The role of ethnicity in care of elderly Finnish immigrants

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CONTENTS

ABSTRACT

The role of ethnicity in care of elderly Finnish immigrants

Most Western countries are becoming increasingly multicultural because of immigration. Many of these immigrants grow old in a second homeland and will need health and elderly care in the future. In Sweden, the largest immigrant group comes from its neighbouring country, Finland. Little is known about how this group experiences present health care or their expectations of future elderly care.

The overall aim of the thesis was to describe and to obtain a deeper understanding of elderly Finnish immigrants' experiences of health care and elderly care and the role that ethnicity played in these experiences. The specific aims were to: elucidate the elderly Sweden-Finns' experiences and beliefs about health care in Sweden, in order to gain an understanding of how ethnic background affects the elderly immigrated persons' experiences and beliefs in the host country (**I**); illuminate the role that culturally appropriate care plays in relation to the elderly Finnish immigrants' wishes and expectations of institutional elderly care (**II**); describe and compare the elderly Finnish immigrants' perceptions of health care, both among those who have continued to live in Sweden and those who have re-migrated to Finland (**III**); describe the cultural adjustments that had been made at a specific elderly care setting, the Finnish Home, and illustrate the impact of cultural adjustments on care, as conditions that promoted the well-being of the residents (**IV**).

All the participants were born in Finland and Finnish was their native language and they lived (**I-II** and **IV**) or had lived in Sweden. In **I-II**, the 39 participants were 75 years or older and in III-IV, 65 years or older. In **III**, 217 persons participated in Finland, and 643 persons participated in Sweden. All residents, staff and visitors of Finnish Home participated in **IV**. Qualitative interviews were conducted in the participants' homes (**I-II**), a mailed questionnaire was used in Study **III**, and an ethnographic study design was used in Study **IV**. Several different analysis methods were used: Hermeneutical 'ad hoc' analysis (**I**), latent content analysis (**II**), statistical analysis (**III**), and an ethnographic method (**IV**).

The results show that the Swedish health care system is congruent with the elderly Finnish immigrants' expectations (**I**), and their experiences of care were good (**III**). Their experiences of the Finnish health care system were also good (**III**). However, sharing the same ethnic background as the care providers was believed to lead to better care (**I**). When thinking about future elderly care, the elderly Finnish immigrants wished to feel familiarity, continuity in life, security, and companionship. This could be achieved either in the well-known physical environment of their current homes, in an elderly care setting in their part of town, or in a well-known socio-cultural environment at an elderly care setting where Finnish was spoken and the care providers and fellow-residents were Finns (**II**). When being cared for in a culturally adjusted elderly care setting, the care became culturally congruent as the care providers, and the residents played the same 'language' and 'ethnicity game' (**IV**). The conclusions from the thesis show that ethnicity and ethnic identity, a shared mother language, and the place, play an important role in the care of elderly Finnish immigrants. In addition to this, the elderly Finns experienced a feeling of at-homeness when being cared for by members of their own ethnic group, in a familiar place, with people who spoke the same native language.

Key words: older people, immigrants, Finns, health care, elderly care, culturally congruent care, wishes and expectations, experiences, perceptions, ethnicity, mother language, environment, at-homeness

ORIGINAL PAPERS

This doctoral thesis is based on the following original papers, which are referred to in the text by their Roman numerals:

I   Heikkilä, K. & Ekman, S-L. (2000): Health care experiences and beliefs of elderly Finnish immigrants in Sweden. *Journal of Transcultural Nursing*, 11 (4): 281-289.

II   Heikkilä, K. Ekman, S-L. (2003): Elderly care for ethnic minorities – wishes and expectations among elderly Finns in Sweden. *Ethnicity & Health*, 8 (2): 135-146.

III   Heikkilä, K. & Sarvimäki, A. & Kulla, G. & Palo-Bengtsson, L. & Ekman, S-L.: Perceptions of health care among elderly Finnish immigrants. (Manus)

IV   Heikkilä, K. & Sarvimäki, A. & Ekman, S-L.: Culturally adjusted care for older people. (Submitted)

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INTRODUCTION

This thesis has two starting points. The first is related to my own experience of ethnicity and the complexity of it. I am the daughter of a Finnish father and a Swiss mother and I grew up in Finland. When I was young, we moved from an industrial area in Western Finland to a rural part of Eastern Finland. Questions such as, 'where do I come from?' and 'where do I belong?' were part of my adolescent thinking. Later, when I emigrated from Finland and came to live in Sweden, I was regarded by others as a Finn, an identity that I found relatively strange in the beginning. When starting the interviews as a doctoral student, I gained entry to people's homes and their lives as Finns. During the interviews I noticed that I am, after all, very Finnish as I could understand the meanings of the interviewees' experiences of Finnishness. A new process of defining 'me' began; perhaps this is an endless process, which only deepens with time.

The second starting point for this thesis goes back to the early 1990s, when I was given the opportunity to carry out a survey about the living conditions of elderly Finnish immigrants. The survey was based on a WHO-questionnaire (Heikkinen *et al* 1993) and it was designed to include interviews in the private homes of the participants. There was one question where the answers puzzled me. When I asked the participants about their rating of health care, most of the participants started telling horror stories about their experiences. When I then asked them whether they meant that they had "bad" or "very bad" experiences of health care, they said to me: "No, no, no". My experiences have been good, put a cross on 'very good' ".

Later, as a doctoral student, I was given another opportunity to interview elderly Finnish immigrants in Sweden, and I realised that one of the areas that I wanted to study at a deeper level was related to people's experiences of health care. I wanted to see whether these horror stories still existed, and if they did, I wanted to find out what kind of issues the Finnish immigrants referred to and what this meant.

BACKGROUND

Finns in Sweden

Finland and Sweden are neighbouring countries, and have a partly common history, as Finland was part of Sweden for approximately 600 years. Throughout this history, there has been a migration movement from Sweden to Finland and vice versa. In Finland, there is Finnish-speaking majority and a Swedish-speaking minority.

During the Second World War, many Finnish children were sent to Sweden as "war children," because Sweden did not take part in the war. Some of them stayed in Sweden, while the majority of them re-migrated to their parents in Finland when the war was over. Because Finland had participated in the war, the Finns had to build up the country afterwards. There was a shortage of accommodation, it was difficult to find work, and therefore, many Finns looked for better living conditions in Sweden. In 1954, new rules regarding the free mobility of the work force in Nordic countries came into force. This eased migration to Sweden, where industrial workers were needed because the Swedish export industry was expanding rapidly. In the 1960s, a rapid industrialisation and urbanisation process added to the problems in Finland while in Sweden the need for labour force was at an all time high. All this meant that approximately half a million Finns emigrated to Sweden in the years1945-1990, although more than half of them re-migrated after living for just a few years in Sweden (Snellman 2003; Korkiasaari 2000). Today, approximately 200 000 persons that were born in Finland are living in Sweden (SCB 2002). About half of them are Finnish citizens (*ibid.*) Finns constitute the largest immigrant[1] group in Sweden.

Because the Finnish people and their descendants have been living in Sweden as far back as the medieval times (Snellman 2003), they were given a minority status in 1999. This means that the municipalities are required to provide services in Finnish. However, in practice this is still rare.

Elderly Finns in Sweden

At present approximately 46 000 persons, born in Finland and 65 years or older are living in Sweden (SCB 2002). It has been estimated that this number will double during the next 15 years, as in the age group 50-64 years there are

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[1] In Sweden, the word immigrant refers to people who are born abroad (first generation immigrants) and to their children (second generation immigrants). Terms such as, Sweden-Finns and Sweden-Turks have not come into use. The minority status still has no impact on the definitions. In this thesis, the word 'immigrant' will be used, following the Swedish practice, because the participants in the studies defined themselves as immigrants.

approximately 75 000 persons born in Finland (*ibid.*). A large majority of elderly Finns in Sweden are Finnish-speaking (about 75-80 percent; Heikkilä 1994; Population Register Centre in Finland 2001).

Older Finns live in all Swedish municipalities, but Haparanda, located in the Northern part of Sweden, is the municipality where the largest part of the older population is Finnish. The majority of elderly Finns in Sweden live in the Stockholm and Gothenburg areas (Population Register Centre in Finland 2001; (SoS 2001).

Elderly Finns and their situation as the largest immigrant group of elderly people in Sweden, has yielded some interest. In the 1980s, Haavio-Mannila (1986) carried out the first study of elderly Finnish immigrants in Sweden. She found that older Finns that had lived for less than 15 years in Sweden suffered from loneliness and isolation, had poor health, and led a passive life. The elderly Finns who had lived for more than 15 years in Sweden led an active life and their financial situation was good, but even this group felt isolated. In both groups, many people could not speak the Swedish language adequately. However, a large majority wanted to stay in Sweden.

Jansson *et al* (1986) found that almost half of the elderly Finnish immigrants in Eskilstuna (a city in Central Sweden) could not speak Swedish adequately and they needed an interpreter for their interactions with people working in municipal and health care services. They wanted to stay in their own homes for as long as possible, and then move into an elderly care setting where care would be provided in Finnish.

Nieminen Kristofersson (1993) found a large variation among the elderly Finns, when it came to social networks, language skills, and activities in Olofström, a town in Southern Sweden. Nieminen Kristofersson found that this group included people who were socially isolated and people who were socially active, where some managed well in Swedish while others did not. Kristofersson classified the Finns into two groups: those who have resources and alternatives, and those who do not. The latter persons were dependent on the social services and needed a Finnish interpreter for these interactions.

Heikkilä (1994), in her study among elderly Finns in Stockholm, found that a majority of Finnish people had lived for a long time in Sweden, and more than half had lived in the country for more than 35 years. The persons in her study suffered from many serious health problems. The most common diseases were repetitive strain injury and heart disease. One third of them had been granted a disability pension. However, a majority of them rated their health as relatively good. They had friends, considered their social networks to be good, and were

satisfied with their lives. Most of them regarded their skills in Swedish as good, but about 10 percent needed an interpreter in their contacts with the municipalities. A greater part of the group stated that they wished for elderly care in Finnish.

Even Pudaric *et al* (2003) found that the elderly Finnish immigrants had poorer health and an increased risk of impaired IADL compared to people born in Sweden.

Grönlund (1995) studied retired Finns who had re-migrated to Finland and found that some of the reasons for emigration to Sweden were connected with work and finances that is, 'having' reasons, while the main reason for remigration was homesickness, a wish to live in Finland and this was related to 'being'-reasons (*cf.* Allardt's theory of quality of life). Although many Finns have experienced problems because of the economical restrictions connected with retirement pensions from Sweden (taxed both in Sweden and in Finland) they were satisfied with their current lives and considered their health to be as good as the health of other Finns.

THEORETICAL FRAME

Culture, ethnicity and ethnic identity

The words 'culture' and 'ethnicity' are often used interchangeably (Rowland 1991), but in this thesis, culture is seen as the inherited ways of life, including beliefs, value systems and norm systems typical for a certain group (*i.e.* Keesing 1981; Blakemore & Boneham 1994; Leininger 1991; Friedman 1994). It can also be seen as an ideological phenomenon that provides means for interpreting the world (Kontos 1998). Ethnicity is seen as a broader concept that includes *i.e.* culture.

