Somali immigrants’ needs and expectations towards health care services in Helsinki metropolitan

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SOMALI IMMIGRANTS’ NEEDS AND EXPECTATIONS TOWARDS HEALTH CARE SERVICES IN HELSINKI METROPOLITAN

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Many western countries are becoming increasing multicultural because of immigration. In Finland the fourth largest ethnic immigrant group comes from Somalia. Little is known about how this ethnic minority group experiences present health care services or their needs and expectations in health care system.

The aim of the study was to describe and to obtain a deeper understanding of Somali immigrants’ needs and expectations of the health care services and the role culture plays in these experiences and how ethnic background affected their receiving of culturally congruent care in the host country. And to describe the cultural adjustments that had been made by this ethnic group and illustrate the impact of cultural adjustments in health care as conditions that promoted the delivery of congruent health care services

Data was collected using semi-structured group interviews, which were divided into two groups, females and males group. The informants consisted of 11 Somali adults and they were 19 to 58 of age. They had been living in Finland in between four to seven years and they were all from Helsinki metropolitan.

The study was analyzed according to “Papadopoulos, Tilki and Taylor Model for developing of Transcultural Competence” mainly the three cultural themes: Cultural awareness, cultural knowledge, and cultural sensitivity. Cultural competence was discussed very little in this study, because the research aim was not to charge the health care providers’ competence rather to grasp information from the informants’ point view whether their cultural backgrounds were taken into consideration during health care delivery.

The result of this study shows that the Finnish health care services are not culturally congruent according to the informants’ expectations and needs. Most of the informants had experienced difficulties accessing the health care services due to language problems and poor understanding of the primary health care system. Mother language, ethnic identity, ethnicity, immigration and cultural skills in the health care providers, were highlighted as the main aspects affecting the Somalians' needs and expectations towards health care services. The majority believed that employing Somalians in health care services would help them a lot and cut on the cultural crashes that are currently being regarded as barriers their congruent care. They believe having Somali speaking health care professionals would not only provide such care themselves, but they would also help others to understand the Somali culture and apply this knowledge when caring for Somalians.

The Finding of this study could be used in strategic planning of services for people from minority groups like the Somalians.

Keywords: Somalians, Immigration, culture, ethnicity and ethnic identity
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1. INTRODUCTION
In Finland, different ethnic (foreign) minorities have increased dramatically in 1990s and 2000’s. Rapid increase of foreign population creates at present growing pressure insight health care systems in Finland. People have natural right to expect health care services which corresponds their own culture. The theory of Cultural Nursing corresponds this need in every day healthcare practices. (Hassinen-Al-Azzani 2000.) Correspondingly the Finnish legislation position on rights of patients, stress of care of mother tongue, individual needs and cultures in the healthcare. (Lohiniva-Keskela 2004.)

In Finland, all citizens regardless of their ethnic background have the same possibilities to get good services in health care area. But the assessment of the patient coming from a different culture is more complicated than that of the mainstream for the healthcare professionals. Misunderstandings are more frequent in communications in health care especially when all cultures have their own beliefs of health and sickness. This means that health care providers need to have good knowledge about culture (habit, religion and so on.) especially beliefs of health and sickness in patient’s culture, after that a professional is able to give congruent care to patients belonging to ethnic minority (Lohiniva-Keskela 2004).

According to Liebkind (1993) there has been only comparatively little research concerning health condition of immigrants in Finland. The focus of the research has been in psychiatric symptomology, eg depression and anxiety (Leininger and Mcfarland 2002). Since there is little research concerning health condition of the immigrants in Finland, the researchers decided to do their research project among Somalis who consist third largest ethnic minority community in Finland. The researchers have decided to do their study on this particular group, because they share same culture, religion and language.

Health care providers may think that the services delivered is cultural congruent while the Somali community themselves do not see that their culture is being taken into consideration. Health care professionals need to know how to deal with Somali clients since they form the third visible ethnic minority who consume health care services. The subject is researchable, relevant, feasible and interesting to the researchers.

It has been found in previous studies that the health condition of the immigrants is poorer than that of the natives (Meleis et all. 1992). In previous studies, the following probable reasons have been pointed: Immigration as stressful life event, cultural background and economical has also social deprevation (Zola 1966, King 1972, Trip-Reiner and Dougherty 1985).
In the Australian study, it was found that the majority of Asylum seekers reported serious difficulties accessing medical and dental services. The data supported the previous findings that asylum seekers are particularly disadvantaged in accessing healthcare services (Silove et al. 1999).

2. THEORETICAL FRAMEWORK

2.1. CULTURE AND COMMUNITIES

2.1.1. Culture and ethnicity

The words ‘culture’ and ‘ethnicity’ are often used interchangeably (Rowland 1991), but in this thesis, culture is seen as the inherited ways of life, including beliefs, value systems and norm systems typical for a certain group (i.e. Keesing 1991; Blakemore & Boneham 1994; Leininger 1991; Friedman 1994).

Ethnicity is seen as a broader concept that includes i.e. culture. The word ‘ethnicity’ comes from the Greek word ‘ethnos’ which means ‘people’, ‘nation’ or ‘tribe’ (Betancourt & Lopez 1999). This is not the case when the word ethnicity is used in American culture, as there is often used as synonym for the word ‘race’ (cf. Gaines et al. 1999).

Here however, the word ‘ethnicity’ is used to show that one belongs to a certain ethnic group and to an idea of who people are as members of a collective group. (Junila & Westin forthcoming; Meleis et al 1992; Breton 1987). Means that ethnicity refers to situations where human collectives live and co-operate. It expresses perceptions both of the nature one’s own group and of other groups (Sintonen 1999). Bulmer (1996:35) defines an ethnic group as:

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

Therefore, ethnicity refers to a sense of belonging and to a group identity Bulmer (1996); see also Junila & Westin forthcoming; Blakemore & Boneham 1994; Meleis et al 1992; Rempusheski (1989). Ethnicity and ethnic group belonging (as well as culture) should also be seen as dynamic and changing, as they are socially constructed (cf. Bruni 1988; Emami 2000; Gerrish 2000; Khan & Pillay 2003).

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

As a collective meaning system, ethnicity becomes meaningful when there are other ethnic groups from which ones group can be contrasted (Sintonen 1999).

Barth (1969) designates an ethnic group as a population which: (1) Is largely biologically self-perpetuating; (2) Shares fundamental cultural values, realized in overt unity in cultural forms; (3) Makes up a field of communication and interaction; and (4) Has a membership which identifies itself, and is identified by others, as a constituting a category distinguishable from other categories of the same order” (Barth 1969: 10-11).

It should also be stressed that group does not need to be a fixed belonging to a group, but can also be an imagined belonging to a group (Juniila & Westin forthcoming). Ethnicity is based on an idea of group membership or “we-feeling” that is part of a gradual and continual definition of self (Rempuseski 1989; Isajiw 1990). It is a subjective group identification process, where people use ethnic signs when they define themselves and when they encounter other people.

Chataway & Berry (1990) defines the acculturation process as a culture change that results from continuous, first hand contact between two cultural groups. The processes often involves certain types of stress symptoms which occur during the process, and which Chataway & Berry (1990) call for ‘acculturative stress’ acculturative stress to stress where the stressors are identified as originating during the process of accultutation referring to the behavioural shifts that occur: a) assimilation, where the group or individual relinquishes their cultural identity and socially disappear into the dominant society and maintains their cultural identity; b) Marginalization, where the individual and the group is alienated from their cultural group and the dominant society (Chataway & berry 1990).

2.1.2. Ethnic identity

According to Isajiw, ethnic identity refers to the “way in which people, taking their ethnic origin to account, place themselves psychologically to one or more social systems and how they regard other people to place them to these systems” Isajiw (1990, 35).

Barth claims that belonging to an ethnic group implies being a certain kind of person and having that basic identity. This belonging also implies a claim to be judged, and to judge oneself, by the standard that is relevant to that identity:
“The identification of another person as a fellow member of an ethnic group implies a sharing of criteria for evaluation and judgment. It thus entails the assumption that the two are fundamentally playing the same game, and this means that there is between them a potential for diversification and expansion of their social relationship to cover eventually all different sectors and domains of activity.

On the other, a dichotomization of others as strangers, as members of another ethnic group, implies recognition of limitation on shared understandings, differences in criteria for judgment of value and performance and a restriction of interaction to sectors of assumed common understanding and mutual interest.” (Barth 1969: 15).

Ethnic group identity is dependent on the maintenance of boundaries to other ethnic groups (Barth 1969). When immigrating to a new country and in interaction with other ethnic group, a person ethnic becomes visible (Junila & Westin forthcoming; Haggstrom et al 1990).

