Health literacy Among Adult Immigrants in Ostrobothnia

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Summary

Migrants are faced with many challenges as they come, speaking a different language, have different education, cultural backgrounds, cultural beliefs, and behaviours. This study aims to describe the obstacles to gaining health literacy and describe the ways that can promote and improve health literacy among adult immigrants in Ostrobothnia. The background of this thesis features literature borrowed from the related research study. Theoretical frameworks by Leininger's culture theory of diversity and universality and the Sunrise model were used for this study, to mirror the background and the results formed. The study was carried out by using qualitative semi-structured interviews and using an inductive approach. The study participants consisted of 6 adult migrants, 4 males, and 2 females.

The results of this study showed that communication is an essential tool for immigrants to have access to health care. It proved that communication is a common obstacle in gaining healthcare services among adult immigrants in Ostrobothnia. The language barrier is the main factor that lessens participants` confidence concerning the effect on the quality of care and clinical outcomes.

Language: English Key words: Health literacy, healthcare system, adult immigrants, communication, cultural competence

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1 Introduction

This topic was chosen after we noticed an influx of immigrants in Finland, which many of whom experienced or could still be experiencing difficulties in receiving proper health assistance due to health illiteracy. Today, there is no study found on health literacy among the immigrant population in Ostrobothnia. As a result, this motivated us to pursue this study. The focus of the research will be primarily on the immigrant population in Ostrobothnia. The aim is to describe the obstacles by adult immigrants gaining health literacy and to try to find a solution on how to promote and improve their health literacy.

Health literacy has acquired significant attention across the world in recent years. People cannot achieve potential health unless they can take control and determine their health. It involves equipping people with knowledge about health and services, and how that can help them make the right decisions and achieve a healthy lifestyle (World Health Organization, 2013). According to the World Health Organization (2019), health literacy is improving people's access to healthcare information and using it effectively. It does not only refer to the ability and responsibility of people to become more health literate but also the ability and responsibility of the systems through which information provided is relevant to health.

Immigrants are faced with many challenges as they come, speaking a different language, have different educational and cultural backgrounds, and have different cultural beliefs and behavior. According to Wikberg (2014), one of the challenges while treating migrant patients is communication. The reason could be due to a lack of a common language or lack of shared understanding, even though the patient and caregiver speak the same language. The patient's lack of understanding could be a lack of health literacy.

With the increase in the multicultural population, there are many reasons why healthcare providers should strive to be culturally competent. There is, therefore, less time for nurses to learn about and become accustomed to new cultural groups. Lack of nurses with transcultural nursing competence presents a severe barrier in providing the health care needs of various client populations (Leininger & McFarland, 2002). Part of being health literate is for patients to make healthcare decisions and efficiently navigate the healthcare system. It also involves following doctor's instructions, asking questions, and keeping track of their health (Parnell, 2014). European Health Literacy Survey found that migrants with limited levels of education or/and low skill in the national language, negatively affect their health literacy. Migrants with low health literacy competencies are also likely to have less healthy choices, take more risks, have poorer health, less self-management, and are often hospitalized (World Health Organization, 2013).

Cultural values in health literacy should not be underestimated. The immigrant's experience and understanding of health and illness are based on their culture (Andrews & Boyle, 2007, 261, 263). Health care professionals must provide care and education to patient populations who have cultural, linguistic, and health literacy barriers. Ways used to improve health literacy through culturally appropriate health systems include training the staff to improve assessment methods, enhancing cultural communication skills, creating patient-friendly written materials to develop sustainable and effective interventions (Gillis et al., 2012).

According to Erunal, Özkaya, and Kucukguclu (2018), individuals with low literacy have a difficult time comprehending health information. For example, understanding appointment slips, medication labels, vaccination guidelines, health education materials, social security applications, general health information provided by health professionals, and health information on social media (Health Literacy Europe, 2010). An individual with a sufficient level of health literacy can take responsibility for their health and their family's health. They can recognize what factors influence health and how to address them (Parnell, 2014). Today, immigrants must have basic knowledge regarding their health status, and be able to describe their health conditions to a health provider and seek proper medical treatment. When immigrants take charge of their own health decisions, they communicate better with health professionals, navigate the health system, and have knowledge of their existing health conditions (Naus, 2017).

The hope is that this study will serve as a helpful and useful tool for health caregivers when they interact with immigrants in their field of work. At the same time, it will be a practical guide for health providers to get a more in-depth view to promote health literacy for this group. Educating healthcare professionals on a culturally based perspective in health care is essential when dealing with immigrants.

2 Aim and research questions

This thesis aims to describe the obstacles to gaining health literacy and describe the ways that can promote and improve health literacy among adult immigrants in Ostrobothnia.

The main questions to be answered are:
1. How do adult immigrants describe the obstacles to gaining access to health care services?
2. What are the ways that can promote and improve health literacy for immigrants in Ostrobothnia?

3 Background

Due to the rapid increase in changes and the influx of new multicultural populations from around the world, nurses are faced with the challenge of caring for different cultural groups than ever before. The increasing number of immigrants, refugees, and other people from many cultures have increased the need for transcultural nursing among nurses today and in the future. The biggest challenge for nurses is to learn compassion and understanding, taking care of people from different cultural backgrounds (Leininger & McFarland, 2002).

In the coming future, the demographics will continue to change with continuous diverse cultures. There are frequent challenges for health care providers as immigrants come with different language, education, culture, belief, and behaviour (Parnell, 2014). The nurse planning interventions and implementations should be culturally congruent and see that patients and these patients' family's cultural needs have entirely addressed (Leininger, 1991). Cultural competence of health literacy includes four aspects: (1) cultural awareness or sensitivity to values, beliefs and lifestyles that originate from one's culture; (2) cultural knowledge, including worldviews of various cultures; (3) cultural skills or the ability to collect relevant cultural data on clients' health histories and presenting problems; and (4) cultural experience or cross-cultural interactions with clients from culturally diverse backgrounds (Gillis et al., 2012).

3.1 Health literacy and history

The term health literacy has become popular over the past few years. It is largely used across the nation and globally in health contexts; health literacy has completely different meanings to different people (Smith & Ireland, 2020). In 1974 the term health literacy was first initially introduced at the health education conference. Health literacy is more and more important in public health and healthcare (Sørensen et al., 2012). Having health literacy is a valuable tool to allow people to take control of their health, to use health information, which leads to personal and social benefits (Hernandez, 2013).

Health literacy may impact every individual health knowledge, access to health services, and health status. According to the World Health Organization (1998), health literacy represents the social and cognitive skills that determine the individual's motivation and ability to obtain access, understand and apply the information in methods that promote and maintain good health. According to Nutbeam (2008), health literacy is more than an individual's ability to read health information, abide by medical procedures, previous knowledge, culture, beliefs, and other factors that allow them to analyze the data to participate in their health actively. He focused on health literacy as an asset that supports and empowers people in making health decisions. According to Nielsen-Bohlman et al. (2004), health literacy involves health, health care promotion, protection, maintenance, disease prevention, early screening, and policymaking. Skills in health literacy are needed for communication, discussion, reading health information, interpreting charts, the use of medical tools such as the thermometer, and calculating timing or dosage of medicine.

Health literacy is both an Individual effort that focuses on improving individual health behaviors or achieving positive lifestyle changes and population efforts that focuses on improving population health outcomes. There has been a focus to improve health systems to meet better the health needs of individuals, families, and communities. It is focusing on the environment and making health decisions. It contrasts with earlier definitions that focus on an individual's attitudes and behaviors. An example, which accepts these two components, can be seen from the Australian Commission on Safety and Quality in Health Care's Statement on Health Literacy, It follows these definitions: (1) Individual health literacy is the person's skills, and the capacity to access, and apply information to make decisions about health and healthcare and take the right actions. (2) The health literacy environment is everything that makes up the health system and has an impact on the way that people access and apply health-related information and services (Smith & Ireland, 2020).

3.1.1 Levels of health literacy

Nutbeam (2008), talks about the concept of health literacy at three different levels during the last decade of the 20th century. The levels are basic/functional, communicative/interactive, and critical health literacy. It defines the necessity for education and actions taken at both personal and population levels.

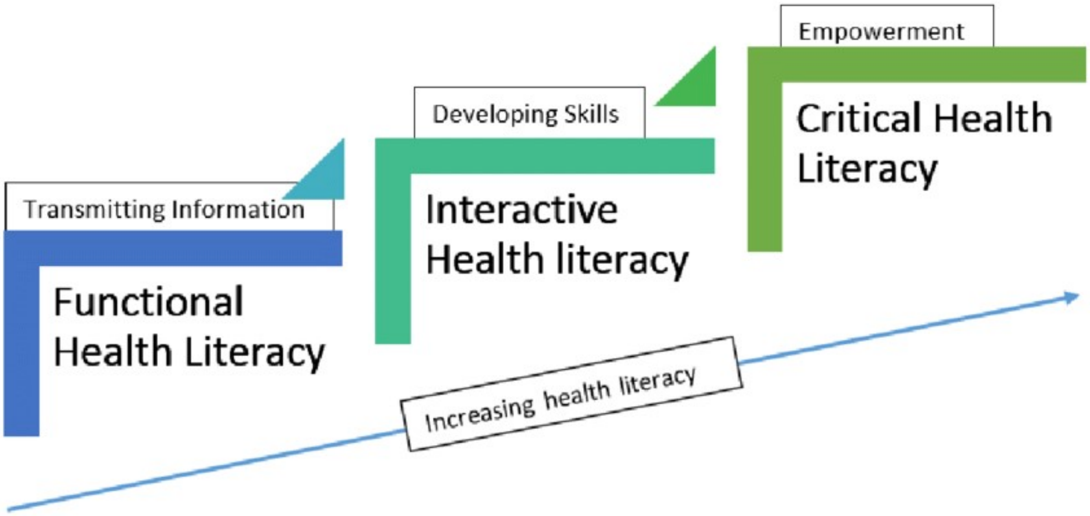


Figure 1: A modified version of Nutbeam´s model (2008) of different levels of health literacy.

Basic/ Functional health literacy

Functional health literacy is using literacy to do a task, such as the basic skills to read, understand, and act on healthcare information and the necessity to function in everyday life. Individuals can understand written and oral information given by health care professionals, understand prescription labels, are able to complete health care forms, able to interpret appointment slips, able to take directions by taking medication correctly, to follow instructions on diagnostic tests, adhere self-care at home, and to understand appointments. Limited functional health literacy is a barrier when educating patients with chronic conditions such as heart diseases, hypertension, and diabetes. Patients with limited literacy cannot follow instructions on self-care and are not able to administer medications appropriately. Basic health literacy information is essential for people to get relevant health information and apply that knowledge in their daily lives (Nielsen-Bohlman, Panzer, & Kindig, 2004).

Communicative/ Interactive health literacy

Interactive or communicative health literacy focuses on creating personal skills to enable active involvement in health care. Personal developmental skills are crucial when solving problems in communication, and the decision-making process that an individual can act independently on the knowledge of health issues. It helps to communicate with others and to apply the new information to changing environments. It enables people to get information and find meaning from different communication forms, to apply what they have learned, changing their circumstances, and to have more confidence with health information provided by health care professionals (Kanj & Mitic, 2009).

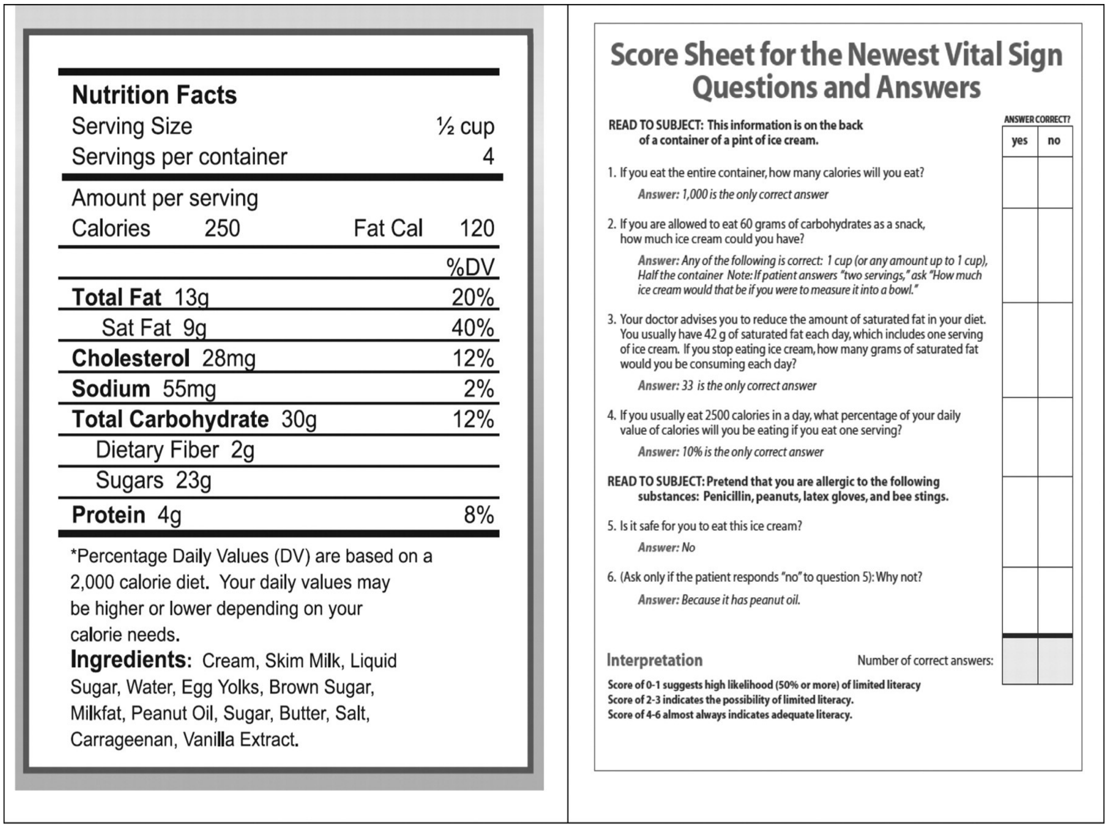
Critical health literacy

Critical health literacy is the most advanced cognitive skill; it focuses on the same skills as functional, communicative health literacy together with social skills. It used to analyze information critically and the data used to find more significant control over life events and situations. The ability to critically analyze, use the data, and to take part in actions that overcome the hindrance of health (Kanj & Mitic, 2009). Critical health literacy used to develop education to judge information that is related to health critically. It can also empower people, where critically health literate might improve health through the political system and membership of social movements. Nutbeam (2008) states that improving critical health literacy improves community development. Therefore, critically literate society can take part in critical conversations involving health and capable of making decisions for health issues.