The word 'ethnicity' comes from the Greek word 'ethnos', which means 'people', 'nation' or 'tribe' (Betancourt & López 1993). This is not the case when the word ethnicity is used in American literature, as there it is often used as a synonym for the word 'race' (*cf.* Gaines *et al* 1999). Here, however, the word 'ethnicity' is used to show that one belongs to a certain ethnic group and to an idea of who people are as members of a collective group (Junila & Westin forthcoming; Meleis *et al* 1992; Breton 1987). Jenkings (1997) means that ethnicity refers to situations where human collectives live and co-operate. It expresses perceptions both of the nature of one's own group and of other groups (Sintonen 1999). Bulmer (1996: 35) defines an ethnic group as a:

> "Collective within a larger population having real or putative common ancestry, memories of a shared past, and a cultural focus upon one or more symbolic elements which define the group's identity, such as kinship, religion, language, shared territory, nationality or physical appearance".

Therefore, ethnicity refers to a sense of belonging and to group identity (Bulmer 1996; see also Junila & Westin forthcoming; Blakemore & Boneham 1994; Meleis *et al* 1992; Rempusheski 1989).

Ethnicity and ethnic group belonging (as well as culture) should also be seen as dynamic and changing, as they are socially constructed (*cf.* Bruni 1988; Emami 2000; Gerrish 2000; Khan & Pillay 2003). Holzberg claims that ethnicity:

> "Constitutes a dynamic system constantly changing, adjusting and adapting to the wider environment of which it forms a part. What remains constant in the ethnic subsystem is the boundary that distinguishes "them" from "us." But even the nature of the boundary changes over time as ethnics come to modify their distinctive interaction patterns and cultural characteristics" (Holzberg 1982: 254).

As a collective meaning system, ethnicity becomes meaningful only when there are other ethnic groups from which one's own group differs in some way, or to which one's own group can be contrasted (Sintonen 1999). Barth (1969) designates an ethnic group as a population which: "(1) Is largely biologically self-perpetuating; (2) Shares fundamental cultural values, realised in overt unity in cultural forms; (3) Makes up a field of communication and interaction; and (4) Has a membership which identifies itself, and is identified by others, as constituting a category distinguishable from other categories of the same order" (Barth 1969: 10-11).

It should also be stressed that an ethnic group does not need to be a fixed belonging to a group, but can also be an imagined belonging to a group (Junila & Westin forthcoming).

Ethnicity is based on an idea of group membership or "we-feeling" that is part of a gradual and continual definition of self (Rempusheski 1989; Isajiw 1990). It is a subjective group identification process, where people use ethnic signs when they define themselves and when they encounter other people. According to Isajiw, ethnic identity refers to the "way in which people, taking their ethnic origin to account, place themselves psychologically to one or more social systems and how they regard other people to place them to these systems" (Isajiw 1990: 35).

Barth claims that belonging to an ethnic group implies being a certain kind of person and having that basic identity. This belonging also implies a claim to be judged, and to judge oneself, by the standards that are relevant to that identity:

> "The identification of another person as a fellow member of an ethnic group implies a sharing of criteria for evaluation and judgement. It thus entails the assumption that the two are fundamentally playing the same game, and this means that there is between them a potential for diversification and expansion of their social relationship to cover eventually all different sectors and domains of activity. On the other hand, a dichotomization of others as strangers, as members of another ethnic group, implies a recognition of limitations on shared understandings, differences in criteria for judgement of value and performance, and a restriction of interaction to sectors of assumed common understanding and mutual interest." (Barth 1969: 15)

Immigration and ethnic identity

Migration within a country, and even more so, to another country, is often regarded as a turning point in the continuity of life (Phillipson 2003), characterised by different losses. The migrants leave behind the social, cultural, and environmental contexts that have given meaning to their lives (Snellman 2003; Torres 1999). The migrating individuals appear to lose, at least temporarily, their social networks, and they encounter difficulties when establishing themselves in a new context. They can also experience a lack of appreciation and recognition from others in their new environment. They have to learn to become orientated in a new, strange environment and they have to organise the practical issues that are important in everyday life. In the long term they have to build up, establish or re-establish social networks that have been cut off due to the migration process. The immigrants also have to deal with situations where they are viewed as foreigners by people in the native population (Junila & Westin forthcoming; Aroian 1990). This means that immigrants are confronted with major changes in life style and environment, they also have many problems to face in the adaptation process and they experience higher rates of emotional distress compared to members of the majority population (Aroian 1990).

Immigration is a challenging process, as it is both uprooting and stressful (*i.e.* Emami & Ekman 1998; Torres 1999; Chataway & Berry 1990; Berry 2002) but usually it also tends to create some gains for the immigrating individual (*i.e.* Torres 1999; Ahmadi & Tornstam 1996). Aroian (1990) found that immigrants experienced resettlement as extremely stressful, but that resettlement also included aspects of self-growth, financial opportunities, and freedom. Loss, disruption, novelty, subordination, and language were regarded as obstacles in the initial phase of resettlement, but over time, depending on the coping strategies; feelings of grief and/or feelings of being at home became evident.

Ethnic group identity is dependant on the maintenance of boundaries to other ethnic groups (Barth 1969). When immigrating to a new country and in interactions with other ethnic groups, a person's ethnic identity becomes visible (Junila & Westin forthcoming; Häggström *et al* 1990). It is commonly believed that immigration leads to an adaptation (Aroian 1990), an acculturation (Chataway & Berry 1990), or a transition process (Meleis *et al.* 2000; Schumacher & Meleis 1994; Meleis *et al* 1992) leading to diffusion and changes in culture orientation and in ethnic identity. Chick & Meleis (1986) claim that the transition of immigration is an eventful process that occurs many years before the actual event and encompasses periods of identity diffusion and integration. Chataway & Berry (1990) defines the acculturation process as a culture change that results from continuous, first-hand contact between two cultural groups. The process often involves certain types of stress symptoms

which occur during the process, and which Chataway & Berry (1990) call for 'acculturative stress'. Acculturative stress refers to stress where the stressors are identified as originating during the process of acculturation. According to Berry, there are four models of immigrant acculturation referring to the behavioural shifts that occur: 1) *Assimilation*, where the group or individual relinquishes their cultural identity and socially disappear into the dominant society, 2) *Integration*, where the individual or group maintains their cultural identity but adopts some of the values in the dominant society; 3) *Separation*, where the group or individual withdraws from the dominant society and maintains their cultural identity; 4) *Marginalisation*, where the individual and the group is alienated from their cultural group and the dominant society (Chataway & Berry 1990).

Meleis *et al* (1992) maintains that acculturation should be seen as a former but not a major component of ethnic identity. They also state that ethnic identity acknowledges ethnic pride and the complex nature of the immigrants' responses to the immigration process.

Ekman (1993) claims that immigration means a break in the continuity of identity. Immigrants find it difficult to identify with the way other people perceive them, because people in their new environment may see them in a different light than they see themselves. Therefore, there is a great risk of identity confusion and repudiation. Ekman believes, (by following the Erikson theory of man's life cycle), that immigrants can reach a greater understanding of life, tolerance, and a deeper feeling of communion in the 'new' country. They can also experience a sense of wisdom, but only if they have managed to solve positively most of the problems that are a part of this life crisis.

To grow old in a second homeland

The terms 'old', 'older people' and 'elderly people' are often used as general descriptions of people who have passed a certain age. Already from early childhood, we grow up in a culture that has various images of different age categories, and we learn the characteristics that are associated with these different categories. The imagery of different age groups is a cultural product. (Hazan 1994; Kaufman 1986).

Ageing is a process that starts from the moment we are born. As we age we are socialised in several different sub-cultures, and during the course of our lives we share different experiences. Thus, in old age, the diversity of people is at its peak (Dannefer 1996; Grigsby 1996; O'Rand 1996). As Rempusheski claims, "elders have had a lifetime to incorporate the beliefs of their heritage into what

to them is everyday behaviour" (Rempusheski 1989: 717). This is also true for immigrants. In addition to the abovementioned aspects, the migration-related aspects, such as the age of migrants, their reasons for migration, the ways they have adjusted to the culture of the second homeland, their skills in the language of the host country, their direction and strength of ethnic identity, vary among the older immigrants and lead to a greater heterogeneity (Ronström 1996). Therefore, one should be cautious when speaking about older people or ethnic elderly as a group. It can also be assumed that *how* the elderly immigrants experience old age tends to be different, depending on whether they have immigrated as younger people or 'late in life' (*cf.* Torres 2001*;* Emami & Ekman 1998; Heikkilä 1994).

Social theories about ageing in immigrant and minority populations suggest that older people from minority groups are in double (Dowd & Bengtson 1978) or triple (Norman 1985) jeopardy, as they suffer not only from the inequalities related to being old but also as representatives for a minority population, and according to Norman, (1985) because of their physical frailty. Kent (1971) maintains that, on the contrary, according to the 'Age as a leveller' theory, the ethnic differences found among the younger cohorts tended to decrease with increasing age. This would mean that with increased time in the second homeland the immigrants are inclined to adapt to the native populations' culture and way of life.

A sense of continuity in life has been seen as part of successful ageing (*cf.* Erikson 1982). Atchley (1989; 1999) claims that individuals preserve and maintain both internal psychological and external structure in the social and physical environment, by making adaptive choices that allow them to feel a sense of continuity between past and current events. In this way, people maintain a stable, yet evolving sense of self as they age. In old age, continuity may exist in specific 'domains', general areas of interest that continue even though the older person's specific activities may change. Continuity is maintained through symbolic connection between old commitments and a person's current level of ability (Troll & McKean Skaff 1997). Troll & McKean Skaff (1997) did not find any significant relation between disruptive events that respondents aged 85 years or more had experienced during the months before the study and their sense of continuity of self. If there had been an identity change, the turning point had occurred much earlier, through the immigration process or widowhood. However, there is also evidence of the cultural nature of identity definitions: Mansour & Laing (1994) found that Saudi elders observed that their personalities changed as they aged.

Torres (1999) means that the impact of migration and the extent to which its consequences are characterised by losses and difficulties are partially contingent upon the age of the people that have migrated. According to her, migration early

in life has been considered less arduous than migration later on in life. Haavio-Mannila's results (1986) point in the same direction: the elderly Finns that had lived in Sweden for more than 15 years were more satisfied with their living conditions and social networks than those who had lived there for less than 15 years.

Care for immigrants and minorities

In its simplest form, care can be described as an attitude or orientation that is beneficial through the acts or omissions, of one person to another (Morse *et al* 1990). Caring is an inclusive human trait denoting a primary way of being in the world that is natural and of primal importance in our relatedness to others (Morse *et al* 1994).

Caring and nursing should meet the needs of all members of society (*i.e.* SFS 1982; Cortis & Kendrick 2003). This means that nurses should demonstrate an awareness of care so that it also relates to clients from ethnic minorities. Cortiz & Kendrick (2003) claim that the cultural dimension of nursing care is frequently ignored or marginalized. Many members of ethnic minorities feel alienated and isolated in health care (Askham *et al* 1995; Cortis & Kendrick 2003).

However, there is an increasing body of knowledge concerning the impact of culture and ethnicity in health care, which is usually based on the notion that illness and health beliefs and practices are culturally bound. This means that in order to provide effective care for patients from different ethnic groups, these beliefs and practices should be taken into account and respected (*i.e.* Kleinman 1988; Helman 1994; Leininger 1991; Giger & Davidhizar 1991; Meleis *et al* 1992; Lipson 1992; Meleis *et al* 1998; Andrews 1999).

The impact of culture has attracted more and more attention in cross- and transcultural nursing, as it has become evident that both the health care providers' and the patients' perceptions of illness and health care practices are influenced by their cultural heritage. The shared and learned values, beliefs, norms, and ways of life of a particular group are believed to guide our health and illness behaviours and how the care is provided (Kleinman 1988; Helman 1994; Leininger 1991; Rempusheski 1989; Andrews 1999).