2.2. IMMIGRATION

The collapse of the Iron curtain in Eastern Europe, the fall of communism in the Soviet Union in 1990, the Persian Gulf War in the middle East, and the other oppressive political war conditions in China, especially Sudan, and the Balkan region with killings, and threats to lives have led to many migrations and refugee placements in freedom countries. For 200 years immigrants and refugees have been a major reason for many people migrating to the USA, Canada, Australia, and Europe. Somalians form the second largest refugees population after those of eastern block.

It is argued that migrants and minority ethnic groups have reduced entitlements in the host societies, they are exposed to poor working and living conditions and they also have reduced access to health care for a number of political, administrative and cultural reasons. Policies aimed at reducing such health gaps need to be accompanied a more general effort to promote integration full participation of these groups in the mainstream society. Bollini and Siem (1995).

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

Castles and Miller (1993), describe push and pull factors when explaining migration. Push factors relate to factors that cause people to leave their homes, for example, demographic growth, low standards of living, lack of economic opportunity and political freedoms. Castles and Miller also argue that many researchers suggest that migratory movements generally arise from the existence of prior links between sending and receiving countries based on colonization, political influence, trade investment or cultural ties.

Migration within a country, and even more so, to another country, is often regarded as a turning point in the continuity of life (Philipson 2003), characterized by different losses. The migrants leave behind the social, cultural, and environmental contexts that have given meaning to their lives (Snellman 2003; Torres 1999). The migrating individuals appear to lose, at least temporarily, their social networks, and they encounter difficulties when establishing themselves in a new context. They can also experience a lack of appreciation and recognition from others in their new environment. They have to learn to become oriented in a new, strange environment and they have to organize the practical issues that are important in everyday life. In the long term they have to build up, establish or re-establish social networks that have been cut off due to the migration process.

The immigration also has to deal with situations where they are viewed as foreigners by people in the native population (Julia & Westin forthcoming; Aroian 1990). This means that immigrants are confronted with major changes in life style and environment, they also have many problems to face in the adaptation process and they experience higher rates of emotional distress compared to members of the majority population (Aroian 1990).

It is commonly believed that immigrated leads to an adaptation (Aroian 1990), an accumulation or a transition process (Meleis et al. 2000; Schumacher & Meleis 1994; Meleis et al 1992) leading to diffusion and changes in culture orientation and in ethnic identity. Chick & Meleis (1986), claim that the transition of immigration is an eventful process that occurs many years before the actual event and encompasses periods of id entity diffusion and integration.

Meleis et al (1992) maintains that acculturation should be seen as a former but not a major component of ethnic identity. They also state that ethnic identity acknowledges ethnic pride and the complex nature of the immigrants’ responses to the immigration process.
Ekman (1993), claims that immigration means a break in the continuity of identity. Immigrants find it difficult to identity with the way other people perceive them, because people in their new environment may see them in a different light than they see themselves. Therefore, there is a great risk of identity confusion and reputation. Ekman believes, (by following the Erikson theory of man’s life cycle), that immigrants can reach a greater understanding of life, tolerance, and a deeper feeling of communion in the ‘new’ country. They can also experience a sense of wisdom, but only if they have managed to solve positively most of the problems that are a part of this life crisis.

2.3. SOMALIA BACKGROUND

2.3.1. Somali history and culture in a nutshell

Somalia is situated in the horn of Africa and bordered by Kenya, Ethiopia and Djibouti. It is twice the size of Finland. Due to the civil war, it is difficult to verify the size of the population but numbers are estimated at 7.5 million. The history of Somalia is as colorful as its people. The area currently known as Somalia was first inhabited in the 10th century by Somali nomads and the pastoral Galla from the southwestern Ethiopia. The Somali nomads then spread out through the horn of Africa over the next 900 years (Lewis, 1997). As a result of this exodus, Somalis can be found in nearly every part of Africa, particularly in eastern African countries. Kenya, Ethiopia and Tanzania have a significant amount of fifth generation Somali minorities that are actively involved in all spheres of the society.

Somalia was a colony of both Great Britain and Italy between the 1880s and World War II. In 1941, Great Britain asserted dominance over Italy and occupied Italian Somaliland. They gave the Ogaden region in 1948 to Ethiopia, although it was populated largely by Somalis. In 1949, the United Nations recognized that Somalia should be eventually granted independence. The two former colonies were united to form the Somali republic in 1959 (Lewis 1997; Isaa-Salwe 1996).

Somalis believe that their forefathers originated from Arabia and that they are the descendants of prophet Mohammed, peace be upon him (PBUH). This is why Somalis tend to identify themselves with Arabs rather than Africans (Serkkola 1992). Many Somalis do not see themselves as racial group and find it hard to racially define themselves in these terms because they perceive themselves as Somalis first and foremost (Abdi 2001).

Islam is a very important part of the identity of Somali people and gives purpose to their lives. Approximately 99.7% of the Somali population is Muslim. Islam is visibly present in their daily lives and gives guidance on how to live a very fulfilling and morally good life (Abdi, Kosow 2001).
The official language of Somalia is Somali. However, Somalis also speak English in Somaliland, Italian in southern Somalia, Swahili in certain parts and Arabic all over. Somalis are articulate speakers and are renowned as poets. They like to express themselves in a colorful way and appropriate oral skills. The Somali language was codified as a written language for the first time in 1970 and is therefore relatively young (Abdi, Kosow (2001).

Somalia had a civilian government until 1969, when president Said Barre came to power in a military coup. In 1976 Barres Somali revolutionary socialist party was founded as the only legal political party. The government decided to take back the areas that belonged to Somalia before the arrival of the colonists. These areas, which included Djibouti, the Ogaden and northwestern Kenya, were inhabited primarily by Somalis and had long been considered lost Somali territories; as a consequence, Somalia invaded the Ogaden in 1977, but Ethiopia regained control of the area through the assistance of Cuba and the Soviet Union.

This led to the expulsion of the soviet forces from Somalia the same year for their support of Ethiopia. Deep seated animosity has led to sporadic conflict between Somalia and Ethiopia which still continues to this day (Alitolppa-Niitamo 2004).

In 1988, Said Barre brutally suppressed the armed domestic opposition led by the Isaaq-based Somali national movement (SNM) in the north other clan-backed groups, such as the Hawiye united Somali congress (USC) and the Ogadeni Somali patriotic movement (SPM), joined the expanding anti-government struggle. Subsequently, Siad Barre fled in 1991 to Nigeria, where he died in exile. Later that year, the SNM declared northern Somalia to be the independent republic of Somaliland, an act that was not recognized by any foreign nation. Northern Somalia has since government itself independently, completing a transition to multi-party democracy through the indirect election of a new president in may of 1993.

Fighting soon erupted in other parts of Somalia between USC rebel groups and their warlords in the 1990s. The situation in Mogadishu continued to be volatile and was even aggravated by the presence of foreign troupes in UN peacekeeping efforts, which eventually resulted in the death of 18 US soldiers at the hands of clan militias royal to Aidid in 1993. This event accelerated the withdraw of the US and UN forces from Somalia. After suffering many casualties, the UN withdrew from Somalia in 1995. This led to the start of the Somali population movement and it is now estimated the over one million Somalis live in the Diaspora outside of Somalia (Alitolppa-Niitamo 2004).

Somali has now the United Nations and regional organizations recognized transitional federal government which has very little power inside the country. All important places like airport, seaport and president’s palace in the capital Mogadishu guarded by troops from African Union
(AMISOM). The government is trying to install its power and expending the administration throughout the country. Even though there is an internationally recognized government civil war continues to ravage innocent lives. There is no public infrastructure that can provide basic services and a functioning health care system. The most hospitals in Somalia are run by voluntary doctors from the Diaspora with the help of international organizations.

2.3.2. Somali communities in Finland

Diaspora can be defined as the scattering of people who share a homeland to different locations throughout the globe. Often a collective tragedy or violent event forces people into exile in another country, which thus creates a diaspora. Diasporic communities share a common cultural orientation to an ancestral homeland which often redefines the homeland as a true and ideal home, retained in a collective memory, vision, or myth (Safran 1991).

The majority of Somalis did not make Finland their primary destination when they fled the violence of the civil war in the 1990s (Alitolppa-Niitamo 2000), but rather viewed it as a transit route to other destinations such as Sweden, the UK, Canada and the United States of America. Somalis in Finland can be characterized as living in diaspora because they share a collective vision of returning to the motherland once peace is attained. They actively seek information about their homeland by calling their families, listening to the Somali BBC and watching Somali programs via satellites dishes, traveling and contributing to the re-building of the infrastructure (Alitolppa-Niitamo, 2000). Moreover, many people in Somali communities consciously maintain their cultural identity despite living in Finland for a long period.