3.1.2 Measurement of health literacy

Health literacy in Europe, Directorate-General for Health and Consumers (DG SANCO) (2013) believes in the necessity to empower the patients in the management of chronic diseases and the significance of health information and knowledge. Health literacy knowledge of simple actions creates a health impact giving, for instance, teaching children to wash their hands to lessen infections and stay healthy. Knowing Health literacy will help future generations (European Commission, 2013). The interest of measuring health literacy skills was first initiated by the National Adult Literacy Survey (NALS) in 1993 of functional literacy in the U.S.A. Reliable and practical tools for clinical settings are helpful in routine screening for health literacy. Measuring health literacy methods mainly focuses on accessing what people can read and understand in health contexts. It does not measure all critical factors, such as how people use information, how healthcare professionals and systems communicate with their patients.

The two main standard tools for measuring patient's health literacy include Rapid Estimate of Adult Literacy in Medicine (REALM) and test of Functional Health Literacy in Adults (TOFHLA). The Rapid Estimate of Adult Literacy in Medicine (REALM) and Test of Functional Health Literacy in Adults (TOFHLA) were initiated with the focus to access the ability of patients to read and write various information forms and instructions in clinical situations. Newest Vital Sign is the new tool used to quickly and simply access a patient's health literacy skills and can be done in about 3 minutes both in English as well as in Spanish. The patient has given an ice cream nutrition label to review and asked six questions about it. The health care providers can assess the patient's health literacy level based on the number of correct answers and access their communication to make sure patients understand (Mayer, 2015).



Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Score Sheet for the Newest Vital Sign Questions and Answers

ANSWER CORRECT? yes no

READ TO SUBJECT: This information is on the back of a container of a pint of ice cream.

1. If you eat the entire container, how many calories will you eat?
   Answer: 1,000 is the only correct answer
2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
   Answer: Any of the following is correct: 1 cup (or any amount up to 1 cup), Half the container Note: If patient answers "two servings," ask "How much ice cream would that be if you were to measure it into a bowl."
3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
   Answer: 33 is the only correct answer
4. If you usually eat 2500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
   Answer: 10% is the only correct answer

READ TO SUBJECT: Pretend that you are allergic to the following substances: Penicillin, peanuts, latex gloves, and bee stings.

5. Is it safe for you to eat this ice cream?
   Answer: No
6. (Ask only if the patient responds "no" to question 5): Why not?
   Answer: Because it has peanut oil.

Interpretation Number of correct answers:

Score of 0-1 suggests high likelihood (50% or more) of limited literacy
Score of 2-3 indicates the possibility of limited literacy.
Score of 4-6 almost always indicates adequate literacy.

Figure 2: The Newest Vital Sign (NVS) screening instrument for health literacy. (The Newest Vital Sign 2011).

It is essential to create a new comprehensive approach measure. The measurement of health literacy is a necessary task facing health literacy research and practice. The task will be a success if conducted with the support of research and practice umbrella organizations such as the World Health Organization (Pleasant, McKinney, & Rikard, 2011).

3.2 Culture

The concept of culture has changed over time (Nyback, 2017). Culture can be seen either as dynamic or static; when culture is viewed from a static perspective, the focus lies on the concrete existence of culture with rules and norms guiding behavior in a group. This view tends to be supported by positivism, which suggests that culture can be measured and predicted without entering people's inner world. When looking at culture from a dynamic perspective, it has no concrete reality and exists only in a person's mind. According to Leininger (1995), defined culture as learned, shared, and transferred knowledge of beliefs, values, norms, and lifestyles of a particular group that leads thinking decisions and actions in patterned ways. Subculture is closely linked to culture and refers to a group that departs in certain areas from the dominant culture in beliefs, values, norms, moral codes, and ways of living with some distinctive features of its own. Nyback (2017) describes culture as a set of guidelines (both explicit and implicit) that persons inherit as members of a particular society and that advise them how to view the world, how to experience it emotionally, and how to act concerning other people, to supernatural forces or gods and the natural environment. According to Papadopoulos (2006), culture is the shared way of life of a group of people that includes ideas, beliefs, values, communications, language, norms, and visibly expressed forms such as customs, art, music, clothing, and etiquette.

Cultural nursing care is the aspect of culture that influences and enables a person or group to improve as human beings and to deal with illness or death. Cultural care preservation is a nursing care activity that helps people of a specific culture to keep and use their cultural care values related to healthcare conditions. Cultural care negotiations create nursing actions that help people adapt with others in the healthcare community to have a shared goal of an optimal health outcome for clients as their own culture (Leininger, 1995).

Culture care is a holistic way to serve human beings during health, illness, and death. Knowledge of a culture is crucial for nurses to know how to provide quality care. Things such as worldview, languages, religious, spiritual, social, political, educational, economic, technological, ethnohistorical, and environmental factors affect culture care values, beliefs, and practices. Good, culturally based care promotes the wellbeing of the patient. By knowing the culture, it is easy to provide competent care to the clients. The clients who get nursing care without the culture being involved, experience stress, cultural conflict, noncompliance, and ethical-moral concerns (Leininger, 1995). Nurses must consider culture as an essential aspect to provide holistic care. Transcultural nursing remains and will continue to be needed, especially for those who seek a professional career in nursing. In every hospital, they should provide care to people of diverse values and beliefs, so education on transcultural nursing and maintenance is crucial to all caregivers. Nurses work best as professional persons when they know and understand people have different cultures, their life experiences, human conditions, cultural values, and beliefs (Leininger, 1995). Leininger (1991) states since human beings are born, live, become sick, survive, experience life rituals, and die within a cultural care framework of reference, these life experiences have significance and meaning to them in any given culture or subculture.

Cultural competence in caring

Cultural competence and culturally congruence are an essential set of culturally congruent practices, behaviors that let health caregivers effectively deliver high-quality services in various cultures other than one's own. The goal is to provide each patient with the best quality care, regardless of race, ethnicity, cultural background, or social-economic status (Nyback, 2017). Madeleine Leininger was the first to talk about culturally congruent care, which was the original term for cultural competence. According to Leininger and McFarland (2002, 128), culturally competent and compatible care is defined as follows: care based on cultural knowledge, which aims to be meaningful, beneficial, and satisfying (Leininger & McFarland, 2002, 128). The cultural competence of the caregiver can be seen as part of intercultural care (Wikberg, 2014, 78). According to Cai (2016), care without cultural competence has a direct impact on health outcomes and can lead to fatal consequences. Cultural competence in health care shows to have several health benefits such as increased patient satisfaction, improved communication, better control of pain, and greater equality of care. Cultural competence can also reduce total healthcare costs (Heizler, 2017).

Campinha-Bacote (1999) describes cultural competence as the process where health care providers strive to effectively work within the cultural context of the client (individual, family, or community). According to Leininger (2002), cultural competence is a process by which one becomes completely aware of other cultures, understands the knowledge about diverse cultural groups, and provides proper cultural care based on everyday human needs. Cultural competence develops when culture patterns and values are acknowledged and used appropriately within different cultural groups. Culturally congruent health care is a learning process and can be achieved by teaching professionals how to give services in a culturally competent manner (Leininger & McFarland, 2002). It integrates transcultural skills in all three dimensions cognitive, practical, and useful (Dreachslin et al., 2012).

The cultural competence concept is described in several models. Purnell created cultural competency that has twelve cultural domains that determine variations in values, beliefs, and practices of human cultural heritage. The model is used for all health care disciplines to apply for practice settings. Campinha-Bacote model is the process of cultural competence in delivering healthcare services. To attain cultural competence, a nurse should develop the capacity to provide efficient and high-quality care. The model encompasses five components to strengthen the cultural competence of nurses practicing in countries around the globe. They are Cultural awareness, Cultural knowledge, Cultural skill, Cultural encounters, and Cultural desire (Campinha-Bacote, 2015). Papadopoulos, Tilki, and Taylor's model for developing cultural competence care consists of four patterns: "*Cultural awareness, Cultural Knowledge, Cultural Sensitivity, and Cultural Competence"* (Papadopoulos, 2006, 10).

3.2.1 Language and communication

Clear communication is also essential in maintaining and improving the quality of life between health professionals and migrants' patients (Parnell, 2014). Settling into a new place and to a new country is not easy for any person or family. Learning a new language might add to the difficulties of new immigrants (Park, Lee & Kang, 2018). A new language can be a barrier immigrants cope with within a new country. It is essential to a migrant's ability to form and to provide meaning to an experience, form relationships, and express what they need. There is a connection between language proficiency, health status, use of health services, and outcome of health care. Language-communication challenges can arise between a healthcare provider and migrant patient due to different cultural norms in understanding and expressing disease and illness (Altschuler, 2016). According to Wikberg (2014), there are challenges in communication between caregivers and patients even when speaking the same language. Most studies between patients with other cultural backgrounds speak about language and communication challenges in nursing care/health care. The language has an impact on someone's health literacy how clearly, he/she can communicate and listen attentively. There are different factors, such as cultural background, socioeconomic status, past experiences, and mental health. Each of them affects how we communicate, understand, and respond to health information or data (Koh, 2010).

Language problems may cause obstacles to social and professional integration, which may create stress, lower self-confidence, causing more social isolation. Findings indicated that language competency and education level have a significant impact on health literacy among migrants (Park, Lee, & Kang, 2018). When caregivers cannot communicate in the same language, patients and their families are not able to make sense of what the care professionals say, ask questions, and understand decisions about their care. It is also challenging to get a clear history, assess the severity of the symptoms and understanding of the patients and their families. A study done in the Netherlands by Graaf and Francke (2009) found that a high percentage of doctors and home care nurses believe problems in communication meant that Turkish and Moroccan migrants who died had not received adequate care or an explanation about their disease they did not understand. Informal careers had been unnecessarily overburdened, and making appointments was very difficult (Altschuler, 2016).

Teach back is a way of providing essential health information to the patient, and the patient's understanding is determined when the patient explains it back in their own words to the caregivers. Patients usually forget the given medical information, or some of the data is incorrectly received. It can also help the caregiver to identify communication strategies that are most commonly misunderstood by patients (Mullen, 2013). According to Federman and colleagues (2009), plain language is the communication that is understood the first time seen or heard. It uses brief grammatically correct sentences to enable patients and caregivers to engage with information, using a more informal tone and standard terms whenever possible. Health information targeted to patients should be simple. Caregivers should use familiar words for low health literate patients who have limited skills. It is essential to test comprehension and plan for further follow-ups to ensure that the required results have been achieved.

Healthcare givers help patients and families build their communication knowledge and information skills during interactions with caregivers. Ask Me 3 has three questions. It is a healthcare communication intervention that make sure a patient understands and gets the right information. Patients are encouraged to ask three questions every time they meet their health caregiver: (1) *"What is my main problem? (2) What do I need to do? (3) Why is it important for me to do this?"* The patient should have pauses to process information and ask questions while health caregivers evaluate the information the patient can have in a particular session. The Ask Me 3 has worked to help patients take an active role in the healthcare system and have asked more questions to help in understanding important health information. (Liechty, 2011, 103-104).

3.2.2 Family caregiver

A family caregiver is a person in the family who provides any type of physical and/or emotional care to a relative at home (Nyback, 2007). According to Stengård (2005), family caregivers are not necessarily family members, but they can also be close individuals who have a strong friendship or bond with the recipient. According to Nyback (2007, 27), many family caregivers today are unpaid providers who do tasks that were previously done by highly skilled and trained professional providers. These family caregivers need help and support to learn how to become care-competent, therefore, there is a need for new models concerning the support of family caregivers.

Stengård (2005) did a study on family caregivers' stress and depression. She found that family caregivers' stress can arise from the recipient's behavior and incapacity, also because of the amount of time spent caring for the loved one. According to Laurie (2008), for caregivers to give care with confidence to their loved ones, they need to have the knowledge and basic skills in providing care. Communication also plays a vital role in the healthcare environment. Moreover, professional caregivers should be able to communicate with family caregivers the necessary information and always have mutual trust and respect (Lewis, 2008). According to a research article done in the USA, found that for minorities giving care to their loved one was so deeply rooted in the culture that the decision to provide care or not to give care was not an option. It was done "naturally" without conscious thought (Pharr, Francis, Terry, & Clark, 2014).

3.2.3 Education

Anyone can face difficulty in understanding health information at some point; that is why health literacy is a critical issue that challenges everyone to a different level. Some people may not experience literacy difficulties in other scopes of life but may easily have trouble in healthcare settings. They might not be used to the environment and in health or medical vocabulary. They can struggle to understand health-related materials with unfamiliar ideas, and their ability to understand information is inhibited. The person can be highly educated and highly literate in their area of expertise, and yet not fully understand complex medical information. Regardless of an individual's literacy level, it is difficult to fully understand what is being said when a healthcare provider uses unfamiliar, technical language or delivers bad news (Koh, 2010).