So far, there has been no consensus on the definitions to be used in the research area of cross-cultural and transcultural nursing (see discussion: Lipson 1999; Brink 1999; Boyle 1999; Leininger 1999; Meleis 1999). Neither has a consensus been reached as to what is meant by cultural competence (Canales & Bowers

2001). Even the outcome of care where cultural or ethnic aspects are taken into account involves a seemingly interchangeable variety of terms. The care is regarded as culturally 'adjusted', 'appropriate', 'aware', 'congruent', 'competent', 'comprehensive', 'relevant' or 'sensitive'. Wenger claims that none of the above terms adequately conveys the idea of commitment on the part of the persons who are "engaged in the lifelong journey that is directed toward learning about cultural diversities while seeking common ground in cultural universalities" (Wenger 1999: 10).

The orientation in trans- and cross-cultural models and theories is often focused on explaining to the health care providers from the majority population how the health care issues are structured and understood in ethnic minority populations. Leininger's theory is one example of models such as these (Leininger 1991). She claims that culturally congruent or beneficial nursing care can only occur when the individuals', the groups', the families', the communities', or the care cultures' values, expressions, or patterns are known and used appropriately by the nurse. This is done with the help of professional assessments when decisions are made about what kind of help the patients should be given, and how they should be helped. Leininger's model consists of: (1) *Culture preservation and maintenance*, which helps people of a particular culture to retain or preserve relevant care values; (2) *Cultural care accommodation* or negotiation that helps people to adapt to or to negotiate with professional care providers for beneficial or satisfying health outcomes; and (3) *Cultural care re-patterning or restructuring* that helps the clients to reorder, change or modify their lifestyles for new beneficial health care patterns.

Another point of view in the field of the caring sciences maintains that people from different ethnic minority groups are vulnerable in health care because of inadequate health care policies. This leads to insufficient access to health care, or cultural incongruence and incompetence in the health care system, which leads to unsatisfactory health provision (*i.e.* Meleis 1990; 1991; Lipson 1992; Meleis *et al* 1998; Racine 2003).

Although there are advantages in considering cultural aspects, critical voices have also been raised regarding the use of the concept of culture in health care and caring sciences. 'Culturalist' models and the utilization of individualistic health frameworks that "crystallize" culture into a static entity have been criticized (Racine 2003). Ahmad (1996) for example, raised the problem of using the concept of culture in research about health, illness, and the health care of minority groups, as culture is often seen in these studies as a basic and static aspect determining the behaviour of individuals. Sheldon & Parker (1992; in Gerrish 2000) claim that in nursing studies where culture and ethnicity are taken into account, culture is often referred to as an explanation for differences. In

cases were the outcomes were negative, it was the client's culture or the patient that was blamed. Furthermore, (pan ethnic) whites are frequently viewed as the norm against which the differences between everyone else are measured and compared (Andrews 1999; Gerrish 1999; 2000).

Care for older people from different ethnic groups

When immigrants enter their second homeland, they are often healthier than the majority or native population (Frisbie *et al* 2001; Stephen *et al* 1994). However, older immigrants often have a poorer health status compared to the native population (Pudaric *et al* 2003).

A large number of studies about the accessibility of elderly care services have been made (*i.e.* Moon *et al* 1998; Wallace *et al* 1997; Wallace *et al* 1998) and the results point in different directions. Some groups seem to have easy access to services, others not (*cf. ibid.*). When finding that access to care is difficult, the focus has been placed on discussions as to whether this is because of cultural differences or socio-economic aspects (*i.e.* Racine 2003; Miller *et al* 1996; Yee & Capitman 1996).

In literature, an increasing number of studies presenting models and interventions of culturally adjusted elderly care for ethnic minorities and immigrant groups have been conducted. In these studies, the use of culture brokers has been popular. Culture brokers are knowledgeable and trusted persons belonging to the same culture as their clients or patients. Their role has been to inform the nursing staff about their clients/patients, in order to increase the nursing staff's cultural competence, and to increase access to the minority communities. An example of this is Boyle *et al*'s (1992) study of home help nursing care staff working in Navajo reservations. The nurses learned that the Navajo elderly people differed in their cultural distance and attitudes towards Anglos. The authors concluded that nurses must individualise care within a cultural framework in order to meet their clients' needs. Jackson *et al* (2000) used culture brokers in order to adjust an existing mainstream occupational therapy programme to Mandarin-speaking elderly people. The staff acquired an increased understanding of culture-bound beliefs relating to old age and activities, and this gave them the opportunity to adjust the programme so that it became more appropriate to the wishes of the elderly persons.

In another model, the elderly people from a certain group have been provided with care by members of their own ethnic group, that is, people that are skilful in the mother language of the elderly persons. For example, in Ekman *et al*'s (1993; 1994; 1995) studies, Finnish-speaking persons who had been bilingual

previously but had lost the ability to express themselves in the second-learned language (Swedish) due to dementia diseases, showed 'latent' abilities when being cared for by Finnish-speaking nurses and a communion between the nurse and the patient became possible. The same care situations resulted in aggressive behaviour among patients and a refusal to co-operate when the nurses could only speak Swedish. Emami *et al* (2000) studied Iranians who had immigrated to Sweden at an older age. Their study showed that the elderly people experienced an increase in their well being when they began to participate at a day care centre that they had also helped to initiate. Members of staff were also immigrants from Iran and they spoke fluent Farsi, the elderly persons' mother language. At the day care centre, the older Iranians were able to meet each other and participate in lectures about the Swedish health and elderly care system in their own language. They also took part in different activities that were typical in their own traditions.

Finns as an ethnic group

Junila & Westin (forthcoming), claim that Finns in Sweden cannot be regarded as an ethnic group, as they come from different parts of the country and speak two different languages. In this thesis, the Finnish-speaking Finns in Sweden are regarded as an ethnic group. They share the idea of peoplehood, based on a common history and homeland, Finland. They also have a distinct language; Finnish (although many natively Swedish-speaking Finns live in Sweden) and they have created Finnish social institutions in Sweden. Many of them also regard themselves as being a particular kind of people with shared characteristics, such as hard-working and persistent, in Finnish this is referred to as having 'sisu' (Palo-Stoller 1987; Sintonen 1999; Stoller 1998).

THE RATIONALE OF THE THESIS

Almost all Western countries are becoming increasingly multiethnic, mainly because of immigration (*i.e*. Pudaric *et al* 2003). This places new demands on the provision of health care services, as the different ethnic groups may differ from the host population concerning their health care beliefs and practices. Because it is known that the number of persons ageing in a second homeland is rising, this means that eventually they will need elderly care. Earlier studies have shown that elderly people from minorities have less access to elderly care, and that the care in the elderly care settings results in isolation, or care that is incongruent to their norms and values (*i.e*. Moon *et al* 1998; Wallace *et al* 1998; Meleis 1990; 1991; Leininger 1991; Lipson 1992; Meleis *et al* 1998; Racine 2003).

In Sweden, Finns constitute the largest immigrant and minority group. The elderly Finnish immigrants have usually lived for a relatively long time in Sweden. This should mean that they have adopted the Swedish health care system and adapted to it. However, a lack of skills in Swedish, found in earlier studies (Haavio-Mannila 1986; Jansson *et al* 1986; Nieminen Kristofersson 1993) suggest that elderly Finnish immigrants may experience difficulties in connection to the Swedish health care and elderly care system. Furthermore, Finns have strived for their own institutions for a long time and in 1995, the first elderly care setting for Finns in Sweden was established.

The starting point for this thesis is related to the elderly Finnish immigrants' experiences of health care in Sweden. Here, experience is understood in a broader perspective, concerning their own personal experiences and the contexts that guide the perceptions and understandings of these experiences, namely, their attitudes, their beliefs, and their ethnic background. These form, and lead to, wishes and expectation of future elderly care. In the case of the Finnish immigrants' in Sweden, if they desire care in Finnish, in addition to ordinary care (read: normal Swedish elderly care and its options), they have the option of remigration or (although this is extremely limited) care that includes different forms of culturally adjusted care.

AIMS OF THE THESIS

The purpose of this thesis is to describe and obtain a deeper understanding of the elderly Finnish immigrants' experiences of health care and elderly care and the role ethnicity plays in these experiences. The specific aims are:

- To elucidate the elderly Sweden-Finns' experiences and beliefs about health care in Sweden, in order to gain an understanding of how ethnic background influences the elderly immigrated persons' experiences and beliefs about care in the host[2] society (**I**).
- To illuminate the role that culturally appropriate[3] care plays in relation to the elderly Finnish immigrants' wishes and expectations of institutional elderly care (**II**).
- To describe and compare the older Finnish immigrants' perceptions of health care, both among those who have continued to live in Sweden and those who have remigrated to Finland (**III**).
- To describe the cultural adjustments [3] that have been made at a specific elderly care setting, the Finnish Home, and to enlighten the impact of these cultural adjustments on care, as conditions that promote the residents well being (**IV**).

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[2] The word 'host country/society' is used to refer to the country that people immigrate to from their country of origin. In literature, the receiving country is often referred to as the 'new' country, or the 'host' country. Both terms are misleading when it comes to people who may have lived most of their lives in that country or at the least for a long period of time because it suggests a connotation of novelty or hosting a guest or visitor. A better term would be 'second homeland' (*cf.* Norman 1985).

[3] Unfortunately, even here the words 'culturally appropriate' and 'culturally adjusted' care are used interchangeably.

METHODOLOGICAL FRAME

In the thesis, different data collection and analysis methods were used in order to provide answers to the specific aims of the research. The thesis includes studies conducted with both qualitative methods (**I-II** and **IV**) and quantitative methods (**III**). As the aim of the research purposes in Studies **I-II** and **IV** was to shed light on the participants' lived experiences and perceptions (interpretations) of these experiences, the qualitative methods were necessary. Personal interviews (**I-II, IV**) and an ethnographic method with participant observations and informal interviews (**IV**) were used for the data collection and three different interpretative qualitative analysis methods, were used for the analysis processes. In Study **III** quantitative methods were used, since the scope of the study was comparative and included respondents from both Sweden and Finland.

Participants

In all studies, (**I-IV**) the participants were elderly people that had emigrated from Finland to Sweden at some point in their lives and who spoke Finnish as their native language. In studies **I** -**II**, the 39 participants lived in Stockholm and were 75 years old or older. In Study **III** the participants were 65 years or older and 642 of them lived in Sweden while 217 had remigrated to Finland. The participants in Study **IV** lived in a combined residential and nursing home in Stockholm, in Suomi-koti (the Finnish Home).

Data collection procedures

Depending on the study design, different data collection methods were used. In studies **I** and **II**, personal interviews were conducted in the participants' homes, in study **III**, the participants answered a mailed questionnaire, and in study **IV**, participant observations and interviews were conducted at the Finnish Home.

Recruiting the participants

In order to recruit voluntary participants to Study **I** and **II**, a total of 181 introductory letters were sent to every 9th person on the name and address list of the 1631 persons that were born in Finland, aged 75 years or older, living in the municipality of Stockholm. This list also included Finland-Swedes, *i.e.* persons who speak Swedish as their mother language. Thereafter, the persons were contacted by telephone. Telephone contact revealed that 45 persons were Finland-Swedes.

Totally, 39 persons agreed to participate in the study. The main reasons given for non-participation were: people did not consider themselves Finnish (6 persons), were not interested in participating, could not be contacted (71 persons)and feeling themselves too ill to take part in the study (20 persons). During the telephone calls with the respondents that had agreed to participate, an agreement was made about the time and the place for the interviews.

