanding, they also face significant challenges. A major concern is the lack of sufficient knowledge and skills to provide culturally appropriate care, compounded by the language barriers that hinder effective communication. These challenges can lead to feelings of inadequacy and uncertainty in clinical practice.

These issues can be addressed by integrating comprehensive theoretical and practical training in transcultural midwifery practice into midwifery education curricula. This should include modules focusing on cultural competence, communication strategies and the specific needs of different populations. Pre-hospital simulations that mimic real-world scenarios can provide students with hands-on experience in a controlled environment, building their confidence and skills. Furthermore, structured clinical placements that expose students to patients from different cultural backgrounds will enhance their ability to deliver culturally sensitive care.

Midwifery programs can prioritize these educational reforms, equipping future midwives with the tools they need to overcome barriers and provide high-quality, patient-centred care in increasingly multicultural healthcare settings.

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