The migrants score lower on literacy and health literacy measures. Information and educational resources programs only partly reach migrants; it is mainly because of economic and social barriers. It creates a barrier for migrants who want to improve their literacy because of a lack of affordable second-language courses for adults. Adult migrants with low health literacy may face challenges to understand instructions given by healthcare professionals or use health information from various sources. When compared to other populations, migrants do not have the advantage of information and health promotion, disease prevention, and care services. Study after study has put these populations at a disadvantage in terms of interventions focused on creating awareness of cancer screening, mental health services, diabetes education, smoking cessation, HIV programs, and child immunizations (World health organization, 2013).

3.2.4 Healthcare system

Navigating health care systems can be a great challenge for patients and their families. According to the World health organization (2013), Health institutions are complicated structures and busy environments with many entrances, busy hallways, many signs and postings, filled with medicines of foreign languages, and varied health professions. These institutions require navigation skills. As an immigrant, it is significant to know and understand how the host country's healthcare system works. It is also essential to know the emergency telephone numbers of the host country in case of a call for medical assistance or emergencies such as fire and accidents.

Immigrants face different challenges when they come to a new country. They also find difficulties in maintaining health and accessing proper health care services due to some basis which includes, language insufficiency, different culture, and low health literacy. Some of the migrants may be unfamiliar with the right health system, and so they turn to the emergency department or go directly to the referral ward in the hospital for conditions that can be treated in primary care. Some immigrants may expect the same care system as they used to have in their own country. In many poor countries, hospitals hold the source of medical treatment care, the community clinic’s primary care can be very inferior, so these immigrants could feel degraded while being offered primary care first (Altschuler, 2016). Immigrants are vulnerable to significant health inequality, with plenty of immigrants experiencing worse health outcomes, such as higher rates of mortality and morbidity (Kreps & Sparks, 2008).

The health issues among immigrants, such as mental and physical issues are often left untreated; they tend to see the doctor less and use the public health system less than the native-born Finns (Yle news, 2011). According to the Suomen Lääkäriliitto (2020), health services are accessible to everybody in Finland, regardless of financial status. The immigrants in Finland are entitled to health services and social welfare even when they are not Finnish citizens if they have been granted a residence permit and have a permanent home municipality.

The person who illegally stays in the country may not be entitled to health care services or may only have limited access to health care. Anyhow, there are limited rights to health services for undocumented migrants in Finland. Generally, in Finland, undocumented persons are responsible for their medical care expenses. In case the undocumented person cannot afford to pay the cost of urgent medical care, Kela will reimburse the costs to the provider of public health care services in question (EU-Healthcare, 2019). According to Hofverberg (2014), the Finnish Institute for Health and Welfare (THL) uses the term "undocumented persons" for the persons from outside the EU currently living in Finland without residency permits (either their residency has lapsed, or the stay is illegal). The non-EU citizens legally arrived in Finland, but the private insurance has expired, or the coverage limit is inefficient. The public health care system may provide urgent care for undocumented migrants at their own cost. The critical care includes quick assessment and care required by sudden disease, injury, urgent oral and mental health care, psychosocial support, and intoxicant abuse treatment (Finnish Institute for Health and Welfare (THL), 2020). To see a specialist in Finland, the first one must book an appointment with a general practitioner. The health center doctor will give a referral to a specialist when necessary. Central hospitals and university hospitals offer exceptional health care to patients. The languages used in health services in Finland are Finnish and Swedish, but the interpreter will be provided when needed. The Constitution of Finland, section 6, states that *"local authorities and the joint municipal authorities for hospital districts should also ensure that citizens of the Nordic countries may if needed, use their own language, Finnish, or Swedish, Danish, Icelandic, and Norwegian when using health care services"* (Ministry of Social Affairs and Health, 2010, 2).

3.3 A conceptual casual pathways model

A conceptual model produced by Paasche-Orlow and Wolf in 2007 is an example concept used in limited health literacy. It explains the causal pathways relationship between health literacy and health outcomes, based on a review of previous health literacy research. The proposed limited health literacy must be viewed as a patient and health system phenomenon. It shows people with less health literacy have difficulties in navigating health services, all the information, and skills needed to navigate the medical care they need. For example, people with limited health literacy have difficulty finding their way in health care facilities, and it can be a result of poor communication (Paasche-Orlow & Wolf, 2007).

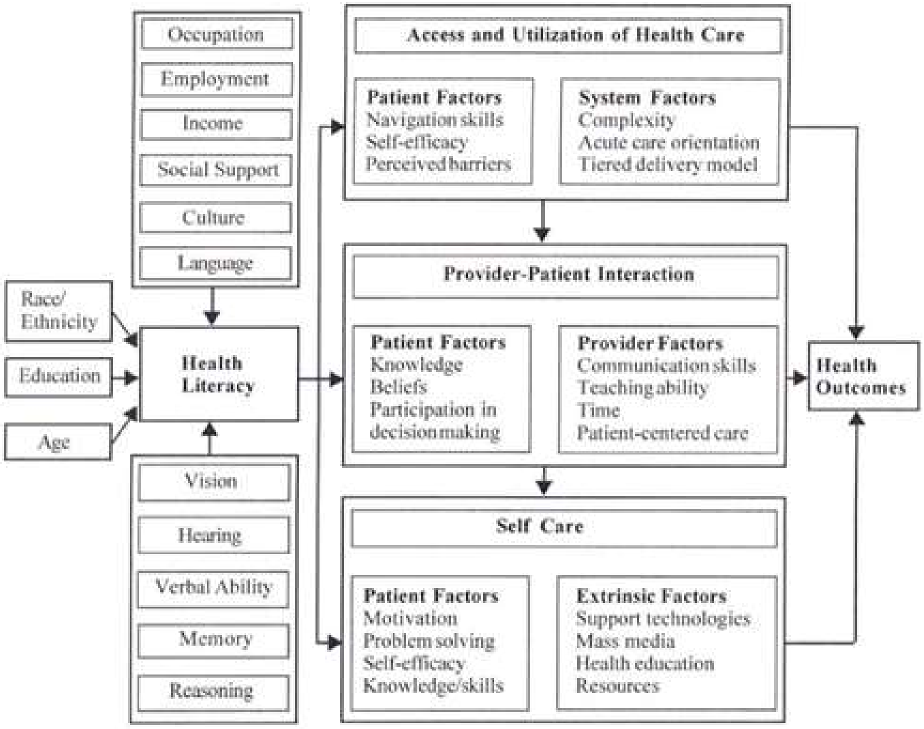


Figure 4: Causal pathways between limited health literacy and health outcomes (Paasche-Orlow & Wolf, 2007).

These include the level of education an individual has reached, age, ethnicity, occupation, and income. The model found three different health domains that impact health literacy on health that connect health literacy and health outcomes. (1) Access to and utilization of health care, (2) Care Patient-provider interaction (3) Self-care. Prevention of diseases depends on patients attending primary care and seeking medical care when they need it. However, those with limited health literacy may delay seeking care due to not understanding prevention and not knowing the signs and symptoms of the disease that would motivate them to act. Additionally, people with limited health literacy seeking care may have a feeling of shame and feel less comfortable with the medical interactions that occur in hospital settings. They often worry that their health literacy will be exposed (Paasche-Orlow & Wolf, 2007). The study in two primary care clinics in San Francisco, California, found Type 2 diabetes patients who have limited health literacy were more likely than patients with adequate health literacy to have poor glycemic control. However, patients with limited health literacy had higher rates of retinopathy than those with adequate health literacy (Schillinger et al., 2002).

3.4 Immigration in Finland

Immigration is the process by which individuals and groups of immigrants move across their national borders in pursuit of a better life in a new host society. Migration involves a two way process whereby immigrants and modern host societies adopt new features due to their interaction (Martikainen, 2013). Immigration has been a part of human history since the very beginning. People migrate from one continent to the other, from country to country or internally inside the country. The International Office of Immigration (IOM) states there are about one billion migrants around the world. This number includes 214 million international migrants. Some people may want or need a change in their present status in life, so they intend to migrate to different places or countries which are different from their home place. More people have forcibly resettled outside their native home; for the meantime, globalization has also enhanced the feasibility of people to voluntarily migrate to another country which is not their country of origin (International Office of Immigration, 2017).

According to Martikainen (2013), Immigration can affect society. These can be seen in the cultural, structural, and political areas of integration. Cultural integration involves both immigrants and their communities adjusting and adapting to local values, norms, and behavioral patterns, and how the host society reacts to aspects of immigrants’ cultural lives. According to the Official Statistics of Finland (OSF), Finland has experienced an increasing intake of migrants in recent years. As the immigration population increases, new challenges arise in healthcare delivery due to communication, cultural differences, and health literacy of migrants. Therefore, there is a high need for health literacy on migrants in Finland. From Finnish statistics, 34,905 people moved to Finland in 2016 (Official Statistics of Finland, 2018). Migrants are entitled to use public health services if they have a municipality of residence in Finland. The right to have a residence in the district depends on the country from which migrants have come from, the reason for coming to Finland, whether they are moving to Finland permanently or staying temporarily, and the length of their stay in Finland. In accordance with the Constitution of Finland, chapter 1 section 10 states that,...

"Local authorities and joint municipal authorities for hospital districts shall make their health care services available to the residents that they are responsible for providing services locally unless regional centralization of services is justified in order to ensure the quality of services" (Ministry of Social Affairs and Health, 2010, 4).

In figure 3, the number of inter-municipal migrations in the year 2018 accounted for 288,443 migrants, which was an increase of 604 from the previous year (2017). In the same year, there was a decline in the number of migrants between regions. A total of 136,400 migrants were recorded, which was a decline of 284 migrants compared to the previous year 2017 that had recorded growth with 3,454 migrants compared to 2017, the year 2018 recorded more inter-municipal migrations with a total of 595,638 which was 3,587 more migrations than in 2017. The Uusimaa region accounted for the most significant migration gain while Pirkanmaa was second. Recorded data showed that while 2,621 individuals immigrated to the Pirkanmaa region, the Uusimaa region had 6,896 new immigrants. Compared to the larger mainland Finland, the Pirkanmaa region gained the highest number of immigrants, about five per mil. On the other hand, the Uusimaa region recorded a slower migration compared to the Pirkanmaa region. The South Savo region suffered the highest casualty in terms of population loss inside the country, reporting a loss of 1,543 persons, which is estimated to be almost eleven per mil. The Kainuu area, however, had a lower migration loss. Overall, in terms of inter-municipal migrations, 15 regions were seen to have suffered a migration loss (Migration Statistics Finland, 2018).

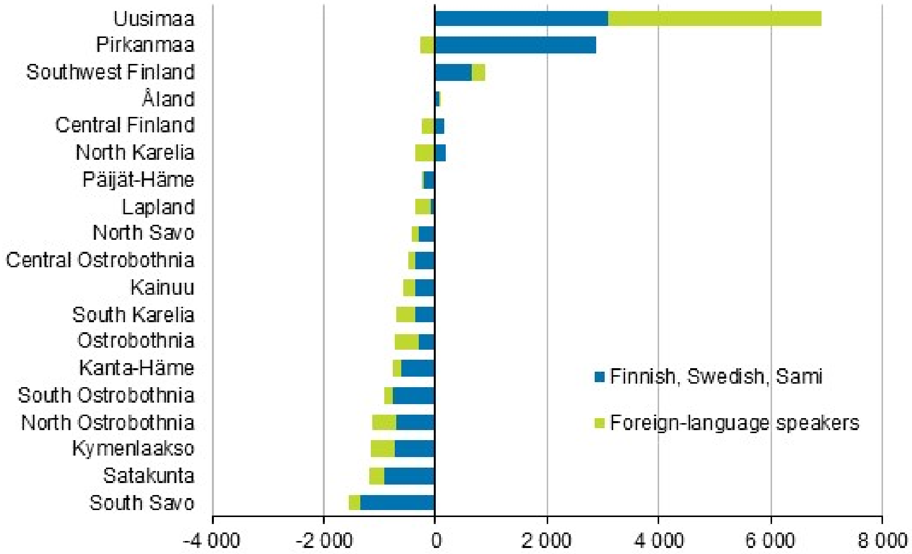


Figure 3: Migration gain for regions from internal migration by language 2018 (Migration Statistics Finland, 2018).

Research has shown nursing and healthcare have been impacted due to the change of migration, providing culturally competent care is challenging and complex. Though there are challenges in delivering culturally appropriate care, there is a growing need for culturally appropriate care that eliminates inappropriate care practices and promotes culturally based care. Truglio (2005) found the need for nursing care that is created on culturally competent ideals. Campinha-Bacote (1999) found that such culturally relevant care should be seen as a continuous process to obtain the ability to work within a cultural context of the patient effectively and to meet their needs.

The immigrants are mostly identified as a vulnerable population and have increased the risk for low physical, psychological, and social health results, and insufficient care (Derose, Escarce, & Lurie, 2007). The immigrants ought to have the same rights to access health care services as citizens of the country. Health care services ought to be obtainable physically and financially for all populations, as well as vulnerable groups, and should be delivered equally (Devillé et al., 2011). An adequate level of health literacy could help reduce these health inequalities (National Center for Education Statistics, 2006). Low health literacy among immigrants could negatively affect their health knowledge, preventive behavior, ability to navigate the healthcare system, and the ability to care for themselves and their children. It has shown that low health literacy ability results in less healthy options, less self control, poorer well-being, riskier behavior, and more hospitalization (Kickbusch et al., 2013).

4 Theoretical Framework

A theoretical framework is framework-based literature research that defines a study's main theory and reflects the hypothesis of the study. There are a few models that have been developed to frame the relationship between health literacy and health outcomes. Previous research provides a basis for future research. Social science research uses the theoretical framework to make a logical argument of a need for their research (Adom, Agyem & Hussein, 2018).