In Study **III,** the participants were recruited in both Finland and in Sweden. Totally 860 persons participated in the study. *In Finland,* all of the 465 Finland-born persons who spoke Finnish as their official Mother language and had re-migrated from Sweden to Finland during the 1990s, after they had reached the age of 65 years, were invited to participate in the study. They received an introductory letter by mail with information about the research project, together with the questionnaire. The name and address list of these persons was obtained from the Population Register Centre in Finland (ordered statistics, 2000). A letter of reminder was sent to those who did not return the questionnaire and a copy of the questionnaire was enclosed once more. A three-question shelf was also enclosed so that an explanation, in the case of non-participation, could be provided. Totally 217 persons (47.1 percent) answered the questionnaire.

In Sweden, a power-estimation with 95-percent level simulation was calculated, before a decision about the sample was conducted. A randomly chosen, stratified sample of 1186 Finland-born persons living in Sweden, who were 65 years or older, and spoke Finnish as their official Mother language was obtained from the Population Register Centre in Finland (ordered data 2001). This list included only Finnish citizens. The stratification consisted of statistical division according to geographical area, age, and gender. These 1186 persons were sent an introductory letter and the questionnaire. A letter of reminder and the 3-question shelf relating to possible non-participation was mailed to those who did not return the questionnaire. Totally, 643 persons (54.2 percent) answered the questionnaire.

The dropouts in Finland, when data was available, showed that these people were older than the respondents, and in both countries, the main reason given for non-participation was poor health.

Study **IV:** After receiving consent from the chief manager at Suomi-koti, the Finnish Home, an introductory letter about the research project was delivered to the staff, the residents and their significant others. Due to the nature of ethnographic studies, all members of staff, residents, and the people who visited the home, were regarded as participants (about 100 persons).

Data collection methods

Qualitative interviews

A qualitative research interview is a dialogue between the interviewer and the interviewee focusing on the topics of interest for the research (Kvale 1996). "An interview is literally an *inter view*, an interchange of views between two persons conversing about a theme of mutual interest" (Kvale 1996: 14). An interview is a meaning creating exercise where the meanings of questions and responses are contextually grounded and jointly constructed by the interviewer and the interviewee (Kvale 1996; Mishler 1995). The interview is therefore always conducted in a certain context, where the interviewer is the main tool for the data collection, (Morse & Field 1995) and the interviewer's background and personality also affects the results of the interview (Kvale 1996; Mishler 1995; Morse & Field 1995; Gordon 1998). Therefore, creating a confidential relationship with the interviewees became a perquisite for a good interview (Kvale 1996; Mishler 1995; Morse & Field 1995). In Study **I-II**, the first author's background as a Finnish immigrant in Sweden increased the interviewees' trust in the interviewer. In addition to this, it probably influenced the way they expressed their experiences and perceptions, as they probably felt that some advantages could be gained by referring to their experiences as Finnish immigrants.

The interviews (**I-II**) were carried out in the participants' homes with the help of a theme guide that covered a life history perspective. The focus of the theme guide however, was to concentrate on the participants' experiences of health care and their wishes about future elderly care. In accordance with the interviewees' requests, three of the interviews were conducted in Swedish and the remaining interviews were carried out in Finnish. The different themes were introduced by asking a general question, "Please, tell me about your experiences/ideas/beliefs of…" and the participants were encouraged to talk freely about the topics. Additional questions were asked in order to confirm that the interviewer had understood correctly or to get a deeper understanding of the participants' meaning. All interviews were audio taped and, after the interviews, they were transcribed verbatim. Also, specific audible expressions, such as laugher, crying, stressing a point, and ironical or joking tones were noted, in order to provide added understanding of the text material.

Questionnaire

In Study **III**, a questionnaire was used that included 117 questions in Sweden and 134 questions in Finland. This mainly contained multiple choices, and some open-ended questions. The questions included several areas of interest from childhood to old age, with particular focus on migration experiences, housing conditions, working life, social networks, health and functional ability and

experiences and attitudes to health care. In both countries, most of the questions were the same, but the questionnaire in Finland included questions about remigration experiences. In the Swedish version, these were changed to questions about current life. In Study **III**, only background questions, experiences of health care, experiences of migration, and a battery of claims that the Finnish/Swedish health care was superior than the other, were included. The questions in focus in Study **III** were created especially for the current study and only the questions regarding migration experiences and experiences of health care have been used earlier (SOU 1997).

The questionnaire was mailed to 465 persons in Finland and 1185 persons in Sweden, together with an introductory letter explaining the design and the aims of the study. Participants were also informed of the voluntary nature of participation and their rights as participants. One reminder was sent to persons in both countries.

Ethnographic study design

In Study **IV**, an ethnographic method was used for data collection. Participant observations and interviews were conducted in all of the four wards at Suomi-koti, the Finnish Home, an elderly care setting for Finns living in the area of Stockholm.

Participant observation is the main data collection method in ethnographic studies. A focused ethnography was used (Muecke 1994; Boyle 1994), where the topics for the data collection were selected before the data collection began. Participant observations, as a data collection method, include observations of the "field" (=Finnish Home) concerning the topics that were relevant to the study (*cf.* Boyle 1994). In **IV**, the focus was placed on identifying the specific characteristics of Finnishness in the culture at the Finnish Home and how these characteristics affect the well being of the residents.

The participant observer can take different roles, *i.e.*, 'complete observer', 'observer as participant', participant as observer' or 'complete participant (Atkinson & Hammersley 1994). In Study **IV**, the first author's role was 'observer as participant'.

The first observations concentrated on finding a general picture of how the Finnish Home functioned, and on the specific culture at the elderly care setting. Thereafter, the participant observations became increasingly focused on the specific research interests. This is the reason that the participation observations were limited to times most likely to enlighten the research questions and to particular events. The author's role during the participant observations was to be

present in the everyday life on the wards, but also (in a limited amount) to give a helping hand where it was needed.

The data collection period lasted for thirteen months. The first author visited the different wards at the Finnish Home on an average of four hours each time, during the daytime, once or twice each week. She also participated in the normal daily routines, the different activities, and the celebrations at the Home. During the observations, notes were discretely written down and later on, directly after the observation occasions, the notes were completed in field notes. A diary, consisting of presuppositions, questions and emerging themes, was also used regularly.

Three audio taped interviews took place with the chief director, a focus group consisting of relatives to the residents, and with one of the persons who took the initiative in starting the project. These interviews were conducted with the help of a theme guide, and later on, were transcribed verbatim. During the observations, many interviews occurred spontaneously, when the participants (residents, staff and relatives) started to explain to the observer (KH) about the different aspects of the Finnish Home and about their experiences. In these interviews, the role of the interviewer (KH) was twofold: to participate in discussions and to ask additional questions according to the topics of the study. Directly after these interviews, short notes were taken, and afterwards, the notes were complemented in the field notes with descriptions of the discussions and the context. The underlying idea was to maintain a feeling of normality and discussion-likeness in these interview sessions.

Data analysis methods

Four different analysis methods were used in this thesis. In Study **I**, a hermeneutical approach was applied following Kvale's notions (1996) of ad hoc analysis. In Study **II**, qualitative content analysis in its latent form was used (Fox 1982; Catanzaro 1988; Morgan 1993; Morse & Field 1995).). Study **III** was analysed with descriptive non-parametric statistical methods (Connor-Linton 2003; Sandberg 1995; Siegel & Castellan 1988). In Study **IV,** an ethnographic analysis was conducted (Morse & Field 1995; Atkinson & Hammersley 1994; Boyle 1994; Tesch 1990; Geerz 1973).

Hermeneutical analysis

In Study **I** a hermeneutical process of interpretation was used. Hermeneutics is a study of the interpretation of signs (Ödman 1991) and texts (Kvale 1996; Ricoeur 1971) or actions (Ricoeur 1971). According to Radnitzky, (1970) hermeneutics studies texts by interpreting them, in order to find out the intended

or expressed meanings. The purpose is to establish a co-understanding, or a possible agreement on the meaning of the text. The understanding of a text takes place through a process where the meaning of the separate parts is determined by the global meaning of the text as it is anticipated. The determination of the meaning of the separate parts may then change the originally anticipated meaning of the totality, and this again influences the meaning of the separate parts. The analysis continues in this hermeneutical spiral, in principle infinitively, but in practice, it ends when the analysis has reached a valid unitary meaning that is free of inner contradictions (Kvale 1996; Ödman 1991).

In **I**, the data was analysed by using Kvale's (1996) notions of ad hoc analysis. By ad hoc analysis, Kvale means that the researcher uses a free interplay of techniques during the analysis. The data analysis began by reading the whole interview material several times, in order to grasp the surplus level of understanding of the contents and meanings of the data. Then the texts were sorted in accordance with the titles in the interview guide. Thereafter, the texts under the headings of experiences and beliefs of health care were extracted to build a new data set. The analysis process then continued to concentrate on this separated data set.

In order to handle the large amount of data, it was divided into meaning units according to the main domain of care, *i.e.*, doctors, hospitals and elderly care. Then the meaning units were categorised once again to include either positive or negative statements about care situations. After this categorisation process, the meanings of the contents were interpreted from the interviewees' perspective, in order to gain an understanding of how they understood their experiences. The interpretation included some specific assumptions, which were stated about the meaning of the statements, and then controlling these against the different meaning units and the whole interview text. This assumption building process continued until a coherent understanding of the meaning of the data was achieved and the understanding was free from contradictions.

Ethnographic analysis process

In Study **IV**, the analysis started concurrently with the data collection and continued throughout the project. The field notes, diary notes, and the interviews were read continuously in order to capture the ideas and the assumptions regarding the meaning of the data, which resulted in suggested patterns. These patterns were then validated, modified, or rejected, in the following interviews and observations. In this way, there was a switching back and forth between the researchers' assumptions, ideas, questions and explanations (the etic perspective) and validating these against the interviewees' viewpoints and observations (the emic perspective), that is, a testing of the etic perspective against the emic (Geerz 1973; Leininger 1991; Boyle 1994; Emami 2000). The

validated patterns then led to analytic categories that were developed into a theoretical scheme by finding links between the concepts and adding new ones (Boyle 1994; Atkinson & Hammersley 1994; Morse & Field 1995). This process continued even after the data collection was completed, until all data built a coherent understanding of the contents and meanings of the data.

Latent qualitative content analysis

In latent content analysis, the common patterns in the data are searched for (Morgan 1993) by using a consistent set of codes to designate data segments that contain similar material and by categorising these codes. The categorisations are then used as a basis for formulating the consistent themes that explain the data appropriately (Morse and Field 1995; Morgan 1993; Fox 1982). In its latent version, the implicit meanings in the content are then interpreted (Morse and Field 1995; Fox 1982).

In Study **II**, based on the headings created in Study **I**, all the texts under the headings "Wishes of future care", "Expectations of future care" and "Interest in culturally appropriate care," were extracted for analysis purposes. Thereafter, the content analysis was carried out with this reduced data set.

Even here, the data was divided into meaning units, which were then coded according to the content of the unit. After the coding process, all codes were categorised according to the answer to the question: *what* kind of elderly care the participants wished for or expected? From the same coding, another categorisation process was conducted, in order to find answers to the question of *why* this kind of care setting was desired. This categorisation also included interpretation of the latent meanings of the content. Following this, both categorisations were studied together and compared to the original data as a whole, in order to find the more general themes that might explain the data. From the analysis, one main theme and two sub-themes emerged.

The second author co-assisted in the analysis by reading every fifth interview and assisted by considering the confirmation and trustworthiness of the categories found by the first author. When disagreements occurred, the coding and categorisations were discussed until both authors could agree on the formulations of codes and categories.