In Finland live about 4621 Somalis and two third of these people domicile in Helsinki area. The language problems are a big barrier to the utilization of healthcare services in Finland. The immigrants in Finland have difficulties to utilize the preventive care eg. On maternal child care clinics, because of Language problems, Cultural obstacles, and Educational background.

The young mothers often live isolated from their original families and can not get knowledge of their own mothers or other older women in the family (Find the information in the Ministry Education’s homepage). Language problem bars them from seeking advice. On the other, the Finnish nurses do not know exactly the cultural features of immigrants. Many times the acceptance of the health education and preventive care requires grounding knowledge which the Finnish people already have from the Primary School. Health care professionals have difficulties to give health education and counseling individually as it is needed by the immigrants.
2.3.3. Somali families
Somalis customarily have extended families which usually consist of aunts, uncles, cousins and grandparents. Before the war, Somali families were unified and tightly knit. The roles of the family members were clear and certain. Usually the head of the family was the father, while the mother was in charge of the running of the family and maintained the family unity. Each family member knew her own place in the unit and roles never overlapped. This led to a fairly peaceful life.

The situation the Somali families in the diaspora dramatically changed and led to the disintegration of these families in many cases. The collapse of the Somali family started during the civil war because it was the men of the family who had to flee the war. Those who were financially well off decided to seek asylum abroad and left their families behind. It was easier for the men to leave because of the difficulties that awaited them. Many felt that women would not able to withstand the dangers of traveling to a relatively unknown country by themselves (Alitolppa-Niitamo 2000). After their arrival in Finland, their families quickly followed them through family reunification schemes.

In exile, many Somalis have faced an alien hostile environment that totally different their own in every way: religiously, culturally and ethnically. The children have started learning the language of the new host society faster than their parents and began adapting to their new environment. Fathers, who were breadwinners in Somalia, had no such role in Finland. These men soon noticed that their role in the family had greatly diminished and, as a result, the other family members had no respect for them.

The authority in the Somali family gradually transferred from the hands of the fathers to that of their children or, in some instances to their wives. Some children became responsible for running the household as well as going to school. This huge responsibility meant that the children had no time to enjoy their youth and, coupled with the dissatisfaction of their family, often led them to abandon their families (Alitolppa-Niitamo 2000).

Many Somali women found new freedom in Finland which meant that they could start to study and eventually obtain a profession. This eased their transition from their homeland to the new host society. These women found themselves taking control of their lives and adapting faster to Finnish society than their men. Many people have felt that Finnish society was more welcoming towards the women and children than men, which led to the integration of individual members of the family rather than the family unity as an entity. Consequently, divorces in Somali families increased and has become common phenomenon nowadays.
It is obvious that no one has lost as much in the integration process as the Somali men. They are left isolated in their efforts to regain their manhood and identity as Somali men in Finnish society. More efforts need to be targeted at improving the status of the Somali family as a unit which could therefore better support it. This would benefit all members of the Somali communities. (Alitolppa-Niitoma 2000).

2.3.4. Unemployment among Somalis

Somalians share the problems of many other marginalized groups in Finnish society, such as high levels of unemployment, poor jobs and racism (Carey-Wood et al. 1995; Bloch 2000; Woodhead 2000). Unemployment is very high in Finnish Somali communities, although the number of Somalis studying in institutes of higher education is the third highest of all migrant groups in Finland (Pohjanpää et al. 2003, 86). Somalis face many barriers to gaining access to the Finnish labor market. According to recent research, institutional racism is reported as a major reason for unemployment by Somalis (Nur 2004).

Institutional racism can be defined as a passive form of racism which reflects the collective failure of society to prevent racial discrimination by allowing normative structures to maintain advantages for dominant groups.

The prevalence of discrimination in both active and passive forms means that Somalis face greater barriers to the job market through an unwelcoming environment and discrimination hiring practices. These practices can be seen at many levels from narrow views of job qualifications to the lack of personal networks in high positions to the impact of personal attitudes of prejudice in hiring and in the workplace. Somalis often find themselves faced with a hostile society that has excluded them from functioning as productive members of the society (Nur 2004).

Because Somalis find obstacles to gaining a descent job commensurate with their education and qualification, a new exodus to greener pastures in other western countries, local knowledge in Somali communities point to a stream of Somalis leaving Finland in search of better job opportunities. The UK has particularly become a new haven and other Scandinavian countries (Diesow 2004).
2.4. CULTURALLY CONGRUENT CARE SERVICES FOR THE MINORITIES

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

Caring and nursing should meet the needs of all members of society (i.e SFS 1982; Cortiz & Kendrick 2003). This means that health care professionals should demonstrate an awareness of care so that it also relates to clients from ethnic minorities. Cortiz & Kendrick (2003) claim, that the cultural dimension of nursing care is frequently ignored or marginalized. Many members of ethnic minorities feel alienated and isolated in health care (Askham et al. 1995; Cortis & Kendrick 2003). However, there is an increasing body of knowledge concerning the impact of culture and ethnicity in health care, which is usually based on the notion that illness and health beliefs and practices are culturally bound.

This means that in order to provide effective care for patients from different ethnic groups, these beliefs and practices should be taken into account and respected (i.e. Kleinman 1988; Helman 1994; Leininger 1991; Giger & Davidhizar 1991; Meleis et al. 1992; Lipson 1992; Meleis et al. 1998; Andrews 1999).

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

So far, there has been no consensus on the definitions to be used in the research area of cross-cultural and trans-cultural health care especially in nursing (see discussion: Lipson 1999; Brink 1999; Boyle 1999; Leininger 1999; Meleis 1999). Neither has a consensus been reached as to what is meant by cultural competence (Canales & Bowers 2001). Even the outcome of care where cultural or ethnic aspects are taken into account involves a seemingly interchangeable variety of terms. The care is regarded as culturally ‘adjusted’, ‘appropriate’, ‘aware’, ‘congruent’, ‘competent’, and ‘comprehensive’, ‘relevant’ or ‘sensitive.’ Wenger claims that none of the above terms adequately conveys the idea of commitment on the part of the persons who are “engaged in the lifelong journey that is directed toward learning about cultural diversities while seeking common grounds cultural universities” (Wenger 1999: 10).
The orientation in trans-and-cross-cultural models and theories is often focused on explaining to the health care providers from the majority population how the health care issues are structured and understood in ethnic minority populations. Leininger's theory is one example of models such as these (Leininger 1991). She claims that culturally congruent or beneficial nursing care can only occur when the individuals’, the groups’, the families, the communities’, or the care cultures’ values, expressions, or patterns are known and used appropriately by the nurse. This is done with the help of professional assessments when decisions are made about what kind of help the patients should be given, and how they should be helped.

Leininger’s model consists of: (1) culture preservation and maintenance, which helps people of a particular culture to retain or preserve relevant care values, (2) cultural care accommodation or negotiation that helps people to adapt to or to negotiate with professional care providers for beneficial or satisfying health outcomes, and (3) cultural care re-patterning or restructuring that helps the clients to reorder, change or modify their lifestyles for new beneficial health care patterns.

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

Although there are advantages in considering cultural aspects, critical voices have also been raised regarding the use of the concept of culture in health care and caring sciences. ‘culturalist’ models and the utilization of individualistic health frameworks that “crystallize” culture into a static entity have been criticized (Racine 2003). Ahmad (1996) for example, raised the problems of using the concept of culture in research about health, illness and health care of minority groups as culture is often seen in these studies as a basic and static aspect determining the behavior of individuals.

Sheldon & Parker (1992), Gerrish (2000) claim that in nursing studies where culture and ethnicity are taken into account, culture is often referred to as an explanation for differences. In cases where the outcomes were negative, it was the clients culture or the patient that was blamed. Furthermore, (pan ethnic) whites are frequently viewed as the norm against which the differences between everyone else are measured and compared (Andrews 1999; Gerrish 1999; 2000).
2.5. TRANSCULTURAL COMPETENCE

2.5.1. Papadopoulos, Tilki and Taylor Model for developing of Transcultural Competence

As can be seen above the model consists of four stages.

The first in the model is cultural Awareness which begins with an examination of our personal value base and beliefs. The nature of construction of cultural identity as well as its influence on people’s health beliefs and practices is viewed as necessary planks of a learning platform (Papadopoulos, Tilki and Taylor 1998).

Cultural knowledge the second stage can be gained in a number of ways.