4.1 Culture Care Theory Diversity and Universality

Madeleine Leininger's (1991) theory of culture care diversity and universality was chosen as a theoretical frame of our thesis. Leininger's theory is sometimes referred to as the theory of culture (Leininger, 2002). It is one of the oldest and most holistic and comprehensive theories that develop knowledge of different and similar cultures (Wikberg & Erikson, 2003). It is derived from the field of anthropology and made relevant in the field of nursing. We choose Leininger's theory for her theory on culture-related care and the sunrise model. Leininger was the pioneer of the transcultural nursing field, and a big part of the theory is available based on her research. The theory focuses on individualized nursing care, the client's cultural beliefs, and thus a good approach to frame up the study. In the end, the theory will compare the results of the research. The theoretical work will help the researchers to understand and explain and evaluate the results that will come out in the study. The theory will also help researchers to focus on cultural practices related to health and how caregivers can use these practices and improve the client's nursing care.

Leininger believes that man was created in a cultural context, beliefs learned values and forms of life guide people's thinking and behavior. The goal of her research was to develop transcultural nursing. The reason why Leininger wanted to develop knowledge in the subject was that she felt that nurses had too little cultural competence (Leininger, 1991, 13-18). In Leininger's theory, patients are the focus, and they should have a right to have proper care based on their cultural values and beliefs. It is nurses' responsibility to provide culturally competent care to improve patient outcomes to provide meaningful nursing care services according to their cultural values. It is, therefore, essential to promote cultural competence among all nurses. To be able for nurses to provide good holistic care, Leininger says they need to develop their knowledge of cultural differences. She, therefore, developed a visual tool that can be used by both researchers and healthcare professionals (Leininger 1991, 13-18).

Leininger proves that culture is the broadest, most comprehensive, holistic, and universal feature of people. She also believes that people's cultural backgrounds influence care. Caring should be a method of helping people, while care should be a phenomenon to be understood, as well as to support one's actions and decisions. Health care should be a unique opportunity to serve people from all cultures and be influenced by ethnology, culture, social structure, and environmental factors. As a caregiver, one must have the knowledge needed to help people with their care, both healthy and sick (Leininger, 2006).

Leininger proved that to rediscover health, the human cultural background is of great importance, especially in cultures where relatives usually assist in nursing and in cultures where human nursing is more important than technical devices and medicines (Thorsén, 1992, 223-226). For nurses to provide culturally oriented care, Leininger (1991), stated that nurses should be knowledgeable of patients' social structure and worldview in language and environmental factors to provide culturally congruent care that is beneficial to the people they take care of. The main goal of nursing care is to provide culturally congruent care; it can be achieved through three transcultural models. (1) Cultural care preservation and/or maintenance safeguard and maintain the patient's cultural care values, beliefs, and expectations within the nurse-patient relationship. (2) Cultural care accommodation and/or negotiation, the development of flexible nursing interventions that assist patients from different cultures to adapt to and to negotiate their way through healthcare delivery and recovery. (3) Cultural care repatterning or restructuring, to improve patients' damaging health behaviors while valuing their cultural beliefs, values, and expectations about care, health, and wellbeing (Leininger, 1991).

According to Leininger (1991, 1988), care and culture are the most significant phenomena in healthcare science. Caring is the essence of care and the most central and most crucial content of care work, which must have a cultural context to be understood. Patients have different cultural backgrounds and cannot be treated as if they were the same (Leininger, 1991a). Cultural competence is the process in which the health care provider strives continuously to reach the ability to successfully function within the cultural context of the patient (individual, family, or community) (Campinha-Bacote, 1999).

Selected concepts by Leininger:

Care: is a used noun, to help or support a man maintain or expected needs to alleviate or improve a human condition (Leininger, 1994, 30).

Caring: a verb that refers to actions or activities intended to assist, support, or enable another individual or group to alleviate or improve a human condition or lifestyle (Leininger, 1994).

Culture: is a way of life belonging to a particular group of people (Leininger, 1994). It learned, shared, and transmitted knowledge of values, beliefs, norms, and lifestyles of a particular group that guides thinking, decisions, and actions in patterned ways (Leininger, 1995).

Madeleine Leininger models help to provide knowledge to improve practice, guide research, and to identify the goals of nursing practice in different cultures. She explains that; (1) Caring is universal and varies trans-culturally (2) Caring improves human conditions and life (3) Care is the essence and the dominant feature of nursing (Leininger, 1991).

4.2 Leininger’s Sunrise Model

Leininger developed the “Sunrise Model," a conceptual model of nursing to help nurses discover multiple dimensions related to the theoretical belief in the theory of culture care (Leininger & McFarland, 2002). Leininger’s sunrise model was renamed enabler to clarify it as a visual guide for the exploration of cultures. Using the enabler model, nurses make cultural evaluations of patients and can progress through the significant care constructs and social dimensions of the theory to providing holistic, culturally competent, and congruent care. This model is multiple components of the theory used as a significant guide to exploring aspects and various influences on care and culture. There are worldviews and cultural and social structure dimensions. This model contains seven components: technological factors, religious and philosophical factors, kinship and social factors, cultural values and life choices, political and legal factors, economic factors, and educational factors.

All the different factors affect each other and human behavior in different contexts (Leininger, 1991). They form sun rays that influence individuals, families, and groups in health and illness. This dimension describes how the nurse can access both general knowledge and professional knowledge. By general knowledge meant the individual's self taught knowledge includes experiences and common sense in how to treat and care for another person. Professional knowledge means care knowledge that is formally learned and practiced. For a nurse to be able to provide proper care, they should take part in both generic, general knowledge and professional knowledge (Leininger, 1991). Sunrise model also shows diverse health care systems from healthcare practices to nursing and professional systems. Leininger maintains to provide culture congruent care; health professionals should be able to combine generic and professional care to benefit the client (Leininger, 1991). Leininger explains that the model helps to keep in mind the overall shape of various influences to describe and explain care with health and well-being (Leininger & Reynolds, 1993).

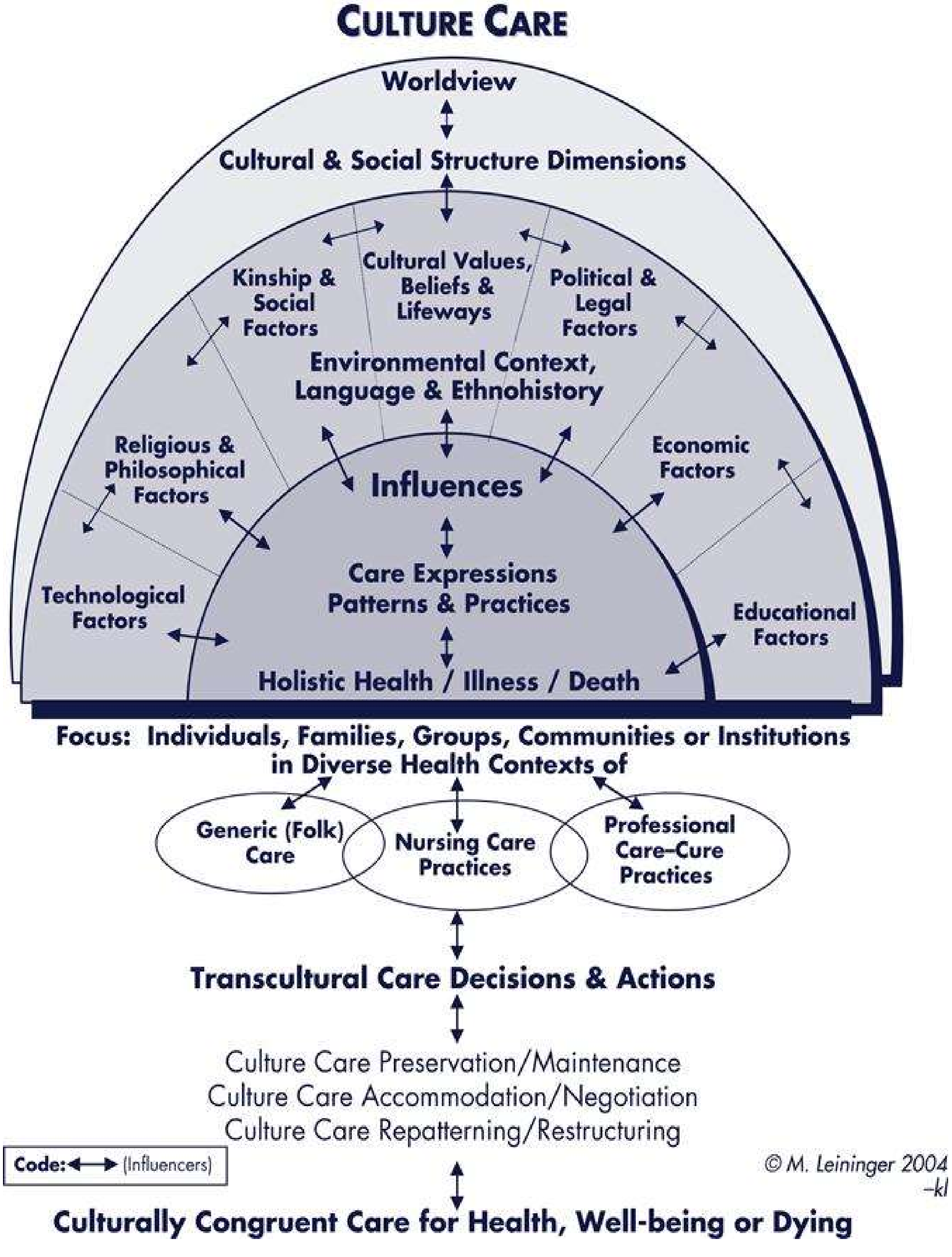


Figure 5: Leininger’s sunrise enabler to discover culture care (Leininger, 2011, 2)

5 Methodology

This study will be done using a qualitative study method approach. This is because researchers seek to describe the participants' experiences, observations, and opinions in their own words about the research questions. We show how data is collected and the materials used as well as how it is analyzed and prepared for the study. The study is qualitative interview research with semi-structured questions to answer the study's purpose and questions. The qualitative interview method suits this study because the researchers want to share the participants' experiences (Henricson, 2017). According to Henricson (2012, 165-168), the qualitative interview study can be structured or unstructured. This study chose a structured interview because it encourages an open discussion with the participants. The researchers led by asking questions and allowed the participants to talk freely about their experiences.

5.1 Data collection

Qualitative interviewing is the most appropriate method for the collection of this data since it allows the participants to describe their experiences in their own words. According to Hirsjärvi and Hurme (2010, 14, 35), interviews are flexible and suitable when doing research. With interviews, one can search for sensitive or several subjects. Interviews are also an appropriate method when unknown or little searched topics are known. The interview questions are semi-structured, with eight open ended questions. The open questions allowed the participants to talk about their own experiences in the healthcare system. According to Jamshed (2014), semi-structured interviews are those in-depth interviews with pre-set open-ended questions that must be answered by the participant. Semi-structured interviews are based on a semi-structured interview pattern, which is a simplified presentation of questions and needs to be analyzed by the researchers. The interview questions are based on previous studies in the background. The questions were designed to answer the study's purpose, and Leininger's studies on the subject influenced the questions.

The study began with a pilot study on one participant who answered the same questions before the interviews. The pilot test interview was carried out in mid-November 2019 and lasted about 30 minutes. The test study interview was included later in the main study. Piloting for an interview is a significant useful aspect in the process of conducting qualitative research as it emphasizes the improvisation of the major study (Majid, Mohamad, Othman, & Lim, 2017). According to Hirsjärvi and Hurme (2010), it is essential to do pilot testing to check how the interview frameworks and themes work in practice. It shows strengths and weaknesses in question study, and it predicts the length of the interviews. Based on the pilot test interview result, the researchers were able to know how the main interview would be, such as the time length duration of the interview and how the participant´s would answer the questions. According to Denscombe (2017, 242), the pilot study shows if things can be improved before the research is done, thereby avoiding what might cause serious problems for the research.

The main interviews were conducted in Ostrobothnia towards the end of Nov 2019. The interviews were conducted in English, and they were based on the interview guide method with eight sets of open-ended questions found in Appendix 2. The interview for each participant was about 30 minutes in length. The participants were informed about the study questions and the focus of the interview. They received needed information beforehand, such as the aim and purpose of the study, as well as information about the researchers, to build trust between the researchers and participants. Each researcher interviewed 3 participants individually, with two people in the interview setting, the researchers and the participant. The interviews were conducted in a peaceful setting, at a place and time most convenient to both the participant and the researchers. Two of the interviews were conducted at the workplace, two were at the researcher's home, while two were at a cafe. The criteria for site selection for an interview should be in a quiet environment where the interview is free from interruptions and disturbance from other people (Denscombe, 2010). To be able to get an idea of the participants' backgrounds, the interviews started with a collection of the participants' demographics, such as age, marital status, education, and occupation.

The interviews were done face to face, and it allowed the researchers to capture every participant's gestures and emotions. The participants were little reserved first at the beginning of the interview, but as the interview progressed, they became more open. With the participants' permission, the interviews were recorded using the phone audio recorder. Extra attention was paid to the respondent's body language as it is a good measure of the level of discomfort in questions from the participants' respondents. The researchers had the opportunity to probe and ask to follow up questions from the participants as needed to capture and obtain as clear, detailed information as possible. According to Clarke (2006), researchers should be sensitive and respectful towards the participants and avoid interrupting them while talking or explaining issues. The number of transcribed materials was about 20 pages of text done in Times New Roman font and font size of 12.