Statistical analysis

For the purposes of Study **III**, the questions about experiences of health care and about health care providers' treatment in both countries were collapsed to the variables: Experiences of doctors' treatment in Sweden, and, among re-migrants, in Finland. The same was done with questions about the experiences of nursing staff in Sweden, and among re-migrants in Finland. These sum variables were calculated by taking the individuals' median of the four questions referring to treatments. Each respondent's answer was categorised to 'good experiences', 'cannot answer' or 'bad experiences'. The attitudes to the Finnish and Swedish care and care providers were formed into statements suggesting the better quality/characteristics of Finnish care or Swedish care and care providers, and the respondents were asked about their level of agreement with these assertions. The questions were summed up into two sum variables: 'Better care and care providers in Finland', and 'Better care and care providers in Sweden'. The multiple choices were calculated to an individual median of all the "better Finnish care" -answers and "better Swedish care" -answers so that the answers of each respondent were either placed in the categories, "does not agree," "cannot answer" or "agrees" with the assertion. Even the migration experiences were re-categorised according to this 3-step ordinal scale. Cronbach's alpha was used to test the reliability of the sum variables. A majority of the questions had nominal and ordinal scales, so chi^2-tests were used to test the levels of differences and association (Connor-Linton 2003; Sandberg 1995; Siegel & Castellan 1988). The level for significance was set at 0.05. The data analysis was conducted with the data programme SPSS.

Methodological considerations

The qualitative studies (I-II and IV)

Eakin & Mykhalovskiy (2003) propose a substantive judgment in the evaluation of qualitative research. According to them, a substantive approach opens the reader's evaluative gaze so that they are able to focus on the analytic content. The judgement should emerge from a deeper engagement in, and understanding of, the interpretations and the proportions that are presented and an assessment of how they are produced and rendered convincing by the research practices used. It should function as a starting point that helps to provide an understanding of the analysis.

This substantive form of judgement urges people to use the research question as a positioning device for comprehending the nature of the investigation and understanding its findings. The information on how the data was collected

should demonstrate that the research was systematic and help the readers to grasp the meaning that is attributed to the data (*ibid*).

The evaluation of the researchers subjectivity should be based on an understanding of its active and creative use throughout the research process and as a resource that is seen as a critical point of reference that allows the reader to apprehend both the research process and the substantive analysis that is proposed (*ibid*).

Eakin & Mykhalovskiy (*ibid*) want the reader to question how the sampling process and the sample itself guides the actual data collection, and whether this is also the case during the interpretation of the material. This information should contribute to the readers' ability to make sense of how the research was performed and the claims being made about it, as well as how and why the analytic focus evolved in the way it did. The information concerning how the data was collected should demonstrate that the research was systematic and help the readers to grasp the meaning that is attributed to the data (*ibid*).

The analysis process judgement should be based on improving the readers' ability to 'feel' the texture of the account that is presented, to understand the conceptual development and the foundation of the analysis and thereby, help the reader to comprehend the leaps of imagination and creative thinking that constitute the feature of research (*ibid*).

Researcher as a tool

In qualitative research, the researcher is the main tool when collecting data and analysing it (Lipson 1991). After the introductory letter, the fact that I had a Finnish-sounding name, probably increased peoples interest in the study. This positive effect probably improved during my telephone calls to participants, as this gave them the opportunity to express themselves in Finnish.

During the interviews, the participants were given the opportunity to express themselves relatively freely because the questions covered an extensive area, which gave them the option of choosing which particular aspects they wished to emphasise. Because a qualitative interview stipulates reciprocity and is regarded as a discussion about certain topic(s) where both the interviewee and the interviewer participate (Kvale 1996), the participants asked me some questions, which they expected me to answer. The most commonly asked questions related to my family life and personal experiences of immigration. Because of this, my 'Finnishness' was confirmed, and this meant that the participants now treated me as "one of their own," a person that they believed was worth talking to about their experiences. They felt that I shared their experiences as a member of the same ethnic group. Therefore, the "moreness of the Finnish" was frequently

expressed and was often a taken-for-granted assumption underlying the interviews. These kinds of beliefs would probably not have been revealed if the interviewer had been from a different ethnic group. My presence helped to draw these beliefs to the surface.

However, the shared understanding of the specific underlying assumptions and knowledge of "Finnishness" that made it easier for the participants to be frank with me about their ethnically based thoughts, was also a risk factor. Because it was assumed that, I 'knew' and 'understood' these culturally based beliefs and ideas, I was not expected to ask for explanations for them. In fact, as I thought that I did recognise and understand, it did not occur to me to ask the participants for an explanation for these taken-for-granted aspects. This was revealed during the analysis phase, when I realised that I had not always asked the participants for confirmation about whether I had understood correctly. This might suggest that their experiences and beliefs have been studied on a superficial level. However, the advantages of having been trusted as a Finn provided a perspective that would have not been enlightened without these assumptions of understanding.

During the participant observations, belonging to the ethnic group of Finns in Sweden, probably eased my entry to the "field." My presence was accepted by the residents and the staff because I was Finnish and spoke the same native language. There was also an expectation that I would prove to the world; how beneficial care provided in the residents native language is. As this was also my underlying assumption, the need for a critical stance was important.

It has been considered difficult to carry out research about one's own culture (*i.e.* Sandelowski 1993), because there is the risk of 'going native', which means not noticing typical aspects in the culture. An observer coming from another culture would probably have seen aspects that were 'hidden' from me. To be aware of the specific features of the Finnish Home, I worked for three days in another elderly care setting, on different wards. This helped me to see the similarities and the differences between the Finnish Home and an 'ordinary' Swedish ward. In addition, the lengthy period of the observations, and the detachment that I gained throughout the on-going analysis process, helped me to view the life in this elderly care setting, as a 'professional stranger' (Agar, 1996).

Both of the authors in **I-II** were Finnish immigrants living in Sweden, and the second author was an active member of Finnish associations aiming at establishing elderly care settings in Finnish. At the same time as this study was carried out, another study was in the process of recruiting elderly Finland Swedes for their study. This is why the recruitment of participants to Study **I**

and **II** was based on a systematic selection of people from a name and address list. A large sample was chosen for mainly two reasons: Partly, because we did not know how many people in the sample would be Swedish-speakers, and partly because we expected a large number of drop-outs, because earlier studies (Heikkilä 1994; Leiniö 1984) have found that the number of Finnish immigrants on disability pensions is higher than among native Swedes. Therefore, it was anticipated that the elderly Finns would be frail and that is why the age limit was set at 75 years instead of 80 years, which is usually the case in Sweden when referring to 'older older people.' One of the ideas was to study how interested people were on the topic of culturally adjusted elderly care, and we expected the younger and healthier to be less interested than those who might have to move to an elderly care setting in the foreseeable future.

About one fourth of the selected persons were Swedish-speakers, which is a common estimation regarding the population of elderly Finnish immigrants in Sweden (see Heikkilä 1994; Populations Register Centre 2001). When the Swedish-speakers were not included, the number of drop-outs was 97. A fifth of these felt that they were too old or too ill to participate. This means that the healthiest people were more likely to have participated in the study. Over 50 percent of the drop-outs reported that they were not interested in the study. This might mean that those who participated in the study were persons with a stronger identity as Finns, because the introductory letter was addressed to Finnish immigrants.

Analysis processes

In three studies, a hermeneutics based interpretation method was used (**I-II** and **IV**). In Study **I-II**, the method was used after the first reading of the whole material and after the material was categorised according to the topics in the interview guide. During this process, the surrounding meanings were taken into consideration so that the utterances and narratives were understood within their context. Thereafter, the categories in focus were separated into new data sets. Parts of the data sets were the same in both studies because the contents from the studies were intertwined.

In both studies **I** and **II**, the analysis process was rather similar, with a division of meaning units and a categorisation of the units. The differences are found in the role of interpretation. In Study **II**, the content of the 'why' categorisations was interpreted in order to find out the latent meaning of the content of the participants' utterances and narratives (what did the participants mean when uttering or narrating?). In Study **I**, the meaning of the participants' utterances and narratives was investigated (what the utterances and narratives meant).

In Study **IV**, the analysis process started at the same time as the observations. After each observation, a preliminary analysis was carried out. In the beginning, this led to more questions and reflections, which were then focused on during the next observation. Preliminary hypotheses were confirmed or rejected when new data was added to the previous data. When saturation (Morse & Field 1995) was achieved and the observations ceased, the analysis process continued, and the fact that I was no longer 'in the field' provided me with the advantage of seeing it from a new perspective.

In all three studies (**I-II, IV**) the tape-recorded interviews were transcribed verbatim and when the interviewee emphasized a certain issue or their tone of voice was ironic, sad, etc these expressions were added as remarks to the text. However, although several aspects vanish in the transcription process from tape to text, the text built an understandable data.

During the interviews (**II**) and later on during the analysis process, my personal opinion about the advantages of elderly care in Finnish was a risk. When asking questions my body language and the way I expressed myself might have shown my own 'approval' or 'disapproval' of the interviewees' utterances and narratives. Afterwards, when listening to the tapes and transcribing them, I carefully looked for any indications that might have influenced the responses to the questions *i.e.* the tone of my voice, the way I presented the questions etc, aspects that would reveal biases such as these. However, I did not find any such indications, but I did notice that my own genuine curiosity as to why people were *not* interested in Finnish care was sometimes obvious. This was also the case during the analysis process.

During the observations (**IV**) it became clear that the residents were unable to discuss the benefits of care in Finnish, because they found this natural or believed that they had nothing to compare this with. Therefore, the planned audiotaped interviews were rejected as a data collection method. However, this data collection strategy placed more emphasis on my role as an observer. The suggested patterns, when positive to the care in Finnish, were challenged with a negative suggestion and then they were carefully considered in order to find my own biases during the observation and analysis process. That is why the discussions with the second author were crucial for the verification of my suggested findings. However, the residents' and the staffs' negative utterances were taken into account – perhaps at an exaggerated level.

In the final phase of the analysis process in Study **IV**, the results were presented to the staff, and they agreed with the findings (*cf.* Guba & Lincoln 1989).

In Study **II**, the second author co-assisted in the analysis by reading the coding and categorising every fifth interview. A high level of agreement existed, and the disagreements were discussed and re-analysed until an agreement was reached (*cf.* Guba & Lincoln 1989, Morse & Field 1995).

In all studies (**I-II** and **IV**), the co-authors read the whole data material, and the emerging themes were discussed and dealt with, together with the co-authors. This was part of the analysis process, so that the researches would be aware of the leaps of imagination and creative thinking (*cf.* Eakin & Mykhalovskiy 2003), and to confirm whether the interpretation was reasonable (*cf.* Ödman 1991). However, in Study **IV**, the third author did not participate in the analysis process, as she was one of the founders of the Home.

The quantitative study (III)

Study **III** is part of a larger research project. The questionnaire that was created is tentative, based on earlier findings of mainly qualitative data about elderly Finnish immigrants in Sweden and re-migrants to Finland (*cf.* Heikkilä 1994; Grönholm 1995; **I**). Among the questions that were focused on in Study **III,** only the questions relating to the experiences with health care providers have been used in earlier studies (SOU 1997). The assertions were mainly constructed by using utterances from the interviews in Study **I**, and have not been tested earlier. The idea was to test whether these assumptions were common among all Finnish immigrants or only the Finnish people that had participated in this earlier study.