Meaningful contact with people from different ethnic groups can enhance knowledge around their health beliefs and behaviours as well as raise understanding around the problems they face. Through sociological study we should learn about power, such as professional power and control, or make links between personal position and structural inequalities. Anthropological knowledge will help us understand the traditions and self care practices of different cultural groups thus enabling us to consider similarities and differences (Papadopoulos, Tilki and Taylor 1998).
An important element in achieving cultural sensitivity the third stage is how professionals view people in their care. Dalrymple and Burke (1995), have stated that unless clients are considered as true partners, culturally sensitive care is not being achieved, to do otherwise only means that professionals are using their power in an oppressive way. An equal partnership involves trust, acceptance and respect as well as facilitation and negotiation (Papadopoulos, Tilki and Taylor 1998).

The achievement of the fourth stage cultural competence requires the synthesis and application of previously gained awareness, knowledge and sensitivity. Further focus is given to practical skills such as assessment of needs, clinical diagnosis and other caring skills. A most important component of this stage of development is the ability to recognize and challenge racism and other forms of discrimination and oppressive practice. It is argued that this model combines both the multi-culturalist and the anti racist perspectives and facilitates the development of a broader understanding around inequalities, human and citizenship rights, whilst promoting the development of skills needed to bring about change at the patient _client level(Papadopoulos, Tilki and Taylor 1998).

The researchers’ use of Papadopoulos’s transcultural model did not mean to charge the health providers’ competence. The researchers’ aim was to grasp information from the clients’ point view whether their cultural backgrounds were taken into consideration during health care delivery. The interview concentrated on the three concepts of cultural awareness; cultural knowledge and cultural sensitivity.
2.5.2. Language and its influence on the health care services

Language and cultural diversity are two of the differences between Somali and the mainstream dialects. It is often assumed that all Somalis speak the same language and thus understand each other, but this is not the case. Different dialects, such as Rahawen and Bantu, are hard to comprehend by those who do not know them and can therefore cause confusion. The role language and culture diversity has a major impact on how health care is delivered because communication is an essential element of the health care encounter. According to Gudykunst (1991), inter-cultural communication can be defined as direct face-to-face interaction between people of diverse cultural backgrounds. This communication is also influenced by gender, social class, ethnicity and the language spoken (Cortis et al. 2000). Language provides the tools (words) that allow people to express their thoughts and feelings.

Thus language barrier present a grave threat to Transcultural communication between health care professionals and clients. There are several types of language barriers that impede communication in Finland. These include; a) Foreign language b) Different dialects and regionalisms and idioms (Luckman 2000)

The relationship between culture and language has been researched countless times by anthropologist (e.g. Leininger 1970; Spradley 1979). According to Leininger, culture determines how language is used, and how it changes and develops (Leininger 1970). Language and culture thus come together in the act of expressing oneself. Hence the significance of inter-culture communication should be recognized as a basic competency skill in the caring professions.

The definition of health used by the World Health Organization (WHO, 1946) is “…a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity” (WHO 1946) in this definition, health is viewed as an absence of disease and therefore tends to be one-dimensional. In many non-western countries, health is viewed as a balance relationship among people, between people and nature, as well as between people and the supernatural world (Helman 2000). Emotional or physical symptoms are viewed as reflecting imbalances in these relationships. This holistic notion of health underlines this study.
2.5.3. Finnish health care services

The Finnish National Health Services is based on the Act on specialized Medical and Primary health care Act laws. These laws require that municipalities organize health care based on the needs of their residents.

Health care is divided into primary health care and specialist medical care. Primary health care is handled by local health districts. Their function is to provide guidance in health matters, including public health education and family planning, and to organize medical examinations as well as screening for local people. They also run maternity and child health clinics, and arrange for school, student and occupational health services, in addiction to dental treatment.

The aim of primary health care is to ensure that all non-urgent cases are able to see a doctor and have the need for treatment assessed within three working days, whereas the aim of specialized treatment is that examination and assessment is made within 1-2 weeks of a referral being received by a hospital. (www.stm.fi).

On the whole, Finnish health system can be said to work quite well and to be effective. According to both Finnish and international assessments, the standard and distribution of health care in Finland is on a high level (WHO 2000). However, these measures tend to be based on solely western criteria which often exclude more holistic ways of viewing health. By comparison, in Somalia, the health care system consists of both Italian (western) curative medicine and traditional healing practices (Serkkola 1992; Hassinen-Azani 2002). Health has tended to be viewed more historically in Somali culture. The traditional healing practices are most commonly used and include religion practices (reading from the Quran), traditional healing (chasing out spirits) and traditional treatment (skin lacerations). Hence there are many fundamental cultural differences in how the role of health care services is perceived by Somalis and how it is provided in Finland.

Finland’s health care system is divided in three main health care services which receive public funding; these are municipal health care, private health care and occupational health care. The employed persons have the possibility to choose between these three. In practice the only choice for low-income people is the municipal health care system. The differences between these systems are, for example in the scope of services, user-fees and waiting times (European Observatory on health systems).

The financing mechanism for health care services in Finland is based on municipal taxes and National Health Insurance (NHI) funds. Municipalities fund municipal health care services (except outpatient drugs and transport costs) and NHI funds, for example, private health care,
occupational health care, outpatient drugs, transport costs and sickness allowance (Vuorenkoski 2008).

According to Vuorenkoski (2008) the largest share of health care services is provided by the municipal health care system (71% of outpatient physician visits, 59% of outpatient dentist visits and 95% of inpatient care periods). In 2008 there were 415 municipalities in Finland, with a median number of inhabitants of 5000.

The municipal health care services are financed by municipal taxes, state subsidies and user-fees “All municipalities are, by law (Primary Health Care Act), obliged to maintain health centres for the provision of primary health care services, either on their own or jointly through a local federation of municipalities”. Vuorenkoski (2008) says that there were 237 health centres in Finland in 2007 (excluding Åland Islands).

Vuorenkoski (2008) states that all health centres have general practitioner (GP)-run inpatient units or an arrangement for using such beds in a nearby health centre. Health care centre can establish one or two municipalities. Municipalities with their own health centres usually use prospective budgets but federation-owned health centres the budgets are built in a similar way but the sharing of costs between member municipalities is usually determined by the volume of services given.

Even-though the payment system of physicians in health care services varies usually GPs are salaried employees of the municipalities. Specialist level care in the municipal health care system is provided by 20 hospital districts. “Each municipality must belong as a member to one of the hospital districts (Act on Specialized Medical Care)”. Each hospital district has one or several hospitals, of which one is a central hospital. The hospital district organizes and provides specialist medical services for the population of their member municipalities. Hospital districts are managed and funded by the member municipalities. Hospital districts have varied methods for collecting funding. The majority of funding collected is based on actual clinical services used (Vuorenkoski 2008).

Municipalities are allowed to purchase health care services both primary health care services and specialized health care services from other municipalities, other hospital districts, private providers or from the third sector (European Observatory on health systems).

“The Åland Islands are an autonomous Swedish-speaking region with 16 municipalities and 26 000 inhabitants The Åland Government is responsible for providing health care services in the region. Services which are not provided in the region are purchased from Finland or Sweden”.
Seventeen per cent of the total cost of health care in Finland is financed by the statutory NHI scheme. The scheme is run by the Social Insurance Institution (SII, Finnish acronym KELA), with about 260 local offices throughout the country.

SII falls under the authority of Parliament. The main funding to NHI comes from the state budget (28% in 2006), the insured (33%) and employees (38%). NHI covers part of outpatient drug costs, part of medical costs in the private sector, part of the costs of occupational health care, compensation of travel costs to health care units, sickness allowance and maternity leave allowance “Of services funded by public sources (municipalities and NHI), about 16% of outpatient visits to physicians, 41% of outpatient visits to dentists and 5% of inpatient care periods are provided by the private sector” (European Observatory on health systems)

According to Vuorenkoski (2008) the employers are obliged to provide preventive occupational health care for their employees (under the Occupational Health Care Act). As part of occupational health care, many large- or medium-sized employers also provide curative outpatient services.

The pharmacies are mainly privately owned by pharmacists. There were 804 pharmacies in Finland in 2006. They are regulated in several ways: their margins and prices are fixed by the Government, they cannot be owned by companies, and the National Agency of Medicines (NAM) decides in which locations pharmacies are placed and who runs them. Outpatient drugs are partly reimbursed by NHI. These reimbursements are paid mainly directly to pharmacies (Vuorenkoski 2008).

The Ministry of Social Affairs and Health directs and guides social and health services at the national level. It defines general social and health policy, prepares major reforms and proposals for legislation, monitors their implementation and assists the Government in decision-making.