5.2 Selection of participants

Participants were selected through conscious criteria aimed at the aim of the study. According to Henricson (2012, 165), the selection of participants for a qualitative interview study should be done with the purpose of the research by deciding who is most relevant to the study. When finding participants for the study, one should look for people with different backgrounds and experiences. The study participants consisted of 6 adults, four (4) males, and two (2) females with a migrant background. They aged between 30-60, and all came to Finland from different continents (two males and one female from Asia, one male from South America, and one male and one female from Sub-Saharan Africa). The study used inventive names to protect the participants' identities.

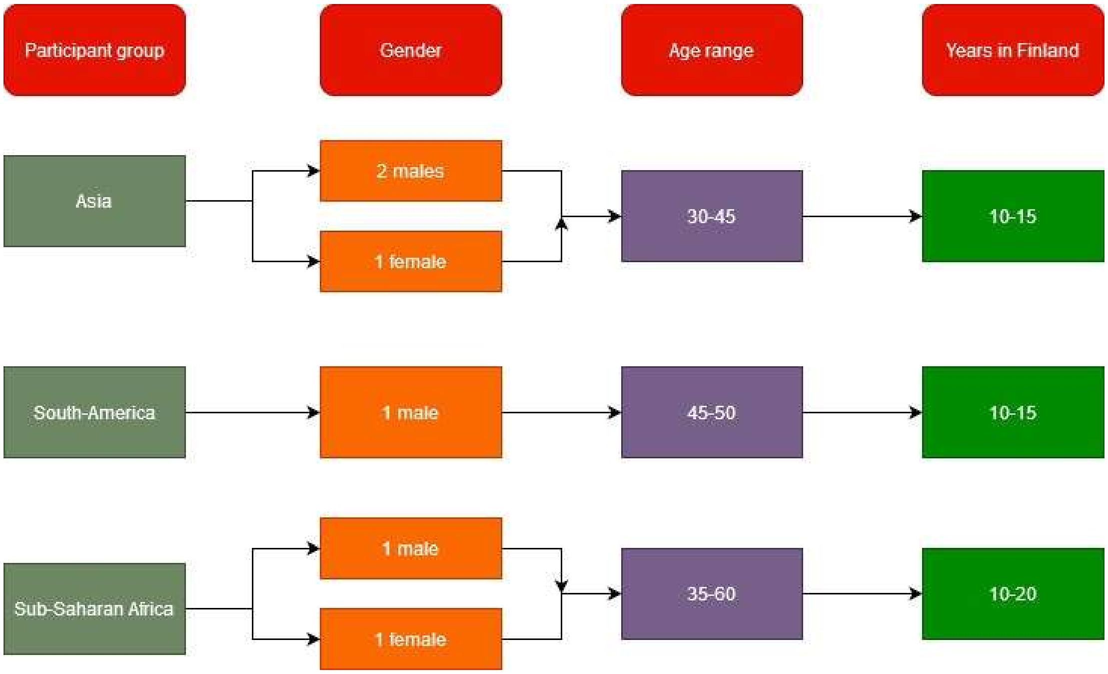


Figure 6: Participants´ profile

The participants now reside in Finland permanently, and they all gave different reasons why they chose Finland as their permanent residence. Paulina, Arman, and James came to Finland for further studies and later found jobs and established life. Daniel came to Finland because of a work opportunity. Nicole and Ford came to Finland because of family ties. The interviews were conducted in English. All the participants spoke fluent English, and all of them were from the countries where English is the official language. At the time of the interviews, they each spoke varying levels of Finnish and Swedish languages.

The two participants were acquaintances of the researchers, and the other participants had recommended four participants. The researchers reached the participants over the phone and explained the purpose of the study. A meeting was arranged for an interview after the participant expressed an interest in the study. The consent form was given to the participants, indicating that the interview would be voluntary, their identity would be protected, and that they could stop at any time if they so wished (Appendix 1). The participants were familiarized with the study questions and the main headlines of the interview. The participants also were informed that they could speak in their own words, express themselves according to their own experiences and that they were at liberty to talk freely.

5.3 Qualitative data analysing method

In this study, the collected material was analyzed by an inductive content analysis that uses research questions to narrow the study. According to Henricson (2017), it is a suitable method for material with a few qualitative interviews in the text. The starting point for the analysis is the study's purpose. It moves to a way in which observations have combined into categories. In this study, an inductive approach was used for analyzing the data. The inductive content analysis approaches analyzing data in three phases: preparation, organization, and reporting (Kyngas & Vanhanen, 1999).

Throughout the interviews, the conversations between the researchers and the participants were recorded using the phone audio recorder. The audio quality of the recordings varied, but all were relatively easy to transcribe. It was important for researchers to take notes and write down observations in order not to miss out on some crucial details. Recording the interviews helped with the analysis phase, allowing the researcher to listen repeatedly (Denscombe 2017, 395). It made the analyzing process more accurate and allowed results to be more precise.

After the interviews were conducted, they were transcribed verbatim, and the researchers verified the accuracy. According to Streefkerk (2019), transcribing is a usual practice when conducting interviews because it allows you to perform analysis. During the transcription process, some of the irrelevant material was taken away; for example, the information that was out of topic. Before the recorded data were transcribed, each answer was checked correctly.

The researchers analyzed the transcribed text by doing the coding and defining the categories and subcategories. Participants' quotes that answered the purpose of the study were color coded in the transcribed interviews (Henricson, 2012). The similar units were found and color-coded while another meaning unit has given a different color. The researchers used the color coding method to have a better overview of the material. The coded meaning units were placed on the same document and started to form subcategories and categories. The categories are created based on subcategories that are similar to each other. The categories and subcategories are then named based on their content (Elo & Kyngäs, 2008, 110–111).

Every collected data was organized and categorized into three parts. Every category was classified into different subcategories. The first category was based on the healthcare system, the participants' experiences in accessing healthcare services in hospitals or health centers and economics that define subcategories. The second category was based on care; here specified participants' experiences based on caregivers' approach in giving health service and ethics. The third category was based on communication, on how language and accessibility affect the participants in getting the right healthcare services.

5.4 Ethical issues

This study followed professional rules in the codes of conduct and research guidelines, as stated by the Finnish Research Ethics Delegation (TENK, 2019). The Finnish Research Ethics Delegation TENK (2019) emphasizes on the respect for the person's right to self determination, avoidance of harmful personal integrity and data protection in or when conducting ethically acceptable research. Research ethics have three main objectives. To protect human participants, to ensure the research has been done in the interests of the individual groups and society and to look at issues such as risk management, confidentiality protection and to have informed consent (Holloway & Wheeler, 2016).

Conducting the study this way ensured that ethical principles were followed and implemented systematically. When selecting the participants, the purpose of the study had been clarified in the consent letter that also stated the fact that participation was voluntary and that the participants would stop at their own will (Appendix 1). The interviews were conducted with the utmost respect for the participants and in a safe and quiet environment.

Integrity protection is a right protected by the Finnish Constitution. This study followed by careful planning of data protection. The interviews are phone audio-recorded, and contents are on flash drives securely stored and designated for this purpose only. After the presentation of the study, the audio files will then be destroyed. The interviews are transcribed and anonymized to protect the privacy of the informants. Researchers should collect, analyze, and report data without compromising the identities of their participants (Varantol et al., 2012). The researchers need to show respect for participants and protect their fundamental rights and values. To preserve the confidentiality of participants in the best possible way, the researchers chose not to use their real names. According to Varantol, Launis, Helin, Spoof, and Jäppinen (2012), we must avoid any kind of harm by respectfully reporting the findings in research publications. The participants also were informed that all the information collected during interviews would be handled with confidentiality and anonymity. Ethics is essential during research that involves human participants. It raises an ethical, legal, social, and political factor. It is essential for researchers to know and be aware of sensitive matters and possible conflicts of interest. Usually, the interview is associated with confidentiality, informed consent, privacy, and kind of sharing of secrets too (Orb, Eisenhauer, & Wynaden, 2001).

According to Sanjari et al. (2014), involving human participants needs an awareness of the ethical issues that may be obtained from conducting interviews to avoid any ethical dilemmas. It has attested that qualitative research that concerns sensitive topics in depth can cause emotional and other threats to both participants and researchers. The interviewer must be aware of the impact their questioning can have on the subjects, particularly people who are vulnerable, and suggests that a reflexive approach will facilitate and minimize the chance of harmful effects (Clarke, 2006). In Finland's constitution, an individual's rights to privacy are protected by the law. In a research study, ethics is of paramount importance, and it is an established principle. Data protection is key to privacy protection, particularly in the area of collection, processing of the research data, and the publication of the results. Participation in research should always be voluntary and should be based on informed consent (Research Ethics Delegation, 2009).

6 Results

To analyze the results, different categories and subcategories were determined. Every main category was classified into various subcategories. The subcategories that were formed from the analysis results and were placed under the main category of this thesis. The content of the subcategories is explained by the researchers and verified with quotations, which are followed by a correct reference.

According to Elo & Kyngäs (2008), the development of categories is a practical and a theoretical task, which the categories are based on. A content analysis demands that the researcher, trustworthily conduct, can clarify the data, and assemble categories that correspond with the study issue. The first main category is the healthcare system, the second is caring, and the third is communication in healthcare. Under the main category healthcare system, two sub-categories were identified: healthcare service and economic. The second main category is caring; it has two sub-categories: caregivers and ethics. The third main category is communication in healthcare; two sub-categories have found: Language and accessibility. The quotations by the participants reinforce the themes that come up when analyzing the interview (Henricson, 2017, 296). These quotes were italicized, and the names of the participants were changed to protect their identities.

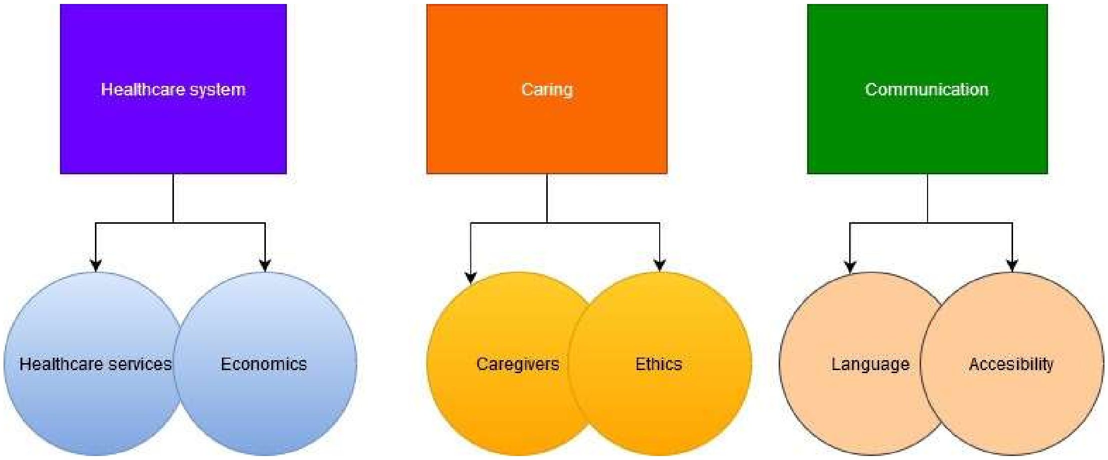


Figure 7: An illustration of main categories and subcategories.

6.1 Health care system

This category shows the feelings and experiences of the immigrant participants in accessing the healthcare system in Ostrobothnia and getting healthcare services in the different health care settings (outpatient clinics and hospitals). The healthcare system category is divided into two sub-categories: healthcare services and economics. The immigrants ‘responses were varied and diverse.

Healthcare services

Most of the participants experienced no challenges in accessing healthcare services; they were impressed and satisfied by how the healthcare system works, it is easy to access healthcare services except that one participant who had no valid residence permit in the country. However, some participants complained about long waiting times in the emergency department.

James appreciates how the healthcare system works here in Finland. He compared the health care services to his own home country. He recognized the quality of healthcare services here works better compared to his home country.

> "*So far my experience staying in Finland ...with healthcare services is very excellent compared to what I received in our country, everything here is sophisticated and organized and healthcare is quality.….*well hmmm* How can I say the total healthcare is excellent for me, so from calling the health center for example. I think it's a very good environment in general in hospitals in Finland." (James)*

> *"I would say that healthcare services here are very standardized and very modern and very organized." (James)*

The participant had good feedback about his experience at the hospital in terms of its cleanliness, waiting time and crowd size. He attributed it to the fact that appointments are important for hospital visits to reduce long queues.

> *"It is very clean, with no strong odour like in my country, it is also very calm and noiseless. People have appointments, so it is not crowded." (Ford)*

According to Daniel, in just a few years that he lived in Finland (2 years to be exact), he felt comfortable when seeking treatment in the hospital. As an immigrant he said that he did not feel discriminated against by this society.

> *"It was my first time to go to the hospital after being in Finland for 2 years, I was very impressed, and I felt very welcomed as an immigrant. It felt very safe and comfortable too." (Daniel)*

Daniel did not know that going first to the local health center is part of the healthcare care system. He thought going straight to the district hospital will provide him better health care services than in a local health center. Daniel got a referral from the health center for further check-ups and laboratory tests at the hospital.

> *"My wife told me I had to first go to our local health center, but of course they did not find the cause of my problems, they then gave me a referral to the hospital." (Daniel)*

According to Daniel, the tests were done step by step (in details) and the results came out very fast. He noted that healthcare in Finland provides clear and immediate medical test results.

> *"They did many tests step by step in detail and the results came quite fast." (Daniel)*

Daniel expressed his satisfaction with healthcare services and how well the health care providers coordinated with him from the start of his first visit until he got results about his health condition. He felt so humbled and grateful by how they took care of the situation in an orderly and organized way (blood test, urine, and faeces test). It mattered to him when he got a follow-up letter and when a doctor called him with the test results.