The assertions where the participants were asked to compare the health care and health care providers in the two countries resulted in numerous 'cannot answer' responses. Some of the respondents had made some comments next to these assertions, where they stated that they could not answer them because they did not have any experience of Finnish health care, and some people thought that the statements were racist. The 'cannot answer' responses can be seen as a neutral viewpoint, showing that people did not want to, or could not take a standpoint regarding these statements.

In Finland, the sample included everyone that had re-migrated to Finland from Sweden after the age of 65 during the 1990s. These included both Finnish and Swedish citizens. In Sweden, the stratified sample that was requested from Finland included only Finnish citizens. This was because of the problems involved when trying to gain access to relevant data in Sweden. Heikkilä's (1994) study showed, however, no differences between the elderly Finns who were Finnish citizens and those who were Swedish citizens. However, the sample in the earlier study was small and consisted solely of persons living in

Stockholm. Further studies are necessary, in order to show whether citizenship influences health care perceptions among elderly Finnish immigrants.

The number of drop-outs was high, in both the Finnish sample and the Swedish. The analysis of the drop-outs in Finland shows that these people were somewhat older than the respondents were. In Sweden, the data did not reveal the ages of the people in the sample, but in the short questionnaire the most common reason given for non-participation was illness. This suggests that younger and healthier persons participated in the study. It can also be discussed whether people who were less satisfied with health care had refused to participate, because the results showed a very high number of positive experiences.

The entire questionnaire, from which the questions in Study **III** were taken, was extensive, with a total of 117 questions in Sweden and 134 questions in Finland. This certainly influenced the number of drop-outs. In addition to this, the questions that were of specific interest to the study were at the end of this lengthy questionnaire, which might be one of the reasons that a large amount of respondents did not complete the entire questionnaire. The results of the study should therefore, be interpreted with caution.

Ethical considerations

The studies have been scrutinised by the Ethical Committee at Huddinge University Hospital, Karolinska Institutet (dnr 134/97, 293/02, 206/00 and 498/00). The participants in Study **I** and **II** gave their oral consent to take part in the study. They were also informed of their rights as participants and their rights to withdraw from the study at any time. In Study **III**, the participants were informed of their rights and about the purpose of the study, in the introductory letter. When the respondents had mailed the questionnaire back to the researchers and had replied to the questions, the researchers interpreted this as written consent. In Study **IV**, consent was requested from the chief manager at the Finnish Home, who also delivered the information shield to the residents, the staff, and the residents' closest relatives. During the observation period, the researchers carefully observed whether any of the participants seemed unwilling to take part. The observer was aware of her role as researcher at all times during discussions with the residents, the staff, and the participants' relatives.

RESULTS

Ethnic identity (**I** and **IV**), mother language (**II** and **IV**), skills in the language of the care providers (**III-IV**), and environment (**II**), were highlighted as the main aspects affecting the elderly Finns' experiences and perceptions of health care and elderly care. In the following section, a short summary of the main findings regarding the elderly Finnish immigrants' experiences and perceptions of health care and of elderly care will be given. Next, the findings about the role of ethnic identity, the role of the mother language, the shared language with the care providers, and the role of place will be summarised.

Experiences and perceptions of health care

According to the quantitative results (**III**), the re-migrated Finns in Finland and the Finnish immigrants in Sweden had mostly good experiences of care in Sweden. Even in Study **I,** the participants had mainly positive experiences of health care. However, Study **I** gave a more complex picture of the elderly Finnish immigrants' experiences, as they differentiated their own experiences from their friends' and neighbours' experiences. If their neighbours had had bad experiences, the elderly Finns believed that health care services were not satisfactory.

Study **I** showed that the health care that the elderly Finnish immigrants had received was, or had became with time, culturally congruent. In their experiences, doctors and their ways of encountering their patients played a crucial role. If the doctors were considered as friendly then they were also believed to be skilful. Negative experiences were commonly related to one particular doctor, mentioned by name. This doctor treated the patients in a routine manner and did not regard them as valuable persons.

The elderly Finns discussed nurses as a collective 'nursing staff'. In hospitals, they were usually regarded as friendly, nice, and considerate, while in elderly care they were regarded as persons with an uncaring attitude (**I**).

The elderly Finnish immigrants' experiences regarding the availability of care varied from person to person. Several of the elderly Finns who needed an interpreter during their interactions with health care staff had chosen a family doctor that was located far away from their homes, because the doctors spoke Finnish (**I**).

According to Study **III**, no significant differences were found regarding experiences of health care in Sweden among those who continued to live in Sweden and those who had re-migrated. However, the re-migrants were

significantly more satisfied with their experiences of health care in Finland compared to their experiences in Sweden. This refers to their experiences with doctors, but especially to their experiences of nursing staff. Both groups (those who had stayed in Sweden and those who had re-migrated to Finland) were more positive about the health care and the care providers in Finland, although the results were not significant. Migration experiences were also significantly associated with experiences of health care in Sweden.

Wishes, expectations and experiences of elderly care

Study **II** showed that elderly Finnish immigrants appreciated their autonomy greatly. They wanted to stay in their homes for as long as possible. Some Finnish immigrants wished to stay in their own homes until they died, and they hoped that they would die suddenly without any great suffering beforehand. However, a majority of the elderly Finnish immigrants expected to be cared for in an elderly care setting with high quality nursing care, later on, when they became too frail to manage in their own homes.

When the elderly Finnish immigrants thought about future elderly care, most of them wished to feel continuity in life, familiarity, a sense of security that the care would be good, and companionship with others in the elderly care setting. Many persons hoped that these wishes would be fulfilled in an elderly care setting close to their current homes, where they felt at home in these familiar surroundings. They wished to remain close to their friends and families in a place where they believed that the care would be skilful. Others expected that a culturally adjusted elderly care setting would satisfy their wishes by offering care provided in their mother language, among care providers and fellow-residents sharing their own ethnic background. This was also expected to lead to a feeling of continuity in life and provided a sense of security that they would have companionship and good care (**II**).

When being cared for in a culturally adjusted elderly care setting, the use of the Finnish language, the Finnish customs and celebrations, and the shared ethnic background with other residents and the nursing staff enabled good caring relationships, which, in turn, increased the likelihood of well-being (**IV**). In the Finnish Home, the cultural adjustments led to culturally congruent and competent care, according to the residents (**IV**), because the whole concept of caring was provided in Finnish, which meant that the residents' Finnish identity was taken into consideration.

The role of ethnic identity

Study **I** revealed that the elderly Finnish immigrants were bearers of a strong Finnish identity, and that this identity affected their perceptions of health care. Although they had positive experiences of health care in Sweden and of Swedish health care staff, they nourished a belief that care in Finland and by Finnish people was something more. This "moreness" of the Finnish was not based on actual experiences, but on a perception based on the belief that when care providers belonged to the same ethnic group as their patients, they would also share the attributes commonly believed to be Finnish "traits" *i.e.*, hard working. The elderly Finns also believed that there was a likelihood of mutual understanding due to this shared ethnic background. - Although not statistically significant, even Study **III** showed that the elderly Finnish immigrants regarded Finnish care and care providers to be superior to Swedish care and the Swedish care providers.

Study **II** showed that ethnic background played a major role for the elderly Finnish immigrants who wished for culturally adjusted, Finnish, care. They expected this kind of care to feel similar to 'being at home' as the Finnish language would be spoken there. They also expected that the shared mother language and mutual ethnic background with fellow-residents and members of staff would enable them to feel companionship. They also believed that they could identify with and relate to others regarding their ethnic identity, as they would be together with people who were familiar with their ethnic history and background. For these people, this meant that they would be cared for in a well-known socio-cultural context.

In the Finnish Home (**IV**), culture-specific features were actively used in the care of the residents. Because staff also had Finnish backgrounds and spoke the Finnish language inside the Home, almost all communication was in Finnish and the residents' Finnish history was vital in caring situations with the nursing staff. The residents also had discussions with each other about current Finnish events, and the communication through the media was in Finnish and about events in Finland. Finnish customs and habits were practiced and the Finnish high festivals were celebrated. Therefore, the residents' ethnic identity as Finns was acknowledged. The shared knowledge about the Finnish history, the geography, and an interest in what is happening in Finland, eased the care situations as the staff could refer to the residents' everyday reality. Staff also believed strongly that a shared ethnic background increased the residents' well being. This belief was also shared by the residents' relatives.

The role of the mother language and a shared language with care providers

The meaning of the mother language and a shared language with the care providers was a recurring theme in all the studies (**I-IV**), although it was emphasised more in Study **II-IV**. In Study **I**, four participants lacked adequate skills in the Swedish language and this resulted in a suspicious attitude towards the care they were given. They were also suspicious about their medication. Two of these participants had contact with a Finnish-speaking family doctor although the doctor's surgery was located far away from their homes. They felt that this was necessary because it made them feel confident in the care providers. The elderly Finnish immigrants believed that culturally adjusted elderly care would provide the means for communication and companionship. They felt that it was crucial to use the mutually understood mother language, especially for those elderly Finnish immigrants who could not speak Swedish. The participants who wished for culturally adjusted care in Finnish expected the use of their mother language to result in a home-like feeling and companionship with fellow-residents and staff (**II**).

In Study **III**, skills in the Swedish language were significantly associated with a feeling of satisfaction with health care among those who had stayed in Sweden. Even the experiences that the re-migrants had with nursing staff in Sweden were significantly associated with their skills in the Swedish language. This suggests that when the care providers and the care receivers do not have a shared language, satisfaction with care decreases.

The studies also showed that the elderly immigrants believed that speaking the mother language gave them several advantages and meanings. Residents believed that by speaking Finnish they would be able to communicate perfectly with the care providers. This meant that they felt secure because they were certain that they had been understood correctly, especially in cases of those suffering from dementia diseases (**II**). It was also shown to facilitate comprehensive communication (**IV**) and a feeling of trust in being understood in a care situation and therefore, given the right kind of care (**II** and **IV**). It also had the wished-for (**II**) and actual (**IV**) role as a creator of affinity and companionship to other residents and even with the nursing staff. The shared language was believed to create a feeling of being at home (**II**) and it facilitated the mediation of oneself as a person and an individual (**IV**). In care situations, the shared mother language facilitated caring relationships between the nurses and the residents (**IV**). The residents enjoyed having company and felt 'at-homeness', due to the mutually understood language and by the fact that people (other residents and the staff) understood their life history and thus, acknowledged their identity and provided continuation in their lives as Finns (**IV**).

The role of the place

Place, in a metaphysical meaning, was an important aspect for many elderly Finnish immigrants when they thought about their future in elderly care (**II**). According to the elderly Finnish immigrants, home was the best place to be, as it included the likelihood of living independently and feeling familiarity and continuity in life. The idea of home as the foundation for one's roots in the second homeland could also include well-known surroundings close to their current homes, that is, if the elderly Finnish immigrants had lived in the same neighbourhood for a long time. For many, if the day came when they could not manage at home anymore, a sense of 'being at home' in a well-known geographical environment was the reason for preferring to be cared for at an elderly care setting close to their present home. For this group, a familiar geographical environment where they felt settled and at home, was more important than the otherwise important culturally appropriate care (**II**).

The place could also be regarded metaphorically, as a socio-cultural environment where they would feel at home with the language, the customs, and the habits of the environment (**II**). The elderly Finnish immigrants who preferred culturally appropriate care in a Finnish-speaking care setting with Finnish care providers, believed that a place such as this would help them to feel settled and at home in their new environment. In the Finnish Home (**IV**), the residents felt that being in a Finnish-speaking environment was natural and they believed that it was the only type of elderly care setting that they would feel comfortable in.

Study **III** revealed that geographical closeness to children and grandchildren was the main reason for staying in Sweden, while the main reason for remigration was homesickness. This can be interpreted as a longing for a well-known place.