According information available on the page the National Public Health Institute (KTL, Linnanmäki & Koivisto 2008). The new National Action Plan was issued for the years 2008–2011 outlines proposals for strategic policy definitions and the most important measures to reduce socioeconomic health inequalities in Finland. Despite the separate action plans and efforts taken by Finnish health and social policy makers to reduce health inequalities the objectives have not been achieved, however the inequalities have partly even grown but to compare to the most EU countries the gaps health inequalities is may be better. Narrowing health gaps has been the objective of Finnish health policy since the 1980s (KTL 2008).
“The National Action Plan to Reduce Health Inequalities is closely linked with the Government’s Health Promotion Policy Programme”. “The Action Plan will also for its part implement the aim of the national “Health 2015” programme to reduce mortality differences by a fifth by 2015” (KTL 2008). Improving and reducing health inequalities entire population groups often take a long period of time to see in practice and this should be multisectoral work.

The reduction of health inequality Action plan operates mainly these areas:
- The social policy measures which is improving income security and education, and decreasing unemployment and poor housing.
- The strengthening the prerequisites for healthy lifestyles, that measures to promote healthy behaviour of the whole population with special attention to disadvantaged groups where unhealthy behaviour is common.
- The development as a follow-up system for health inequalities is The Ministry of Social Affairs and Health is responsible for the implementation and its monitoring and assessment of the National Action Plan to Reduce Health Inequalities. (KTL 2008).

3. THE RESEARCH PURPOSE AND RESEARCH QUESTIONS
The purpose of this research was to describe the Somali immigrants' needs and expectation towards health care services.

- What are the needs and expectations of Somali immigrants in health care services?
- How culturally congruent care is seen among Somali community in relation to the health care services?

The aim of the study was to describe the Somali immigrants' needs and expectations towards the health-care services. The study reviews immigrants’ access to health care services, particularly Somali immigrants’ experiences the issues in cultural context. The aim was to enlighten their needs and expectations they have on the health care services.

The objectives in this study was not to review or measure the competences of the health-care professionals, but on the basis of the experiences from the Somali informants, the health care services can be developed in way that the services could be culturally congruent to Somali immigrants.
The data produced in this study can be used to develop health care services and can be applied to the other ethnic minorities. The result of this study can be the basis of further researches on immigrants’ health care improvements in long-term developments.

The researchers’ aim was to find out what knowledge and elicit from Somali immigrants’ point view on health care services in relation to their needs and expectations. Second question of how knowledge information was sought by researchers on how culturally congruent care is familiar among Somali immigrants, and how they perceive the current health care services, if their cultural background is being taken into consideration by the health care providers.

4. METHODOLOGY
A qualitative method has been used in this study because it gives space for the more subjective feelings of the respondents to emerge. Qualitative research is useful where little is known about the area of study and the particular problem setting or situation, because the research can reveal processes that go beyond surface appearances. It also provides fresh and new perspectives on known areas (Holloway and Wheeler 1998).

Qualitative research methods can be very effective when little is known about a topic or when the investigator suspects that the present knowledge may be biased, (Field and Morse 1994). The researchers’ interest in this study was to bring out the voices of Somalis, in which the participants think that are rarely heard in Finnish health care services.

The reason why the researchers used qualitative approach was that they wanted to develop understanding between Somali ethnic community and health care professionals through the experiences of informants in health care services.

As Leininger (1985) states individuals are more than body systems or diagnostic cases, therefore research must focus on the whole person rather than merely on a physical part.

According to Talbot (1995. 421), qualitative approach attempts to preserve the wholeness of individuals’ subjective experiences instead of reducing it to distinct variables. Such a holistic approach focuses on capturing the subjective experiences of individuals. Talbot (1995), also says qualitative data allow nurses to explore such phenomena as empathy, caring, suffering, restlessness and hope which are not easily segmented and measured, these data are words or text placed into the text of the particular research problem and gathering instrument comes from the researchers themselves, rather than a questionnaire, therefore it is human experience in which researchers instead of computer collects and analysis the data.
Face-to-face semi-structured group interviews were conducted in Espoo in two different locations: Matinkylä, (Alma Multicultural activity centre) and Espoonlahti, (Kivenkolo neighbourhood activity centre). The third group in Helsinki, Itäkeskus (Somali Activity Centre).

The themes of interviews were derived from Papadopoulos, Tilki and Taylor Model for developing Transcultural Competence. Each interview lasted approximately 90 minutes to 2 hours. Audiotape was used during the interviews.

4.1. Informants

The researchers have chosen informants carefully to make sure that they are suitable and representative of the target group (Holloway and Wheeler 1998), according to them Leininger (1985) claims that a large number of general participant without specific knowledge of a topic does not necessarily useful (Holloway and Wheeler 1998).

In this study, the informants were Somalis, who were randomly selected through contacts to their community centers and community leaders. The informants voluntarily provided information to the researchers through group semi-structured interviews about their experiences and perceptions on Finnish health care services. They were very much willing to express their concerns through our study with fact that they did not need to use a foreign language, as they interviewer was insider who shared the same mother language. The groups interview was in form of conversation and the researchers had positioned themselves as conversation mates, but were very much aware of their role in the interview. It was easy to being an insider and at the same time keep to a researcher’s role.

The informants helped to transform the researchers’ limited understanding of the culture into something with meaning for the non-insider researchers own culture.

The informants were selected to participate in this study because they:

- Lived in Finland ranging from 4 to 7 years.
- Have been hospitalized or had visited a health care centre.
- Were Somalians and immigrated in Finland as a refugee.
- Were permanent resident in Finland
- Had not lived in a third country than Somalia and Finland
- Their age ranged in between 18-65 years.
- The informants were residents of Helsinki metropolitan.
In advance, the researchers and the informants agreed when, where and how the interviews will be held. The informants were given brief information about the research project in the informed consent form. The interviews were conducted in groups of men and women. The men informants consisted of 2 groups, English speaking group and Somali speaking group, while women group were only one Somali speaking group with interpreter, who was also member of informants. The interpreter’s personal comments were useful because she was not excluded from the group. Most the women informants were able to understand English but had difficulties to respond in English.

The age of the male groups were from 35 to 58 of age and their education was from primary school to higher education. The women group consisted of 4 but the original plan was to interview five female informants, unfortunately one fell ill on the day of the interview and could not make it. Three of them were 43 to 53 of age and young lady who was 19 years. The young informant also played in the group as interpreter but made comment for her own.

The education of female informants were either nothing or few years of primary education and all of them were housewives, except the young lady who graduated from junior high school in Finland and studying in vocational school. No name, social security number or address was recorded neither written form nor recorded in audiotape or even asked.

4.2. Data Collection
As Silverman (2004) claims the interview should be conducted in a private place, because it allows the informants to speak openly by not affecting the presence of others.

When using semi-structured interview, questions are not the same for everybody or informant, as it depends on the process of the interview and answer of each individual. However the researcher guides and makes sure that all informants will be collected similar types of data (Holloway and Wheeler 1998).

In group interview discussions in the group may not only develop ideas, problems and questions which researchers have not thought about before, but also find answers to some of these questions. The ultimate goal for the researchers is to understand the reality of the informants (Holloway and Wheeler 1998).

Group interview had been used by business and market researchers since 1920s and today is used by a wide variety of researchers in different disciplines including communication, policy, marketing and advertising. This kind of method of data collection became popular in caring
professions in 1990s (Holloway and Wheeler 1998). The differences between group and individual interviews are the group explores and stimulates ideas based on shared perceptions of the world (Holloway and Wheeler 1998).

The informants received information in Somali language about the research almost two weeks before the interview. The informants came to the interview place with a full knowledge of what was going to happen. Before the interview started the interview consent form was given to each and every person both in Somali and English language and better explained to the informants incase somebody was not able to understand correctly. The researchers’ aim was to make sure that the informants understood clearly what the study was all about and what the researchers were looking for.

Data was collected by using qualitative method through semi-structured group interviews with the help of a theme guide that covered a holistic perspective. The focus of the theme guide however, was to concentrate on the informants’ experiences, needs and expectations in the health care and their wishes about the future health care for their ethnic group. Data collection continued until the research questions were answered to the researchers’ satisfaction.

The interviews focused on the theme guide of culturally congruent care and the Somali experiences with the health care services and their wishes in Finnish health care services.

The data collection themes were derived from Papadopoulos, Tilki and Taylor Model for developing of Transcultural Competence, mainly the three concepts of cultural awareness, cultural knowledge and cultural sensitivity as mentioned in the methodology.

The themes consisted of two sections. The written demographic part which has nothing to do with the above transcultural model and this consisted of such personal information like age, sex, education and the length of stay in Finland. The other section was the interview part, which used audiotape to collect data.