> *"My experience in the Finnish hospital was really good. The doctor ordered several tests (blood test, urine, and faeces test). They still did not find anything; I took more tests and took long before they discovered what was wrong with me. The doctor ordered me to take 10 days of antibiotics, after leaving the hospital, *ooh* I received a follow-up letter and the doctor called me to tell me the results. The doctor and the nurses were very cooperative." (Daniel)*

When Paulina was asked about her experience in healthcare services, she was a bit disappointed. She said visiting the health center or the hospital is not an assurance that she will get the right services that she expects or needs. According to her, visiting the health center or even going to the hospital is time-wasting sometimes because of the uncertainty in getting proper services.

> *"Sometimes with good service, sometimes it feels like it is useless to visit a health center or even hospital." If you go to an emergency place there is always a long queue… *anger*."* (Paulina)

Ford states that waiting time at the emergency department was too long. His expectation was that with an appointment, he would be attended on time. Despite being unhappy about the length of his wait, the main concern expressed was the lack of information about why he is waiting.

"I had to book time before I went to the emergency department, but then when I got there, I had to wait for a very long time to be attended to. I did not know what was going on behind the closed doors, why some patients who waited less time were seen first, or why sometimes no one appeared to be treated at all." (Ford)

He said about not knowing what was going on behind the closed doors, why some patients waited less time than others were seen first, or why sometimes no one appeared to be treated at all. Further information should be made available to those waiting, possibly putting posters in the waiting area outlining the order of priority of different illnesses or injuries.

Economics

It is important as an immigrant student in this country to have a valid private health insurance in case the situation needs healthcare services. Hospital fees and private doctors' fees can be relatively expensive.

Paulina came to Finland more than ten years ago as a student at University. She came with a valid private health insurance. She narrated her experience of getting health services as a student from outside the European Union with the expired insurance.

> *"I am a student from outside the EU and it was not easy to get healthcare services, because it was very expensive………. My private medical insurance had expired already for a few days."* (Paulina)

Paulina decided to go to the private clinic because she was advised by someone to use private instead of the health center. However, she never thought that it would be costly after her insurance coverage had lapsed. As a student her economic resources were limited. Therefore, she was disappointed when she received the medical bill. The bill was expensive, and she had to cover it on her own.

6.2 Caring

The participants, in general, were satisfied with the quality of care they received from the healthcare providers. Healthcare providers somehow play a unique role in easing the patient´s and the family's emotional burden during their visit to the health center or hospital. Providers' caring is a vital component in healthcare. Emphatic, compassionate, and respectful care may have an impact on the effectiveness of treatment and can also help patients from unnecessary suffering. Within the category of caring, it is divided into two sub-categories: caregivers and ethics.

Caregivers

It is essential as a nurse or caregiver to treat everyone equally with dignity, compassion, and respect. It is beneficial for a caregiver to establish a healthy caregiver-patient relationship.

The participant had some positive feedback about the caregivers on how they treat the patients humanly and professionally. A few years ago, Arman was operated on in his appendix in the hospital.

> *"I got good and professional service from the caregivers. Sometimes." (Arman)*

A simple gesture by the caregiver could mean a lot to the patient, and it can even impact their recovery process. Nicole was somehow happy when she encountered a friendly nurse during her visit to the hospital.

> *"My experience in the hospital was very good, the nurse was very friendly." (Nicole)*

Nicole said that her hospital experience was great, and the nurse was accommodating. As an immigrant, it feels good when going to a hospital or health center with accommodating healthcare providers.

Ethics

Finnish caregivers may not be as expressive or compassionate compared to their foreign counterparts, but they provide professional care and treat patients with respect and dignity. They respect the rights of every individual patient.

According to Paulina, healthcare providers know how to observe professionalism when giving care to the patients. However, she noted that caregivers of the foreigner backgrounds appeared more enthusiastic in assessing patients' needs. Although the Finnish caregivers were not generalized, she pointed out that some of the Finnish caregivers are likely polite, but they lacked compassion.

> "*Many caregivers with foreign backgrounds usually are more enthusiastic in helping patients." Finnish people are more like they follow professionalism, they are polite but there ́s missing compassion or empathy *sad face* but, not all care providers." (Paulina).*

James considered the Finnish culture as not open, anyhow he appreciates how people are honest, caregivers are straightforward when giving information or instructions concerning health. In his opinion, the Finnish caregivers generally are not either expressive or compassionate towards patients, but they treat patients with respect and dignity.

> *"Finnish culture is reserved, so maybe it can be shown in the hospital, but one thing I like here is that people are direct…. the nurses and doctors when giving the healthcare services, they are polite...I can say in general I do not experience any difficulties, they are usually friendly here, and they are direct in giving information and care procedures. Maybe the negative thing also is that maybe the Finnish culture is not expressive and compassionate." (James)*

Nicole expressed her disappointment about the situation when she visited the antenatal care unit. During her visit, she told the nurse about her worries in her pregnancy and giving birth because she had female genital mutilation. However, Nicole was not satisfied with the nurse's response. Perhaps, the nurse did not understand what the female circumcision procedure is, otherwise she could have at least given an ethically sensitive advice or moral support to Nicole.

> *"When the nurse asked if I have any fears or phobias, I said I was circumcised if it would affect my pregnancy or if I will have to go to an operation to give birth, she did not give me any good answer. I had no problem with the nurse's culture except she did not understand the level of my pain, but she said I should just take Panadol every time I was in pain." (Nicole)*

However, the caregivers could have an important role in educating the female migrants who have undergone the circumcision procedure. From her point of view, the nurse's culture was not an issue, except the nurse misunderstood the level of her pain.

6.3 Communication in healthcare

Clear communication is important between health caregivers and patients. Within the category of communication, two subcategories have been formed, Language and accessibility. Patients with inadequate health literacy may feel uncomfortable communicating with healthcare providers and find it difficult to ask questions concerning their health.

Health Caregivers should be aware that not all people understand medical terms. Patients facing difficulties in understanding their health status due to unfamiliar medical terms may result in ineffective treatment. Although health professionals may try to speak the language that the immigrants prefer, understanding still poses a challenge due to the health illiteracy of a patient. In some circumstances, some patients may face difficulties in understanding medical words used by caregivers.

> *"The communication was in English because I didn't speak Finnish at that time. Sometimes it is difficult to understand what the caregivers are saying because they use medical terms, but they don't explain what it means." (Arman)*

In Arman´s situation, he was able to use the English language when he communicated with the caregivers. However, when the caregivers used medical terms, he said that he experienced difficulties. English may be a common language for patients and caregivers, but they may not have standard knowledge when it comes to medical terms.

Language

Language was considered a major challenge for the participants, during their healthcare encounter. They were not able to speak good Finnish or Swedish and interpreters were not provided. One participant was accompanied by a family member in case he needed an interpreter.

James pointed out that the language barrier was the main problem because he could not speak the Finnish language. He was fortunate enough that the nurses and doctors he encountered were able to speak English with him.

> *"I didn't really have anything that I would say was an obstacle. Aside from the language Finnish language. But the good thing here is, the healthcare providers could speak English *smiling*." (James)*

Paulina cited not being proficient in the language of the host country is challenging. She admitted that explaining her health issue was not easy because she could not speak Finnish or Swedish language.

> *"I experienced that without enough knowledge in their language (Finnish or Swedish language), *hmmm* it is difficult to understand and explain clearly health issues or needs." (Paulina)*

Ford said the major issue that he encountered was the language barrier to communicate with the nurse. The nurse can speak little English, but it was quite difficult for Ford to understand her. When he got home, he went online to check more information about the condition in English.

> *"I had problems with communications, I can't speak Finnish and the nurse English was not good. English was not clear when I tried to explain something and she did not understand, so I went home and tried to research for myself." (Ford)*

Nicole visited the hospital for the first when she was expecting her first child. The midwife who could speak little English. Her partner demanded that the midwife must explain in English so she could understand better. The midwife did all she could to explain to Nicole.

> *"The midwife could not speak English well, it was very difficult for her to explain, it took a lot of time for her to find the right words and find how to phrase them. She tried to use the internet to translate. My partner is Finnish, but he insisted that the nurse must speak in English that I can understand everything that I was told." (Nicole)*

When Daniel went to the hospital, he decided to bring his wife to help him navigate the language barrier. He was lucky though since the doctor gave him a choice of three different languages Finnish, Swedish and English.

> *"I went to the hospital with my wife in case I had language problems. The doctor was very helpful, he gave me a choice which language I wanted to speak (Swedish, Finnish, or English). I speak my little Swedish and no Finnish." (Daniel)*

The participant said although he could speak little Swedish, he still wanted to take his wife with him; that she could help him to understand the situation if the healthcare providers did not speak the English language.

Accessibility

Healthcare should be easily accessible, affordable, and equal to the immigrants. According to the Suomen Lääkäriliitto (2020), the immigrants in Finland are entitled to health services and social welfare even when they are not Finnish citizens if they have been granted a residence permit and have a permanent home municipality. Some information regarding patient's rights and their access to health care service was considered not clear to some participants. Information accessibility is the right to see, receive, and convey information and ideas concerning health issues (World Health Organization, 2020).

The modern world has internet access where people can search for the information. It gives the possibility for people who want to get information, learn, and gain more knowledge. Healthcare websites provide instructions and information about the services, for people to check information in advance.

James gave credit to the health care system how the information and instruction can easily be found. The patient can look up their personal health information online and be able to receive a medical case summary and patient's appointment schedules through the mail post. The doctors usually call the patients, or vice versa, to discuss their health condition if needed.

> *"The good thing here in Finland you can see all the information online so you can read it in advance and you also receive a letter from the hospital and I also got a call. from the doctor and nurses asking about my opinion. You can call anytime actually to the hospital." (James).*

A year ago, James had an operation on his gallbladder. The procedure was a success and everything else went smoothly. His only concern was that the nurse did not give him clear instructions about the post-operative care, and about his daily diet and activities. He had to rely on the information on the internet about postoperative care.

> *"There is not really clear like…*hmm*...basic detailed instruction, after the operation, there was no detail for post-operation of what to do or what not to do." (James)*

According to Nicole, she had an issue about the signs in the hospital that she visited. Some signs were a bit unclear to follow so she needed to ask the right direction from someone. She also added the information she got from the internet website was different from the information provided by the hospital and doctor.

> "*The signs in the hospital are not clear, they may give the wrong direction, you will have to ask someone which direction to take. Also, the internet might say something, and, in the hospital, they might say something else. For example, the doctor might say one thing, and, on the internet, it means something different *aargh*." (Nicole)*

Once Ford went to the hospital, he was being asked to fill up the forms. The forms were all written in the Finnish language. He was able to fill up the forms using the google translation. The advantage of this generation is you can access the internet at anytime and anywhere.

> *"All the forms were in Finnish; I had to use google translate to fill the forms." (Ford).*

Paulina mentioned that there were no forms accessible in English. The diagnosis was written in the Swedish language even though they were aware that the patient has little knowledge of the Finnish language.

> "*It is challenging, often they don't provide information in English and sometimes they write diagnoses in Swedish although you understand Finnish or English *hmmm*. Doctors or nurses may also have difficulties in understanding you or to explain to you what to do." (Paulina)*

The participant said he got a referral to the hospital written in Swedish, but the forms that he needed to fill up were both in Swedish and Finish. Both the test results, as well as the follow up letter, were sent to him in Swedish. The good things he was able to use google translate to be able to fill up by himself.

"The referral letter I received home was in Swedish. The forms were all in Finnish or Swedish. The follow-up letter and the results were in Swedish." (Daniel)

The medical information that the caregivers are using is not always easy to be understood by patients. Caregivers could at least use simple words for the patients to easily understand. Not all the people have medical knowledge or understand the word.

> "*I only had difficulties in understanding the medical information the caregiver gave me." (Arman)*

Arman somehow did not have any struggle when it came to language because he was able to speak English with the healthcare provider. However, the medical language which he found quite challenging because he needed to ask a few times what the word meant.

7 Discussion of methods

To achieve the goal of this thesis in describing the obstacles faced by adult immigrants in gaining health literacy in Ostrobothnia, and the ways that can promote and improve the immigrants' health literacy, this thesis contains an introductory chapter that informs the reader about the topic of the study and its importance in nursing. It also includes the researchers' thoughts and hope for the future. The study's problem is defined and presented in the chapter's aim and problem definition. The study cannot be resolved in this one thesis, but the information can be used as a stepping-stone to more comprehensive research that could be done in the future.

The chapter background of this thesis features literature borrowed from related research studies. Primary sources of the material and the references are included at the end of the report. The literature comprises both old and new literature. To give the researchers and the readers an understanding of the study's performance, the study included definitions of specific subjects. During the research, to obtain better results and improve the quality of work, the background was rewritten a couple of times. The study sourced some information from Finnish and Swedish sources for them to obtain reliable information as much as possible that could be applied to this study. The data sourced was then translated into English. There was also a consideration of health literacy among adult immigrants in other countries as they are structured differently compared to the Finnish model.

To do this study, Madeleine Leininger's theory of culture care diversity and universality and the Sunrise Model was chosen as a theoretical framework. Leininger was chosen because she was the pioneer of the transcultural nursing field, and a big part of the theory is available based on her research. The theory focuses on individualized nursing care, considering the client's cultural beliefs. It guided the study's work in focusing on cultural practices related to health and how nurses can use these practices to improve the client's nursing care. Having a theoretical framework and a model based on the same theory made it more reliable since having the theory supported by some model gives it more useful in practice. The Sunrise Model highlights the seven cultural components that the nurse should consider identifying circumstances that affect the care of a patient. The study used some of the information as a guide when analyzing the data to view the trend in them, and this helped in comparing the different formed categories, as illustrated in the results.