REFLECTIONS

At-homeness

Zingmark *et al* (1995) and Zingmark (2000) found that a close relationship was at the core of at-homeness, through which patients can feel related to themselves, to time, place, events, and things. Zingmark (2000) claims that the two terms 'sense of being at home' and 'at-homeness' are used analogously in the literature and mean an understanding of oneself as being related, being connected and being present. She also argues that a new home world cannot be constituted in a new place without the existence of genuine familiarity (*ibid*).

The aspects of at-homeness are related to the aspects relevant for this thesis: the roles of ethnicity, language, and place. It will be argued that at-homeness for elderly Finnish immigrants is connected with relatedness to people that are regarded as near ones, either as relatives and friends, or as fellow-members of the same ethnic group. This feeling of relatedness creates a feeling of familiarity, companionship, continuity in life, and security. Being familiar with a language and its subtle distinctions, especially regarding the mother language, creates a feeling of being connected to other people, and familiar mental or physical places create a feeling of being present. The need for feeling at-homeness is part of mankind's being in the world (Zingmark 2000), and not just an issue for elderly immigrants. However, these issues probably become more important for immigrants and elderly people, as they are more vulnerable due to physical frailty and the fact that they belong to a minority population.

Being related

As Barth (1969) claims, the identification of another person as a fellow member of one's ethnic group implies a shared mutual understanding. When dichotomising others as members of another ethnic group, there is recognition of the limitations of this understanding and a restriction of interaction within sectors with an assumed common understanding and mutual interests. Sandbacka (1987) and Sarvimäki (2004) claim that encounters between people from the same ethnic group create a feeling that the two are 'playing the same language (Sandbacka 1987) - or ethnicity (Sarvimäki 2004) – game', and thus, a shared understanding of the game's rules. Finnish immigrants have a strong ethnic identity; this guided their perceptions on health care, and led to a feeling of mutuality with care providers from their own ethnic group. The real and/or imagined boundaries to other ethnic groups affected how health care was perceived and experienced. Andersson & Kelley (1998) claim that in encounters in health care, both the care providers and patients/clients carry legitimate world -views, and that these worldviews constitute the realities of the encounter. They are not merely some conjured up cross-cultural ideas that people can simply

ignore when necessary. Both the care providers and the patients/clients bring their ethnic identity to the health care encounters (Rempusheski 1989).

The elderly Finns felt that people who belonged to the same ethnic group as themselves, shared the same positive characteristics found among people in their particular ethnic group. The belief of mutual understanding created a feeling of security and familiarity when encountering a health care provider with a Finnish background (**I** and **IV**). Similar results have been found by Rempusheski (1989), who claims that ethnicity is an issue in elderly care because of its integrating character. She means that whether the behaviour that is expressed by the elderly persons is a manifestation of symbolic ethnicity, or strongly held beliefs, it is essential to incorporate this behaviour into care, because it is a part of the care relationships.

Being connected

It has been claimed that language is one of the most significant common features of an ethnic group, since language, besides its communicative function, also has a symbolic dimension (Hedberg & Kepsu 2003). Mayhew *et al* (2001; quoting Beck & Heacock 1988) maintains that after survival, the need to communicate is perhaps the most basic human need. It offers the opportunity to develop and maintain a sense of security and belonging. One part of a mutually shared understanding is based on an understanding of the native language. A 'complete' understanding of the repertoire of a language and knowing the rules and how to use them; promotes self-esteem and empowers the individual and the community (Ahmad 1993; in Khan & Pillay 2003). Giles & Johnson (1987) claim that in an encounter with a member of another ethnic group, people who value their language as a core aspect of their group identity; wish to assume a positive identity by adopting various strategies of 'psycholinguistic distinctiveness'. The use of a minority language is a means of expressing solidarity with one's ethnic group. This means that even when a person speaks the majority language of a country fluently, the shared understanding of the mother language has a profound effect on the quality of the care provider-patient relationships, and the subsequent care that a patient receives (Roberts 1994). Roberts (1994) found, in her study, that when mono-linguistic nurses learned and used phrases from the patients' mother language, the bilingual patients' responses to this were overwhelmingly positive. They appreciated the respect that nurses showed for their mother language, and the nurses were considered more pleasant and easy to talk to.

Jones & van Amelsvoort Jones (1986) found that elderly patients from ethnic minorities have less communication with care providers compared to patients from the majority population. Murphy & Mcleod Clark (1993) found that nurses display poor communication skills when caring for patients who do not share the

same language, and they felt that they lacked the competence to provide 'total care', because their care for patients from ethnic minorities tended to be task-oriented. Ekman *et al* (1993; 1994; 1995) showed that in dementia wards, when communicating with a bilingual nurse who knew the patient's mother language, the nurse-patient relationship became more positive, and the patients showed signs of latent skills.

The elderly Finnish immigrants explained that they were afraid of forgetting their second learned language (Swedish) and they were anxious about ending up in a Swedish ward, where the nurses would not understand their language (**II**). For several of the persons that had re-migrated to Finland, the fear of not being understood in a care situation was one of the reasons for remigration. The elderly Finns with poor knowledge of the Swedish language were less satisfied with the health care they had received, compared to those who could speak good Swedish (**III**). When the residents were cared for by people who spoke the same mother language and lived with other residents that spoke the same language, they were able to, not only communicate their needs and wishes (facts), but also mediate their personality and identity (**IV**).

Being present

Immigration is one of the major relocations that can occur in a person's life course (*cf.* Aroian 1990; Meleis *et al* 1992; Junila & Westin, forthcoming). A move from one place to another results in social consequences, such as, the loss of social relationships and the need to form new relationships and means changes in one's daily routines etc (*cf.* Chapin & Dobbs-Kepper 2001). It can be experienced as a traumatic event that invites dislocation (*cf.* Ortiz et al 1999). When settling in a second homeland, the immigrant creates, in different ways, new social and environmental relationships (*cf.* Junila & Westin, forthcoming; Sarvimäki *et al*, forthcoming; Snellman 2003, Torres 1999, Meleis *et al* 1992; Aroian 1990). This suggests that ethnic identity and trying to create a sense of being at home, may be ways of 'placing' oneself in the new social and physical environment.

The transition to the care and the environment of a residential home has been widely demonstrated as a life event that challenges elderly people. Lee (1999) argues that there is evidence of the stressful quality of relocation for all people, but it seems to have a greater effect on older people. The elderly people are confronted with a change in the geographical location of their 'primary living space' and of changes in daily life patterns, social networks, and support (Johnsson 1996; Lee 1999; Chapin & Dobbs-Kepper 2001). However, in old age, people are at a much greater risk of relocation, as life at home might become difficult for them to manage because of physical and other impairments. The relocation to an elderly care setting is regarded as one of the most difficult

problems facing elderly people, creating feelings of loss, grief, abandonment, stress, uncertainty and loss of home (Zarit & Whitlatch 1992; Lee 1999; Chapin & Dobbs-Kepper 2001). For elderly Finnish immigrants in this thesis, the idea of being forced to move from their current homes, was something they did not want to think about, and their own home was the place they wanted to stay in for as long as possible (**II**). Kontos (1998) claims that a place that is construed as home plays a critical role in maintaining a sense of personal identity. Home is a place of psychological rootedness (Andrews 2002).

Place and personhood are, according to Ortiz *et al* (1999) central to narratives about migration, citizenship, and belonging, and they should be treated as domains relevant to the elaboration of social and moral identities in "ethnic" communities. According to Ortiz, discourse of place carries the capacity of describing the essential characteristics and desirable qualities of persons, and the practices necessary for the production of persons and the reproduction of (moral) communities.

According to Kontos (1998; quoting Agnew 1993), the concept of place is interwoven with three elements: locale, location, and a sense of place. Locale is the setting in which an activity and social interaction occurs. Location refers to the social and other processes that affect locales. Sense of place is the subjective territorial meaning of the locale, or structure of feeling. Place is not only a locale, but also a source of emotional and experimental meaning for its inhabitants. In this sense, the positive emotional meaning of place can be called at-homeness (Zingmark 2000).

When in risk of being relocated to an elderly care setting, the elderly Finns wished for familiarity, continuity in life, security, and a sense of affinity with others (**II**). They expected these wishes to be fulfilled either in familiar places with people that they felt close to, and had lived close to for a long time, or in familiar surroundings with people from their own ethnic group who spoke the same language. In both cases, with people, and in places, that they had emotional ties to in some way. They expected this to create a feeling of at-homeness.

In a culturally congruent elderly care setting (**IV**), speaking one's mother language and being related to people from one's own ethnic group created a sense of being a part of and related in place, and this gave the residents the emotional feeling of at-homeness.

Concluding remarks

> "There are Western scientific beliefs, and individual's ethnic and religious beliefs, and ethical belief underlying the profession of nursing. These beliefs are exhibited in care behavior, in choice of patients to whom we give care, in choices of care strategies, attitudes about self-care, shared care, collegial contacts, and a host of other daily activities. The language we choose to speak is a combination of health care/nursing jargon, English, and other languages. The nurse's ethnic identity may be revealed to patients in his or her language. Or a person may reveal an ethnic identity without a language component and be highly criticized for lacking such language skills. A nurse's ethnic biases and stereotypes are grounded in beliefs. These may be revealed in how patient and family are perceived or cared for by a nurse" (Rempusheski 1989: 722).

Most Western societies are becoming increasingly multicultural, which challenges the provision of health care (Papadopoulos & Lees 2002; Anderson & Kelley 1998). That is why cultural and ethnic aspects are now being focused on to a greater extent, in health care and caring sciences. For example, McKenna (1999) argues that culture explains the variation between groups of elderly clients concerning their health and illness related behaviour and practices. Although McKenna does not view culture as the sole determinant of behaviour, she argues that culture is a critical dimension when trying to understand the interactions of elderly clients with their families and the encompassing societal context. Their cultural traditions and the values underlying their actions will influence their preferences for their place of residence, lifestyles, and expectations regarding their future caregivers. Anderson & Kelley (1998) claim that culture has been thought to be a major element of how persons view the world and interact within the health care setting. Therefore, an understanding of how culture influences peoples' behaviour is a necessary first step in comprehending, what Anderson & Kelley's call the: 'ethnic context of intercultural encounters'. Khan & Pillay (2003), however, argue that differences in health beliefs and values, when comparing ethnic minority groups to the white indigenous population, are not addressed adequately. Being knowledgeable about culture does not necessarily guarantee sensitivity in patient care.

Although awareness has increased about the role of ethnicity and culture and their impact on health care practices and preferences, the way in which health services are organised and delivered is mainly mono-culturally based on Western ideologies that can easily become ethnocentric (Khan & Pillay 2003;

Racine 2003; Omeri & Atkins 2002; Papadopoulos & Lees 2002; Burr & Chapman 1998). Racine (2003) argues that notions of cultural sensitivity and cultural awareness are not sufficient to provide culturally safe nursing care, since the relationships between colonialism, dominant ideologies, and nursing practice, are either underestimated, overlooked or left aside. Gerrish (2000) argues that ethnicity and culture are offered as an explanation, meaning that cultural differences lead to health differences among populations. This ethnocentric perspective identifies ethnicity and cultures as the key question and problem (Khan & Pillay 2003). Andrews (1999) claims that when using the term cultural diversity, the white pan ethnic group is frequently viewed as the norm, against which the differences between everyone else are measured and compared. Talabere (1996) suggests that 'cultural diversity' is itself an ethnocentric term because it focuses on how different the other person is from me, rather than how different I am from the other. Even the assumption that members of the same cultural background react and experience health and illness in the same way is a transcultural fallacy (Khan & Pillay 2003). Moreover, Burr & Chapman (1998) warn for 'culturalisation' of the patient/client as it involves the risk of portraying them as the inevitable products of their culture. In literature a great deal has been written on this subject and health care practitioners are expected to interpret and try to understand the clients' culture from these writings. As a result, health care providers are viewed as cultural translators or interpreters. Meleis & Im (1999) assert that despite the usefulness of nursing cultural theories in understanding immigrants' health beliefs and practices, the extent to which health care experiences have been stereotyped, ignored, or mislabelled, need to be questioned.