The different themes were introduced by asking a general question, like “please, tell me about your experiences, needs and expectations in the health care services”. Additional questions were asked in order to confirm that the researchers had understood correctly or to get deeper understanding of the informants meaning.

All in all, groups of interview were 3. Two groups were male informants and another group was female informants. The reason why male informants were extended was that, the group
was not active and information gained was not enough. The women group was active and really spoke enough and there was no need to arrange another group.

The interview places were quiet and with relaxed atmosphere where the informants felt comfortable, secured and ease to express themselves. The informants were encouraged to express themselves freely in conversation circle, and strategies like posing one research question which covered an extensive area, that gave them the option of choosing which particular aspects they wished to emphasize and probing with further questions and alternative listening were used through out interview. The place was reserved only for our interview to avoid the effects and disturbances of the presence of others.

The audio-taped responses were verified for accuracy by a Somali colleague and translated into English. This was done by listening to the somalian language interview tapes, and matching them with English quotations. Also specific audible expressions such as laughter, stressing a point and ironical or joking tones were noted, in order to provide added understanding of the text material.

What was rich in group interviewing was that when asked single question it produced totally different answer among the group and that interaction between the informants, the researchers discovered how individuals think and feel about particular issues.

However, the shared understanding of the specific underlying assumptions and knowledge of “ethnic migrants and insider”, made it easier for the informants to be frank with the researchers about their ethnically based thoughts which can be sometimes a risk factor, because it was assumed that the researchers knew and understood the culturally based beliefs and ideas. The researchers were not expected to ask explanations for them, there were some taken for granted aspects.

4.3. Data Analysis

Data analysis is a complex thing, time-consuming and interactive activity. Researchers must remember this in order to allocate and segment their time appropriately. Its iterative character also makes it more time consuming. This means the qualitative researchers must do data collection and data analysis simultaneously in order not to exceed the time table (Holloway and Wheeler 2002).

Holloway and Wheeler (2002) say “The process of data analysis goes through certain stages common to most approaches: Transcribing interviews and sorting field notes, organizing and ordering data, listening to and reading the material collected over and over again. Coding and categorizing, building themes and so on.
The data was analyzed by using content analysis method. Analyzing of the data collected from interviews. As Silverman (2004) states that using of content analysis in quantitative and qualitative differs in a way that the result of quantitative content analysis are presented as frequency counts, while the result of qualitative content analysis are presented as illustrative quotations.

The tape recorded interviews were carefully listened to for any indications that might have influenced the answers to the questions etc. i.e. tone of our voice, the manner the questions were posed etc as aspects that would review the biases as such. The researchers found no such indications.

The interview with the female informants was conducted with the helper of a interpreter and was tape recorded. This was also carefully listened and checked by a Somali researcher colleague, who was male and could not participated the interview because of his gender. The Somali male colleague transcribed the collected data and translated them into English. From each interview the transcripts were recorded and analyzed deductively using content analysis. Data from the three interviews were compared and categorized according to the themes, which were then broken small sub-themes as new data emerge, they were named as concepts that describe theme content.

The researchers used Papadopoulos model of transcultural competence. Before analyzing anything all recorded data was changed into written form and divided into the four main themes of Papadopoulos model of transcultural competence (Cultural awareness, cultural knowledge, cultural sensitivity and cultural competence) and each one of these themes had small subthemes under which the data collected was arranged in theme category. First three main themes have been deeply discussed.

The data for this study was collected in the spring. The English texts were carefully documented and recorded information was transcribed in sequential order on paper and on computer. The researchers then moved on to rearrange the transcribed information and matched them with the research questions, with the appropriate responses from the informants. All the information that came up in this study was analyzed, but the researchers selected only the information that matched their research questions and combined it with other source information from the literature.

The researchers followed the Papadopoulos, Tilki and Taylor Model for developing of Transcultural Competence steps to arrange the data and analyze and later the findings.
5. FINDINGS
Culturally congruent care is very important and its importance cannot be over-emphasized. Mother language, ethnicity, ethnic identity, immigration and cultural skills of the health care providers were highlighted as the main aspects affecting the Somali communities’ needs and expectations towards health care services in the Helsinki metropolitan. This study reports the findings from group interviews on their experiences, needs and expectations of the health care services from the 11 informants. The study has been organized into 3 main cultural themes:

1. Cultural awareness
2. Cultural knowledge
3. Cultural sensitivity

The concept of cultural competence has been shortly discussed, because the aim of this research was not to measure the qualifications of health care providers, rather to raise how among Somali community see culturally congruent care.

5.1. Cultural awareness
5.1.1. Self-awareness (and of others)
It is individual’s way of thinking of being individual and separate from others and understands also others are self-aware. In this case self-awareness applies to the Somali clients how they are aware of their rights and as well obligations and how the health care professionals are able sensitively to understand their clients’ needs.

The informants felt the cultural values were not taken into consideration by the health care providers. They felt that their wishes were not respected as compared to those of the mainstream. They believed that the health care providers were culturally biased. They did not respect other cultures from their own and generalized other cultures. Some informants described their experiences which were culturally sensitive. One informant revealed this gender issue as follows:

"Most of the clients in the health care centers are women and children, yet many times nurses at the reception refuse to give time to the female doctor, while she wants to talk about women problems. Nurse tells to clients “you are assigned to that doctor (male doctor) and you have to use it” it is not easy for many Somali women to accept to see a male doctor. I hope health care providers especially nurses in the front desk will realize this problem and allow Somali women clients to see female doctors and of course male for male doctor if the problem concerns the intimate part of their body”. He continued saying “Sometimes the doctor and client are females, but a man comes as an interpreter."
It may be possible that the female client tells different story to the doctor to avoid the embarrassment to a strange opposite sex” (male F)

More than half of the informants emphasized that how the shared language plays the biggest role in self-awareness and relationship between the provider and client.

“To be confident and have direct contact with the health care providers depends on first your knowledge of the spoken language and opens the doors to knowing how the health care service works. Once you know how the system works you can demand your rights as well you can be aware of your responsibilities” (male F)

Delivery of culturally congruent care to the Somali clients requires a deep knowledge and direct experience with Somali culture. To understand Somali culture the health care provider needs to have basic understanding about the Islamic religion and how it affects the client’s daily life.

The word Muslim is the practitioner of the faith of Islam. Muslims are divided into two major groups, Sunni and Shi'a. Sunnis are the majority of Muslims, while Shi'a constitute small minority of Muslims. Somalians are Sunni Muslims and share many things with other Sunni Muslims regardless the country of origin. For example Somali from Africa, Pakistani from Asia or Kuwaiti from Arabian Peninsula share common beliefs of God and how to worship, about the Qur'an, the Prophets, Angels the day here after.

To achieve culturally congruent care health care providers need to be aware of the worldview of Muslim client as the culture influence on the daily life of the people.

There are five pillars that Muslims follow as ritual and moral obligations:

There is no God but God and Mohamed (peace be upon him) is the messenger of God as other uncorrupted original monotheistic Adam, Noah, Abraham, Moses, Jesus and other prophets To associate other gods with God (Allah in Arabic) is a capital crime.

To pray 5 times a day. Praying activities are required each and every individual Muslim who is mentally fit. Muslims belief praying is essential to the maintaince of health and well-being, therefore it is recommended if the prayer is desired the health care provider may provide assistance to find a quiet place to perform religious duties. If that is not possible because of the available space the health care provider may find another alternative if asked.

Muslims should perform ritual cleaning before praying including washing the face, washing hands to the elbows, to clean your head and ears with wet hands and washing feet up to the
ankles. The part of ritual worship includes removing shoes, facing Mecca (Saudi Arabia), reading some verses of Qur'an, bowing down in prayer, prostration and sitting down on the floor.

Some other patients may feel uncomfortable with these kinds of performances to prevent so the health care provider has to play a role to satisfy both clients. The third pillar of Islam is giving to the needy (2.5% of your wealth once a year). The fourth pillar of Islam is fasting during the Holy month of Ramadan, with no food or drink is taken between sunrise and sunset.

Many Muslim clients may take oral medications during the food hours, even-though according to the Islamic law the ill person, travelers and mothers during the pregnancy or breastfeeding are not required to fast.

The fifth pillar of Islam is to go to pilgrimage to Mecca (Saudi Arabia) if afford. The concepts of halal and haram are very important to understand in Muslim culture. According to Islamic doctrine halal describes those things that are permissible or lawful and haram describes those things that are forbidden. In Islam consumption of pork or any food product derived from and alcohol are strictly prohibited.