The methodology used for the study is explained in the thesis. The study is done by using qualitative interview method with semi-structured questions to answer the study's purpose and questions. Interviews was chosen because it gives possibility to meet participants and their experience, observations, and opinions in their own words. This kind of setting allowed researchers to make follow up questions and allowed participants an opportunity to seek clarification whenever something was unclear. The information collected was then analyzed to gain an understanding and insight into a topic. The researcher intends to use himself as a research instrument, for example, interviews in a qualitative study (Henricson & Billhult, 2012, 130-133). For the material that must be analyzed in the best way, the researchers needed to be prepared before the interviews began. An interview allows the opportunity to understand the participants' experiences in his own words (Danielson, 2012, 163-165). When using a semi-structured interview, one does not have to be as careful to follow the plan and the questions prepared. It is also possible to ask follow-up questions, and thus it becomes a freer interview (Ritzen, Sagen, Sjöberg & Thunsted, 2016). The study also chose inductive content analysis to process the data, which includes undergoing a pilot phase for prior testing. In this thesis, a pilot phase was done. According to Denscombe (2017, 242), the pilot study shows if things can be improved before the research is done, thereby avoiding what might cause significant problems for the analysis.

In this study both researchers participated in the information search. The interviews were conducted separately except for the pilot interview, which was done together. Both researchers did the analysis process and the final discussions. This gives opportunities for balancing ideas and supporting each other in the development process. Before interviews were conducted, relevant prepared questions were worked out regarding the aim of the thesis, but where more clarification was needed, they did follow up questions to gather more precise and relevant information. In the course of the interviews, the researchers also realized that sometimes they needed to explain more what they meant by the questions in an attempt to get more relevant answers hence increased the need for a one on one setting. At the beginning of the interview, the participants were little reserved, but as the interview progressed, they became more open. It may attribute to the fact that the participants admitted that they thought the researchers would prejudice them if they lacked knowledge on how the health system worked, but they later realized that the researchers were only undertaking the research to improve for a better future.

The entire interview process was performed in English. With the participants' permission, researchers recorded the interviews with a phone audio recorder. Interviews were done face to face, which allowed the researchers to capture every participant's emotions, and gestures. The quality of the recordings varied, but all were relatively easy to transcribe. Both the researchers interpreted and analyzed the material together. When doing the analysis, the researchers realized that they had different thoughts and produced different coding. To be able to reconcile this, the discussions were held to brainstorm the way forward until the researchers came up with a roadmap that both could agree on.

To reach the immigrants and request them to participate in the interview, the researchers first sent information letters and requests for participation by e-mail to some older refugee adults with immigrant backgrounds. That did not, however, yield anything as they did not respond. It was then clear to the researchers that request by email was not an appropriate method of contact and had no option but to change course. As a result, the researchers decided to look for other participants in the hope that they would be willing to participate. Two of the participants were acquaintances of the researchers, and the participants recommended the other four. The researchers reached them over the phone. The interviews were conducted in a peaceful setting, at a place and time most convenient to both the participant and the researchers. The interviews of two participants were done at the workplace, the other two were at the researcher's home, while the other two were at the cafe.

The transcribed interviews were analyzed inductively in an assay matrix. Since the study is qualitative, each of the experiences is nevertheless of interest and enriched the result. The researchers used the color-coding method to have a better overview of the material. The coded meaning units were organized according to their relevant categories. The results use a diagram to show the main categories and sub-categories. According to Henricson (2012), for one to describe the content in-depth, a qualitative content analysis method can be used where after reviewing the material several times, the content was placed in different categories and subcategories. The results were explained by comparing the background and the framework.

In qualitative research, analysis trustworthiness has demonstrated by explanation and presentation of the criteria terms: credibility, dependability, conformability, transferability, and authenticity (Elo et al., 2014). According to Polit and Beck (2017), credibility is the amount of confidence the reader has that the data interpretation presented is truthful and accurate. The trustworthiness of this study is shown by presenting and explaining the collection of data adequately. The data gathered by researchers was done in a trustworthy manner and presented as transparent and rigorously as possible. It was presented by explaining how the categories had formed after the data was analyzed. Polit and Beck (2017) describe how when a piece of research is truthful, it covers all the realities which were shown within the group under study. The conformability of the analysis was indicated by providing the researchers understanding of the results and with quotations to enhance trustworthiness from the interviews. The analysis process was thoroughly explained so that the reader could make their judgment about the trustworthiness of the results. The dependability was presented by explaining every step to ensure the reader followed the researchers' steps. The methods and result analysis used were done carefully with the free text and figures. The information collected in research depends on questions asked in interviews. If interview questions are not well prepared, the material collected may not serve its original purpose. The result can also be possibly wrongly interpreted. It can happen, for example, if a researcher does not understand given answers in the same way as participants mean (Saaranen-Kauppinen & Puusniekka, 2006).

The participants were not coerced and participated voluntarily in the interviews. The data collected was kept private and confidential throughout the study. The participants were free to stop at will and were at liberty not to answer any question if they did not deem it appropriate. They understood the interview questions (or they asked if they were not sure about the meaning) and gave variable answers. Qualitative research often treats intrusive subjects, and thus it's essential to protect the participants' identities. Therefore, the data collection and the data analysis were done anonymously, and participants' real names were not used in the final report. On some occasions, some words and phrases participants used in interviews had changed while compiling the study results for protecting the identity of the participants. However, it was made in a way that the idea of the quotation was not changed (Hirsjärvi & Hurme, 2010, 19-20, Holloway & Wheeler, 2002, 61).

The researchers followed the format and structure principles of thesis writing instructions given by Novia University of Applied Sciences format and structure, while at the same time avoiding excessive or inadequate detailing. In doing this, we used a humble approach to the writing style. The researchers strived to write this thesis to be easily understandable and aimed at for grammatical and spelling correctness of words. This thesis has a title and the target group. At the beginning of the thesis is an abstract that explains the research problem and findings in enough detail. The bibliography for references can be found at the end of the thesis. The appendices accordingly show extended components.

Limitations of the study

This project was very difficult and a challenging undertaking considering that it was done by two nursing students who are at different stages in their lives and their busy work schedules as well as family time that often conflicted with the time allocated for the project. Finding time to sit and work out something together was always an uphill battle, sometimes extending to late hours into the night. All in all, we were able to navigate this hurdle after making a timetable and convincing our families of the need for us to accommodate time to work on the school project.

Working as a team on the same project, we were able to obtain several viewpoints on the same material as one would come up with the idea that the other party had not thought of. However, it was not always easy to work together, as each one of us had different ideas on how to approach the project. However, in the end, this created a wonderful opportunity to learn from each other and resulted in a timely and good quality project. Working together as a team also taught us the benefits of proper communication and having open discussions, and this will be vital in our future careers as nursing involves problem-solving, brainstorming and teamwork is a big part of that.

After taking a closer look into this thesis, a few things came up that otherwise could have been approached a little differently. The researchers were faced with challenges in accessing relevant scientific articles relating to health literacy among adult immigrant communities in Ostrobothnia and in Finland as a whole. We also had difficulties in finding relevant hard books since the libraries were closed as a result of the recent COVID-19 pandemic, and we had to do online research for the books, which was not always easy and also had to rely on supervision from an online team program.

The participants' plight and the challenges faced by immigrants in seeking health care were unknown to the researchers, which led to an eagerness and a curiosity to obtain more information. In the end, the entire process of undertaking this project has been a learning experience. We have gained much knowledge in the process of the study, and especially in the area of data collection and analysis, and in the writing of this thesis. Overall, the research was exceptionally informative, considering the researchers' future careers in the nursing field. The work dragged on a little longer past the anticipated time since after the idea of the project was agreed upon and approved by the supervisor, we then proceeded on to build on the theoretical background, and after having completed most of it, and conducted a pilot

interview followed by the main interviews, one of the participants dropped out and chose not to participate. This was a setback, as it took us a while to find a new participant.
Although all the participants in the study group were familiar with the English language, which somehow eliminated the need for an interpreter and engaged the participants with much more in-depth and meaningful discussions. Participants expressed concern about the language barriers they encountered when they visited the hospitals since the languages are spoken and written are Finnish and Swedish languages. One other thing that could have been done differently was the selection of sexually/culturally/age-diverse participants. This would have captured a better and clearer picture of the questions about culture. All our participants had indicated that they did not have any cultural challenges in the Finnish health system. This could be due to their educational background and the age of participants. Out of the six participants in the interview, two were nurses; two were students at a university college while two were vocational level, college students. Our belief was that had we interviewed a diverse group; we could have obtained different results. The duration the participants have resided in Finland also seemed to affect the results. Had the participants lived in Finland for a short period, the results would probably have been different. Participants in our study group had lived in Finland for years ranging from 10 to 20 years, and they pointed out that cultural differences did not affect them. In case the participants would have been from diverse participants without any educational background and no knowledge of Finnish cultural background, the results gained could have been different. The researchers had difficulties in reaching immigrants. Initially, we wanted to interview adult refugees.

The researchers felt lucky to have had open and talkative participants who were not distracted. Since this is a new experience, during the pilot interview, the researchers were quite nervous, and probably because it was the first interview. In the process, we realized that we talked too much about our points of view and experiences. All in all, we created a conducive atmosphere where everyone was relaxed and was open to speaking out freely on the subject matter. During analysis, it appeared that some interview questions were concentrated on some specific experiences, and thus, not all the questions were answered by each participant.

8 Discussion of results

This study results can be used for future purposes since no previous data have found concerning health literacy among adult immigrants in Ostrobothnia. The study aims to describe the obstacles to gaining health literacy and describe the ways that promote and improve health literacy among adult immigrants in Ostrobothnia. The researchers will discuss the result implication of this study. Therefore, the categories and the subcategories are interpreted, compared, and contrasted contrary to the theoretical background and framework. Some of the main categories formed and paired with Leininger's sunrise model. The sunrise model has seven cultural components that the nurse should consider identifying circumstances that affect the care of a patient. These are technological factors, religious and philosophical factors, family ties and social factors, culturally based values and lifestyles, political and legal factors, economic factors, and educational factors.

According to the findings of the study, communication is a category that appears as an obstacle for accessing healthcare services among adult immigrants in Ostrobothnia. Language competency and education levels have a significant impact on health literacy among migrants (Park, Lee, & Kang, 2018). The main factor that adult immigrants have challenges gaining health services is due to the language barrier and poor language skills. The language barrier can have a significant impact on caring relationships between caregivers and patients. From the background, Wikberg (2014) states that almost all studies involving patients from other cultural backgrounds tell about language and communication problems in nursing care or health care. Also, communication problems between caregivers and patients, even when speaking the same language. The ability and inability to communicate at a sufficient level in the host country language have a substantial effect on immigrants on accessing health care. The study findings show that caregivers' attitude plays a vital role in caring for the patients. The patient naturally needs support from the caregivers. This finding emerged to Leininger's (1994, 30) concept about "Care" to help or support a man maintain or expected needs to alleviate or improve a human condition.

In the background, the Sunrise model has a culturally based value. However, culture has not been an obstacle to accessing healthcare services among adult immigrants who participated in the study. To get even more productive and more credible results in the culture, researchers would have needed diverse participants. Somehow, it shows how healthcare providers are culturally oriented in dealing with immigrant patients. Leininger (1991) stated that cultures know care in various ways. Therefore, nurses shall be knowledgeable of the patient's worldview in language, social structure, and environmental factors to give culturally congruent care that is beneficial and meaningful to the people they take care of. As a caregiver, one must have the knowledge needed to help people, both healthy and sick, with their individual care needs (Leininger, 2006).

It was interesting that all the immigrant participants have a positive perspective on Finland's healthcare system. They described the healthcare system as organized, standardized, and modernized. Some participants had even compared Finland's health services and hospital setting to their own countries. They were impressed with the hospital's environment, cleanliness, and uncongested. Keeping the environment at hospitals clean is an important safety issue for everyone. The participants stated that they had not faced challenges in accessing healthcare services as immigrants in this country. The health care providers were accommodating and professionals at the hospital and health center. Daniel felt welcomed and not being discriminated against by the caregivers. Coming from a developing country, James pointed out that the healthcare service in Finland is far better than in his own country because their healthcare system is not functioning well for everyone compared to Finland. According to the Suomen Lääkäriliitto (2020), health services are accessible to everybody in Finland, regardless of financial status.

When comparing the results to the background, it emerges from the study of Hernandez (2013), that having health literacy is a valuable tool to allow people to take control of their health, to use health information, which will lead to personal and social benefits. The category of knowledge (education) linked to the sunrise model of educational factors. According to the World Health Organization (2019), health literacy is improving people's access to healthcare information and using it effectively. Daniel did not know how the Finland healthcare system works. He believed going straight to the hospital was a better choice instead of going to the health center, but his wife advised him to go first to the health center as the standard system. However, his experience proves how essential it is for immigrants to know how the health system works in the host country. According to Altschuler 2016, in many developing countries, hospitals hold the primary source of medical treatment care, while the community clinic's primary care can be very inferior, so these immigrants could feel degraded while being offered primary care first. The two participants' common complaints concerning obtaining healthcare services were time-consuming waiting to be attended by the healthcare provider at the emergency department. Booking an appointment in advance does not guarantee the patient to get attended immediately by a healthcare provider. Paulina realized that going to the hospital or emergency department is useless sometimes. Ford also expressed his disappointment towards the hospital service, as the situation did not meet his expectations. The queuing process to see the healthcare providers was too long, although he booked an appointment ahead.