To overcome the risk of mislabelling, health care providers need to be sensitive to, and respect the attitudes, beliefs, and values of ethnic minority groups (Khan & Pillay 2003; Racine 2003; Omeri & Atkins 2002; Papadopoulos & Lees 2002; Burr & Chapman 1998). It is therefore important to be aware that because every person belongs to an ethnic group, all nurse-client interactions are inherently transcultural (Andrews 1999).

As Racine (2003) argues, nurses must reflect on their own ethnic background and the stereotypes that may impinge on the understanding of cultural differences. Dominant health ideologies that underpin nurses' everyday practice and the structural barriers that may constrain the utilization of public health care services must be further examined. Racine demands 'cultural hybridity', by which she means acknowledgement of peoples' multiple 'subjectivities' or 'positionalities' through processes of negotiation about cultural meanings.

The interplay of self-perceptions and the perceptions of others is a theme that bears on almost every social interaction, not just among ethnic groups. In ethnic

terms, however, this opposition can be seen in behaviour that is based on stereotyping (Andersson & Kelley 1998). According to Anderson & Frideres (1981), the use of stereotypes is one of the most basic ways in which individuals categorise other individuals. Stereotypes provide the means of securing high predictability and a minimum of attention and effort in any social interaction.

When encountering people from a different ethnic group, it is important to be aware that in these encounters, every person has notions of ethnic stereotypes and biases (Anderson & Kelley 1998; Rempusheski 1989). According to Rempusheski (1989), in elderly care encounters, there may exist two interpretations of the same behaviour, preference, or symbol – the nurse's interpretation and the elderly person's interpretation. Therefore, in health care and elderly care, when encountering people from other ethnic groups, it is essential that the assessment process includes an examination of one's perceived biases and expectations of care, from both the elderly person's and the nurse's perspective. These biases and expectations can be based on ethnicity, and will be revealed partially through behaviour and expectations of behaviour (*cf.* **I**). Anderson & Kelley (1998) mean that both the nurse and the client take their respective understandings about health care to the encounter. These understandings are based on two distinct ethnic enclaves, isolated from each other until the moment of contact. They warn, however, of simply relegating all variation to a convenient bin that we label 'ethnic differences' because a large part of the patients/clients and the nurses understanding is derived from more universal experiences and circumstances that often vary greatly, even within ethnic groups. These understandings are, nevertheless, part of a webbing of interaction based on culturally and ethnically defined perceptions.

In health care encounters and in elderly care, the stereotypes and biases based on ethnicity and shared cultural knowledge can also be used in a positive manner, as Study **IV** shows. There is a shared understanding of culture and a belief that one is playing the same ethnicity and language game (Sarvimäki 2004). In earlier research on elderly care, Emami *et al* (2000) and Ekman *et al* (1993; 1994; 1995) show similar results. Rempusheski (1989) claims that the elderly clients may be more comfortable with a nurse that comes from the same ethnic group, not only because of ethnic biases or expectations, but also because they believe that as a member of the same ethnic group the nurse and the client can understand and relate to each other.

Nursing care for elderly people, who are faced with these problems requires communicative abilities, empathy, and concern (Caris-Verhallen *et al* 1997). Nurses have to support the elderly persons in coping with problems related to their stage of life and to recognize and assess their demands, so that nurses can offer nursing care that is tailored to their individual needs. Communication is an essential prerequisite in this process.

There is growing evidence that being familiar with the culture of a particular group and developing effective partnerships with group members are essential strategies in promoting health, especially in avoiding communication difficulties (*cf.* Khan & Pillay 2003). Cortis & Kendrick (2003) claim that if synergy between ethics and caring is translated to practice then it should reflect and include customs that fulfil the needs of all members of society. This is of crucial moral concern because it is difficult to talk of a 'caring ethic' when research indicates that members of certain minority ethnic communities feel alienated and isolated in their health care experiences.

In order to provide culturally congruent care for elderly immigrants, the care should be provided in an environment that does not cause them to feel alienated and the aim should be to create a feeling of at-homeness. Supporting aspects of at-homeness such as safety, feeling rooted, fellowship, and continuity in life, should be part of care; even for elderly immigrants The best way to achieve this is to provide these people with care from members of their own ethnic group who speak the same native language.

This thesis is about elderly Finns who have immigrated to Sweden. Their country of origin has a relatively similar culture to the culture of their second homeland, and they have lived for a long time in Sweden. There is a need of more research regarding the meaning and the background of ethnicity in health care and elderly care and the perceptions among elderly immigrants. For example, does ethnicity play a similar role in the perceptions about elderly care and health care for elderly Finns who have immigrated to Canada or Australia, *i.e.* in a different socio-cultural context? Alternatively, if the immigrants come from a culture that differs largely from the host country's culture, does ethnicity play the same role for their perceptions and experiences?

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POPULÄRVETENSKAPLIG SAMMANFATTNING

Bakgrund

De flesta västerländska samhällen blir alltmer multikulturella, eftersom invandringen till dessa länder ökar. Detta ställer stora krav på hälso- och sjukvården. Sverige tillhör de länder som har en stor andel invandrare i sin befolkning. Många invandrare kom till Sverige på 1950-70 –talet och har åldrats här. Den största gruppen äldre invandrare är finländare av vilka majoriteten har finska som modersmål. År 1999 fick finska språket status som minoritetsspråk och finländare status som en nationell minoritet i Sverige. Enligt olika studier är de äldre finländarnas hälsa dålig och många av dem har blivit förtidspensionerade. Det finns dock mycket lite kunskap om hur de finskspråkiga äldre upplever den vård de har fått och hur de vill ha sin äldrevård.

Syften

Det övergripande syftet med denna avhandling har varit att beskriva och fördjupa förståelsen av de äldre finskspråkiga finnarnas upplevelser av hälso- och sjukvården samt äldrevården och –omsorgen, och vilken roll etnicitet har för dessa upplevelser.

  Avhandlingen består av fyra delstudier var syften har varit:
- att belysa äldre finska invandrares erfarenheter av och uppfattningar om hälso- och sjukvården för att öka förståelsen om etnicitetens roll i äldre invandrares erfarenheter och upplevelser om vård i värdlandet (**I**).
- att belysa den kulturellt anpassade vårdens roll i de äldre finska invandrarnas önskemål och förväntningar om institutionell äldrevård i Sverige (**II**).
- Att beskriva och jämföra erfarenheter och uppfattningar av hälso- och sjukvården mellan de äldre finska invandrare som bor kvar i Sverige och de äldre finska invandrare som återvänt till Finland som äldre (**III**).
- Att beskriva hur ett vårdhem för äldre finska invandrare anpassats kulturellt och att belysa hur denna vård kan understödja de boendes välbefinnande (**IV**).

Metoder

Data har samlats in och analyserats med olika kvalitativa och kvantitativa ansatser. Studierna har fokuserat sig på personer som är 65 år eller äldre, är födda i Finland, har invandrat till Sverige och har finska som sitt modersmål.

I Studie **I** och **II** intervjuades 39 hemmaboende, 75-åriga och äldre personer med hjälp av en frågeguide om bl a deras erfarenheter av den svenska vården och önskemål och förväntningar om äldrevård och –omsorg. Intervjuerna bandades in och skrevs ut ordagrant. För Studie **III** skickades en postad enkät dels till alla personer som hade återvänt från Sverige till Finland efter sin 65. födelsedag och i Sverige till ett urval av finska medborgare som var 65 år eller

äldre. Sammanlagt 217 personer i Finland och 6443 personer i Sverige besvarade enkäten, men bortfallet var stort. I Finland svarade bara 47.1 procent och i Sverige 54.2 procent av de tillfrågade.

För Studie **IV** gjordes deltagande observationer 1-2 gånger per vecka under ett års tid på alla av Finskt Äldrecentrums fyra avdelningar. Datainsamlingen innehöll även intervjuer med de boende, personal och deras anhöriga.

Olika data-analysmetoder användes för att förstå, beskriva eller jämföra materialet. Analysmetoderna var hermeneutisk 'ad hoc' –metod (**I**), latent innehållsanalys (**II**), statistiska tester (**III**), och etnografisk metod (**IV**).

Resultat

Enligt Studie **I** var de äldre finska invandrare relativt nöjda med den vården de fått i Sverige. Om de hade någon bekant som hade blivit illa behandlad i en vårdsituation, hade de dock en negativ uppfattning om den svenska vården. Trots att erfarenheterna av vård i Finland var sällsynta, fanns det en idealiserad bild av den finska vården och av vårdarnas överlägsenhet där, jämfört med den svenska vården och vårdarna. Den gemensamma etniska bakgrunden mellan de äldre och finska vårdare möjliggjorde större tillit till att få bra vård eftersom de äldre finnarna hade en uppfattning om att de tillhörde samma grupp och att de delade samma värderingar som de äldre hade.

Studie **II** visade att äldre finska invandrare önskade bo kvar hemma så länge de klarade av att leva ett relativt självständigt liv. Därefter ville de få kvalificerad vård på något vårdhem. De gemensamma förväntningarna och önskemålen handlade om att få känna kontinuitet, hemmastaddhet, gemenskap samt trygghet att vården hade bra kvalitet. Förväntningarna handlade om att bli vårdad i antingen i en välkänd socio-kulturellt miljö på ett kulturellt anpassad vårdhem eller på ett vårdhem nära hemmet. Önskemålen om gemenskap, kontinuitet och hemmastaddhet förväntades bli uppfyllda då, antingen genom det egna språket med gemensam etnisk bakgrund med vårdare och de andra boenden, eller genom den välbekanta närmiljön med närboende släkt och vänner.

Enligt Studie **III** både de äldre finnarna som hade stannat i Sverige och de som hade återvänt till Finland var mycket nöjda med den vården de fått både i Sverige och i Finland. Det fanns inga signifikanta skillnader mellan de två grupperna, men återvändare var mer nöjd med den finska vården än de hade varit med den svenska vården. Attityderna till den egna migrationen och språkkunskaperna hade signifikant samband med erfarenheterna av vården. Resultaten tyder på att ett gemensamt språk är viktigt för att kunna känna sig tillfreds med vården.

Den viktigaste kulturella anpassningen på det kulturellt anpassade vårdhemmet (Finskt Äldrecentrum) bestod av att tala det finska språket och av det faktumet att både de äldre och personalen har samma finska bakgrund. Även populärkultur, diskussionsämnen och högtider användes för att skapa en känsla av en gemensam delad finskhet. Tillsammans gav de en grund för en gemensam förståelseram och förståelsen av individerna. Detta möjliggjorde vårdande relationer, vilka i sin tur ökade de äldres välbefinnande.

Slutsats
Studierna i avhandlingen visar att de äldre finska invandrarna ville känna sig hemma i vårdsammanhangen. Detta skulle bäst ske om vårdpersonalen kom från samma etniska grupp som de, pratade deras modersmål och att de skulle bli vårdade i en miljö som de kände igen.

PAPERS I-IV