It is very important for the Muslims to get halal meat. Muslims consider the animal meat halal when slaughtered according to Islamic prescriptions. Many Muslims may not eat meat in hospitals because to their understanding was not killed the animal according to Islamic prescriptions. As one informant describes:

"I only eat vegetarian food in hospital meals, because the available meat is not from the halal shop, we are part of the Finnish society, but yet we can't be provided with Islamic meal. Why do they ask for your meals if they can't offer it?" (male B)

Halal and haram applies also to the dress. According to the Islamic doctrine dress and adornment must take into consideration the principles of decency and modesty both men and women. Muslim women should cover her body except her face and arms and patient dress (pajamas) do not fulfill the requirement of Muslim women's clothing.

A lady from female informants suggested "In maternity wards at least another alternatives than pajamas dress would be more accepted, because as a Muslim woman I can not go even to the toilet if there are male visitors in the room."(female C)
Somali women as many other Muslim women may desire to have another female relative or her husband present during health examination, especially if the health care provider is a man.

Somali patient at the ward may receive from family members the copy of the Qur’an or prayer beads. The use of these is a reminder to Muslim clients of the nearness of God and thereby serves to reduce anxiety and provides a sense of peace and well-being. Muslims believe the Qur’an is the actual word of God and revealed through the angel of prophecy (Gabriel) to prophet Mohamed (peace be upon him) who then transmitted to the people and such sacred object nothing should over be placed on the top of it. It is also brought from home a prayer mat to the hospital. The prayer mat is flatten on the floor and may carry hospital bacteria to home whereby health care providers would not recommend bringing to hospital to prevent infection.

Religion is a major factor of social structure for the Somali client. Another important factor is the family and kinship ties. Somalis are most of the times extended family and worldview of kinship differ from the Finnish society. Many times when Somali client on the ward we find the most visiting hours that there are always visitors present. These visitors may contain relatives, friends or neighbours. The idea behind this visit is to support psychologically and the hope of recovery according the will of God. The health care provider shall anticipate these cultural needs and provide comfortable location in the ward settings that would accommodate several visitors, rather criticizing these needs.

Visitors to the Somali client at the ward may read some verses of the Qur’an as spiritual treatment. The patient heads his face to the Mecca and Qur’an readers sit behind him. There is no physical contact between the patient and Qur’an readers, since this practice does not cause any physical stress the Somali clients hoped to be allowed to perform such rituals. Reading of the Qur’an is not loud to disturb other patients in the room. Patients with mental health problems Somalian believe as other Muslims that the cause might be psychiatric or evil (Jin) cause. Patient with Jin to cure Somalian read some verses of Qur’an and that is the way many times when Somalian come to psychiatric ward read to Somali patient some verses of the Qur’an.

Home visit to the Somali client (home care nurses) traditional part of Somali culture belongs to serve cup of tea cooked with sugar. To refuse a cup of tea from one’s host is considered disrespectful. If the care giver can not or does not want to drink reasonable explanations are expected.
5.1.2. Cultural identity
Cultural identity is the person’s or groups’ feeling of belonging to a group or culture and how influences of being member of that group or culture. In health perspective how culture influenced the recipient of care and how the health care professionals were able to handle the situation.

The study has highlighted a number of barriers to culturally congruent care for the Somalis in the Finnish primary health care, including stigma of being a refugee, difficulties in finding employment, living in poverty, living in poor accommodations, feeling marginalized, having a poor command in Finnish language as well as having difficulties understanding the host society.

This study has revealed that Somalis are being marginalized and multiple forms of disadvantages, including high unemployment and under-employment as described by some informants. When asked if their social status affected their receiving of care.

“I think the issue is not the matter of culture or religion. The issue is how to improve our health including exercises etc. and we don’t have where to go during winter time. We just sit our homes with our problems” (female A)

“We have language problems and to get Finnish language courses will be helpful to manage in health care services. Sitting at home can even cause more stressful and may cause you more health problems” (female B)

The informant reported that gender may not be considered very important in some special cases, like if providing care does not demand to touch the client’s body. This is how male D commented;

“I don’t mind who is my care provider since she is not touching my body, because in Islam physical contact with different sex is strictly prohibited” (male D)

Nevertheless, female informants expressed their worries for their daughters. Women wanted for the doctors and school nurses to know that the Muslim girl is demanded to be virgin until she gets married and hoped female exam should not be performed unless severe medical situation. The women informants insisted that the future of their daughters is under a shadow. They said girls may lose their virginity in such kind of situation and may be in a big stress when they get married. This may cause life threatening psychological problems as one of the informants said:
“........She may lose her face and divorced on a same night after the wedding” (Female A)

Another woman informant continued like this “If you make mistake, of course you accept your faults, but if you are innocent and somebody accuses you, you get mad. This is similar situation, it was not her fault to loose her virginity yet everybody is condemning”( Female A)

5.1.3. Ethnocentricity

First generation of any minority always tries to keep their ethnic identity, what sometimes to be interpreted as ethnocentrism way of behaving. Problem arises when ethnocentricity is present among health care providers, because the client tries to defend his or her culture and see non-touchable phenomena and sometimes much more important than to receive care. To delivery care to culturally diverse client needs the health care providers to look the world primarily from prospective of the culture of their client rather than own culture, race or ethnic origin with combination of health care regulations.

Clients’ opinion how health care professional sees his or her culture; in other words if the health care professional see his or her culture as superior to client’s culture. And or if the client him or herself thinks that my culture is the most important than everything else.

At least three occasions presented by the informants that health care providers started to criticize in advance without knowing their response to the health care delivery or Somali clients suspect there were presence of ethnocentricity among health care providers.

“Are you sure you can come to the reserved time” (male A ) Here the nurse suspects whether the client is able to come for reserved time even-though there was enough time to come back to the health care centre.

“It is not necessary to come to health care centre for everything before explaining which cases belong to home care and what procedures to try before coming to the health care centre” (female A)

Some informants complained of conflicts they face which is sensitive to culturally congruent care and could be a barrier caused by health care providers’ ethnocentric attitudes when rendering the health care services. Here is how one had narrated when asked if culture has influence on his receiving care.

“I have a feeling that many Finnish people place a first in their own culture and consider it normal behavior without realizing that it may offend the others” (male D)
Another male informant explains how existence of ethnocentricity in both client and health care provider may have effect to health care delivery.

“Most difficulties come when health care professional who is very strict in his culture and so the client himself is strong in his culture and none of them does not compromise. exam. When the client comes into room of care provider and the care provider tries to shake hand with opposite sex-client and client says “sorry because of religious reasons I don’t shake hands” and that may offend the health provider and sees his client as a person who has no respect in human. This causes loss of trust because immediately the client reads the care provider’s face that he or she became angry” (male F)

5.1.4. Ethnoadherence
How client is faithful or attach to his own ethnic group and how that effect to accept Finnish way of treating. And in some cases how the health care professionals make links their client to their ethnic background. Mainly what Somali informants saw as important cultural obedience as those derived from Islamic religion but were not sure how facilitate in the health care services.

“Many times health care providers are expecting to me to do something against my faith and I am not willing to do so. Like shaking hands etc.”(female A)

One female informant stated “I know in general western society no matter who is a care giver but for me it does”(female D)

Generic factors that many prevail within cultural group expectations, religious beliefs, trust, mistrust and communication all interact to highlight how cultural differences between client and health care provider can effect care.

“I have been in a situation when I got into the doctor’s room, she tried to shake hand and because of my religion I told her “sorry I don’t shake hands because of my religion” She became very angry and said to me “Why you came to see me if you are not willing to shake my hand” and continued to saying similar things. I left her room because I could not ask any help from a person who is emotionally unstable” (male F)

The above client explanation support and provides evidence for the arguments for care that is culturally sensitive and for the health care provider to be culturally competent.
The above problem redresses some of the failures of not recruiting the staff from the minority groups within the staff and if adequately empowered, they can contribute to the culturally sensitivity health care services.

This will reduce this kind of clashes with clients from the minorities, who usually take it in a negative way when the health care provider cannot give instructions or explanation to their expectations, and they are unable to ask for explanation due to their language disabilities. Most of the clients form the minority groups are used to getting full instructions from the care givers especially on the prescription. One informant told to the female researcher cultural imposition practice while at the health care centres. She described her cultural clash as follows:

“I don’t know why the nurse accepted to take care of me. I was in an observation room with high fever, for some reasons best known to herself, she was wearing gloves and gave me medicine with her left hand and then again the water with her left hand. I refused to take and asked her to put the medicine and the cup of water on the side table. She gave me no explanation for wearing gloves and in my culture a left hand is a dirty hand and I can not take anything given from a left hand. Did she think I was too dirty?” (female B)

This remarks highlights the importance of understanding the world of minority groups who have different ethical and moral values and beliefs. Cultural knowledge to health care providers can reduce this kind of conflicts and imposition practice and prevent cultural problems and offensive acts. Health care providers need to have some written guidelines on culture, religious beliefs, values and life ways of the Somalis so to provide quality care to the Somali community. Interestingly, the nurse could not also ask why she wanted the medication on the table. Either side was obeying their cultural values.