Contrasting the results with the background and the framework, the Leininger's sunrise model, the economic factors, and social factors have linked to the subcategories of economics. The two participants encountered challenges in obtaining healthcare services when their permit and insurance were no longer valid. Paulina considered going to the hospital was costly for her as her private health insurance had lapsed. The background stated that health services are accessible to everybody in Finland, regardless of financial status (Suomen Lääkäriliitto, 2000). Devillé et al. (2011) noted that immigrants ought to have the same rights to access health care services as citizens of the country. Health care services ought to be obtainable physically and financially for all populations, as well as vulnerable groups, and should be delivered equally. Nicole's concern to be discriminated against to get the same treatment as the citizens in Finland since she did not have a valid residence permit in the country anymore. According to The Finnish Institute for Health and Welfare (THL) (2020), The person who illegally stays in the country may not be entitled to health care services or may only have limited access to health care, anyhow the public health care system may provide urgent care.

The background supports the results, Leininger (1995, 60), defined culture as it is learned, shared, and transmitted knowledge of values, beliefs, norms, and lifestyles of a particular group that guides thinking, decisions, and actions in patterned ways. James emphasized how the Finnish culture is not as open as his culture as he noticed the Finnish caregivers are not expressive or compassionate. However, they treat patients with respect and dignity. According to Leininger (1995, 59), nurses function best when they know and understand different cultures concerning people's life experiences, human conditions, and cultural values and beliefs. Paulina noticed Finnish caregivers are well mannered and professional in treating people but not as compassionate and empathetic as caregivers from her own country. The biggest challenge for nurses is to learn compassion and understanding, taking care of people from different cultural backgrounds (Leininger & McFarland, 2002). Nicole cited the nurse seemed not to understand her worries about her pregnancy and to give birth as she mentioned that she was circumcised. She felt the nurse was insensitive not to understand her pain. According to Nyback (2017), Cultural competence is an essential tool to effectively interact, understand, and communicate with people of cultures other than one's own. Cultural competence in health care has shown to have several health benefits such as increased patient satisfaction, improved communication, better control of pain, and greater equality of care. (Heizler, 2017).

Meanwhile, all the participants consider language as the main obstacle to obtaining healthcare services. Maintaining and improving the quality of life between health professionals and migrants' patients is essential to have clear communication (Parnell, 2014). Some participants specified difficulties with expressing themselves and understanding information due to language problems. According to Altschuler (2016), Language communication challenges can arise between a healthcare provider and migrant patient due to different cultural norms in opinion and expressing disease and illness. James did not encounter any significant obstacle within health care services except the language barriers. Paulina considered insufficient knowledge of the host country language poses challenges and has a considerable impact on health issues. Ford and Nicole have similar problems when both could not speak and understand the host country language. In their situation, they needed a support system from their respective partners during their visit to the hospital.

Arman stressed out the difficulty in understanding the medical terms used by the healthcare providers in the hospital. Perhaps, some healthcare providers are not aware or consider the fact that not all people understand medical terms. If caregivers use understandable and plain language, it can help the patient to understand the information quickly. According to Federman and colleagues (2009), plain language is the communication that is understood the first time seen or heard. According to Koh (2010), regardless of an individual's literacy level, when a healthcare provider uses unfamiliar words like medical terms, it is difficult to understand what has been said. The participants emphasize the importance of accessibility of information online, which provides updated information. However, the participants criticized that the instructions and forms of some hospital websites or other related healthcare websites like Omakanta are available only in Finnish or Swedish. Perhaps, it may limit immigrants to obtain necessary and essential data if they do not speak the host country language. According to the World Health Organization (2020), information accessibility is the right to see, receive, and convey information and ideas concerning health issues. However, this access to information must not impair the right to have personal health information treated with confidentiality.

According to the World Health Organization's (WHO) Health Promotion Glossary (1998), health literacy signifies the social and cognitive skills which determine the motivation and ability of everyone to gain access, understand to, and apply information in methods which promote and maintain good health. Immigrant patients with inadequate health literacy may feel uncomfortable communicating with healthcare providers and find it difficult to ask questions concerning their health. It has shown that low health literacy ability results in less healthy options, less self-control, poorer wellbeing, riskier behavior, and more hospitalization (Kickbusch et al., 2013). Therefore, they might leave the healthcare settings even without the proper and right information that they are supposed to know or receive. An adequate level of health literacy could help reduce these health inequalities (National Center for Education Statistics, 2006). Knowing health literacy will help future generations (European Commission, 2013). Ways used to improve health literacy through culturally appropriate health systems include training the staff to improve assessment methods, enhancing the cultural communication skills, creating patient-friendly written materials to develop sustainable and effective interventions (Gillis et al., 2012).

For some immigrants, language barriers may make it challenging to understand instructions during the care procedures, follow or understand the treatment plan, and side effects of medication. The language used by the care providers should be simple and easily understood by the patient. Communication and language barriers such as those resulting in the limited host language proficiency may contribute to misunderstandings between immigrant patients and providers, and it may affect the quality of care and even the wellbeing of the immigrants.

9 Conclusion

This chapter puts the thesis together and gives a conclusion about this thesis. Immigrants are on the increased trajectory in Finland. Therefore, there is a need to study how immigrants cope in the health care system with different cultural backgrounds, beliefs, and behaviors, and as well as educational levels. There are challenges affecting immigrants when they have limited health literacy and the lack of clear instructions on the healthcare systems. To overcome these challenges, we did research aimed to describe obstacles in gaining health literacy faced by adult immigrants in Ostrobothnia and describe the ways that can promote and improve health literacy among them.

The results of the research will help the health caregivers give more effective care to clients of diverse cultures. This study shows that the participants are generally satisfied but indicates that there is still a development need for intercultural care. According to the study results, the main challenge is the language barrier that hinders adult migrants in Ostrobothnia from getting good health care. However, this should raise an "alarm bell" to the health care sector in Finland to take appropriate measures to find ways to improve the quality of healthcare available to adult immigrants as the percentage of immigrants in Finland is on the rise. It is evident from the research group that the population of English speakers is on the rise, and therefore the health care sector needs to adapt to this growing constituent. Thus, one way would be to provide language training to health caregivers so that they can be of better service when providing care to immigrants. The health sector should also strive to accommodate whenever possible provisions for interpreters when the patient in question does not communicate in English, Swedish, or Finnish. This study has attempted to point out the hurdles faced by the immigrants living in Ostrobothnia, especially in the area of communication. It has also offered information and recommendation to health caregivers on how they should strive to provide healthcare to immigrants ensuring equality, quality, and satisfy the needs of the patients.

If possible, to better integrate the immigrant community to society, the government should provide language learning opportunities to them at subsidized costs. It will convince them to learn and help them improve their Finnish or Swedish language skills and literacy as this will also be beneficial to them when they seek care at the hospitals but will also help them better integrate with the society at large. A study by Jacobs (2012) shows patients with low English proficiency in the United States had difficulties in accessing health care, the quality of care they received was poorer compared to those who spoke English. The study also found out that the patients who did not speak English experienced dissatisfaction with health care. This research study is similar to our study because the participants also pointed out the same issues due to a deficiency of lack of knowledge of Swedish and Finnish languages.

Good communication between the health caregivers and the patient is an essential element for improving patient satisfaction, treatment compliance, and health outcomes in health care. So, it is desirable if the information is provided in the patient's native language. In the case of language deficiencies, consideration of interpreting services should be made available to promote the experience of care. Interpreting services can, however, be a sensitive subject; the language skills of the patient in this matter are being questioned. Health terminology is complicated and unknown to many; some patients usually forget the medical information had given, or the information is incorrectly received. Teach back methods should be introduced to the healthcare system. It is a way of providing essential health information to the patient, and the patient's understanding is confirmed when the patient explains it back by their own words to the caregiver. It is also important that caregivers use plain language when dealing with immigrants to reduce language barriers and improve their safety. Healthcare information should be as simple and familiar. The Ask Me 3 program should be introduced to encourage patients and families to ask three specific questions of their care providers to better understand their health conditions and what to keep them healthy. *"What is my main problem? What do I need to do? Why is it important for me to do this?" (*Liechty, 2011, 103-104).

Although this study provides valuable information on adult immigrants in Ostrobothnia, it is vital to remember that the research was carried out on a small group of participants, and the information gathered could not be conclusively taken to be representative of the entire adult immigrants group in Ostrobothnia. To get even more vibrant and more credible results, researchers needed diverse participants, but the researchers were still content with the results they obtained. Healthcare should be easily accessible, affordable, and equal to all immigrants. By doing so, immigrants will find it easier to seek health, and diseases will be eradicated. Health care systems in Finland should also introduce empowerment tools for adult immigrants concerning health and health determinants. This intervention can facilitate the provision of information in immigrants' language; in this case, the English language because the highest population of the immigrants appears to be somewhat familiar with the language.

Immigrants should also be informed concerning their rights and the functioning of the health care system. The healthcare sector should put aside funds for immigrants' service providers to make sure enough services are available to all immigrants. Health caregivers should also receive training on cultural competence and how to provide care by considering cultural differences. This way, the health caregiver and patient relationship will improve, thus improving their well-being. *"All citizens living in Finland, regardless of their ethnic, religious, and racial backgrounds, have the same rights and get the same medical treatment as the local Finns"* (Degni et al., 2012, 348-366). The findings of the thesis found that one participant thought healthcare was costly; this can be explained because the participant did not have a permanent resident. All the participants interviewed said that they had been treated with dignity when they visited the healthcare system.

The government should create innovative ways of evaluating immigrants' knowledge of health. It will find out where health education and training are most needed. Health caregivers should work with immigrant communities and the government to provide health education workshops that provide information about health and recommendations to ensure an individual's well-being is maintained. Health promotion materials and information should be made available to this group of immigrants in the health care system. Perhaps, this will promote immigrants' health and provide information on the prevention of various diseases. The participants also pointed out that there were circumstances when they endured a lack of compassion and empathy from some caregivers; to us, this could also mean they lacked cultural competence. Cultural competence is essential for patient healthcare and patient satisfaction, a policy for quality improvement that focuses on aspects of cultural competence would go a long way in improving patient-centered care, patient satisfaction, and overall quality of care. In the future, healthcare sectors should offer health caregivers frequent programs about cultural diversity and competency to improve the confidence and knowledge of diverse cultures. Health caregivers should be educated on multiculturalism to equip them with knowledge about the basic concepts in transcultural nursing. This education could be introduced in the nursing education curriculum to help future nurses to learn and appreciate cultural differences.

10 Reflection

The researchers are from migrant backgrounds and, therefore, could relate better with the challenges faced by the migrant communities in seeking health care in a country with a different health care setting system from their countries of origin. If we had an opportunity to do this thesis over again, we would probably use a different approach, especially in choosing participants. During that time, we did not have all the knowledge we have now, and in this light, we could have interviewed diverse participants who have been in Finland for a shorter time. However, this is just part of the learning process, understanding how things can be made differently, and taking advice from it so that the knowledge acquired in the process can be utilized in the future. In the end, we were glad about the results, and the supervisor appreciated the final work and saw it as a useful source of information that can be used in the future.

We are glad to have completed this project and met our goal, which was to present a thesis that is easy and enjoyable to read. We are eager, curious, and very anxious to see what the future holds in this unexplored area of study. On the other hand, we are curious to know and see what will happen in the future. Although this study provides information about health literacy among the adult immigrants in Ostrobothnia, future research related to this topic will be essential to improve the health care of immigrants as well as find solutions on how healthcare providers' attitudes on immigrants when offering healthcare can be changed.

The information gathered in this study can be used as a stepping-stone to more research that will be done on this topic in the future. We think this thesis has managed well in its purpose to wake up inner researchers in us and to offer an insight into how to conduct research. One way or the other, at least our understanding of research work has developed, and we have got new competencies that we can use in our future endeavors. The researchers of this thesis would like to extend sincere gratitude to our supervisor Maj-Helen Nyback for guiding us throughout the entire process. She made herself available and was standing ready to help anytime we needed her, and we are very grateful. On behalf of the participants, we would like to extend their appreciation to the health care workers and to the health care they have received in Finland. They also expressed gratitude to the Finnish society and thanked the researchers for taking on this work that has long gone unnoticed.

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List of figures

Appendices

Appendix 1

Information letter and consent form in English

Dear participants,

Elizabeth Yli-Panula and Jovelyn Racasag-Niemi, are two nursing students at the Novia University of Applied Sciences in Vaasa. *We are writing our thesis about Health literacy on adult immigrants in Ostrobothnia. Our thesis aims to describe the obstacles to gaining health literacy and describe the ways that can promote and improve health literacy among adult immigrants in Ostrobothnia.* To answer our questions, we have chosen six adult immigrants to be interviewed, who are now residents in Finland. We will conduct individual interviews in November of 2019. The interviews are audio-recorded and rewritten in text form where all information that can identify the participant be removed; thus, they remain anonymous. Only us researchers will know the identities of the participants. The Audio recording will be saved until we present our thesis work, then they will be destroyed after. The participant will participate voluntarily and can cancel at any time.

We highly value being able to share the participants' experiences in our thesis project.
Best regards,
Elizabeth Yli-Panula and Jovelyn Racasag-Niemi
Email addresses
040-XXXXXXX / 040-XXXXXXX
Informed consent
I have received information about the study, and I will participate voluntarily.

Date: ____

Name: ____

Appendix 2

Interview questions for our study:

Thematic interview

Theme 1: Experiences of service in different care settings (health care, hospital)
1. Tell me about your experiences in healthcare services.
2. Could you tell me the reasons you went to the hospital?
3. What obstacles did you experience while getting health care services?
4. Tell me, what are the challenges you have encountered within the hospital?
Theme 2: Experiences of clarity in information
5. What are your experiences concerning information before, during and after care (signs, forms, information on the internet)?
6. What are your experiences about using your own language, about being understood and understand?
Theme 3: Cultural competence
7. Tell me how your cultural background affects your ability to access and use the health system?
8. How does the caregiver's culture influence your understanding of his/her information and care procedures?