Cultural offenses often exist and this could have been solved by asking and listening attentively to the clients’ explanation and interpretations as to why either side behaved that way. The woman felt indignant. Somalis have some specific ethical values, cultural sanctions, cultural taboos and specific religious conflicts. Some client may be very honest and explain their reasons for refusing certain care practice while others will suffer silently.

Cultural insensitive care is frequently received in the health care services. A female informant told the group on how her daughter was asked by the nurse if they can give breast milk from donor mothers.

“They asked my daughter if they can give her baby donated breast milk, she refused, they still asked if they can give artificial milk then she accepted, Was she the first Muslim to give
birth in that hospital" How can you give another woman’s milk to your child before your own? This is a taboo in our culture” (female A)

5.2. Cultural Knowledge
5.2.1. Healthy beliefs and behaviours
The clients' beliefs and behaviours in modern medicine and the usage of health care services. Some informants described their health seeking behaviors as naturally cultural to the question of if they seek help from the health care professional first when they fell ill.

“It depends, those small problems I first discuss with some Somali friends who are health care professionals and then go to health care centre if needed”( male F)

Self-care such as using over-the-counter " modern medicines" or eating traditional foods i.e. white onions, black seeds, olive oil and honey. Some religious behaviors As male D sees it.

“I believe in modern medicine and I use it, but I have seen many cases where the modern medicine did not help and the person went back to seek tradition healing, good example is the people suffering for jin (evil), when they go back to Somalia they are treated completely and they come back to Finland in healthy condition” (male D)

Another informant says “Yes we use traditional medicines, like white onions, black seeds, olive oil and honey”(female A)

They emphasized that ill knowledge of Finnish language can have negative impact to practice healthy habits. Many said that they still consume similar food as in Somalia and have less access to learn to nutritious and climate fit foods. However they were happy on how the Islamic faith influenced positively their healthy behaviors, like absence of using alcohol.

“We need courses how to make Finnish food, because our cultural food may not meet the required nutrition” (female C)

“None of our family member consumes alcohol and we are all safe from those problems caused by alcohol” (female A)

The definition of mental health is not defined similarly in every society. What is known mental health in a society might be considered normal behaviour in another society. A person with mental health problems in Somali community, family members and friends may not recognize in early stage of mental disturbance. Somalians consider mentally sick when the
person becomes psychotic and early stages of mental health they find another excuse to justify as normal behaviour.

"We have many times problems with the Finnish officials how to define mental health. They tell us one of the family member is suffering from a mental problem, but we don't agree. We need education and example in Somali culture" (male B)

Another informant went on "I think they keep normal person in a psychiatric hospital and the person believes he or she is really mentally sick" (male A)

This shows the level of understanding and worldview of mental health among Somalis. Mental health education can be useful through Somali community centres but the educator should be Somali health profession who knows the culture. There may be available the second generation Somali origin who is health care profession but the culture is purely Finnish and trust of community could be damaged.

The young Somali origin may also have difficulties in Somali language and culture and that limits to give examples of mental health problems.

5.2.2. Barriers to cultural sensitivity
Multicultural knowledge is lacking in the health care sector according to some informants. They feel diversity is little known by the health care professionals. Cultural problems have been highlighted throughout the study. If would be worth to health professionals of the Somali ethnic background both at primary and secondary level so culturally congruent care can be delivered. Through this way the informants believe they would be treated equally by being treated differently with culture being respected and considered. Gender should be considered when assigning clients to the care providers to avoid cultural conflicts.

Some informants highlighted lack of understanding of the primary health care system or method of referral. Difficulties in communicating due to lack of interpreters or through opposite sex interpreter was the main problem. Other negative experience of Finnish health care services were the long waiting times at the health care centre and to get appointment to see the doctor. Other said they had experienced poor or inappropriate treatment, However they could not specify whether this was due to prejudice and racism or simply bad medical practice. Some of the negative experience goes as follows:

"I think time to wait to see your doctor is very long and to get referral to the specialist is also very difficult" (Male F) and "The most difficult I face is to get for the doctor and if get
time for the doctor the second problem is to match the time available and interpreter and then comes female interpreter!" (male D)

Some clients explained that even-through they have self-confident to themselves to have direct contact to health care providers sometimes feel themselves as a passive receiver. According to these informants they prefer to be passive and give providers complete decision-making without question.

“I have to perform something against my faith, “shaking hands” and eye-contact is something else in Finland that people see good communication is established when eye-contacted and in my culture you don’t look somebody’s eyes and if you do it so with different sex, has different meaning”(female D)

Knowledge of cultural difference on one particular culture can be used in negative or positive way. In this study the researchers’ ideas was to identify the informants’ point view and how health care providers used their knowledge of Somali culture in positive way without charging their clients as people who came to Finland as invaders and understanding of Somali cultural issues that they may experiencing.

The health care sought by the informants in Helsinki metropolitan depended on the types of seriousness of the illness, when they had been ill. Almost all of the informants had visited health care centre, some used hospital services or used self-care. Few had consulted with the relatives or friends about their health problems. There appeared to be in some level of knowledge on how to access the primary health care and secondary health care services, the main reason of proper use of health care services was the language barrier which caused insufficient to access to health care services. Most of them described the Finnish health care services as easy to use.

However, the accounts of the informants showed a variation of the migration, culture, ethnic identity etc. experiences all of which impact upon their health in a number of ways. For example one female informant A explained her story;

“My health problem is caused by migration, because I came to Finland as an asylum seeker. I was allocated to a refuge camp to wait for my decision. The process took 3 years and my situation was not stable, I was thinking about the rest of my family whose location was unknown. Because of this stressful situation, I became sick and I have been diagnosed of diabetes and gastrointestinal problems”(Female A).

Some cultural norms and taboos could be barriers to receiving good health care services.
“It is sometimes difficult to transmit your opinion and tell your specific problems because of cultural way of telling things” (male A)

5.2.3. Stereotyping
Stereotype can be one side or another. Clients can have impression that health care providers are not helping them enough because of their ethnical background and they always follow the worker’s actions. Among health care providers are some people who may think that in some ethnic group seek help for fun as two informants explained.

“Nobody goes to the health care centre; there is a reason for seeking help. If I go the health care centre I would expect to get help. Especially if the nurse can’t help, I hope they allow us to see the doctors, because now they don’t allow us to see our doctors and they say they can’t prescribe any medications” (female A)

Another informant said “……we have been forced us now to use evening emergency services, because we are not getting help from our health care centre” (female D)

Health care providers may also stereotype and categorize Somali clients who speak little or no Finnish. Women may be labelled as unresponsive, rude and unintelligent which lead care providers to hold preconceived expectations on women’s behavior and cultural values. In this study, There is some evidence to suggest that, when health care providers can not communicate effectively with their clients, they may become angry and frustrated, which can be manifested in their non-verbal cues. The client may sense this and feel vulnerable and inadequate. Stereotype could destruct the health care provider from exploring other potential reasons for this behavior. A female informant told her stereotyping experiences:

“I have been diagnosed of diabetes, when I go to health care centre, I face such kind of remarks just on corridor “Oh you are here again!”, the next time I was told by another nurse who said “you look so familiar” without asking my problem and she added “Just go home and change the diet”, the question is how did she know my problem?” (female B)

The attitude of the health care providers at primary level towards the Somali clients is a cultural biased. Their attitudes have been described some informants in this study as unfavorable toward culturally congruent care to the Somalis. We can see the stereotyping like this:

“In many situations when you visit to the doctor, he or she has impression that you came with your health problems from the country of your origin, but the reality is you became sick
after being here with a lot of stressors for a while. The doctor may ask you to go under some examinations to check out whether you are suffering from tropical diseases or not and this will prolong your problem and illness will go more deeper” (male B)

Somalians are members of the health care consumers and they hoped their wishes will be heard, they questioned why there is no transcultural committee both in primary and secondary health care services.

“They still continue the monocultural health care delivery even-though Finland is becoming more and more multicultural society. They should establish a committee who supervise how multicultural health care delivery is achieved or take example from other multicultural countries” (male F)

5.2.4. Ethnohistory
Leininger 1991, refers ethnohistory to those past facts, events, instances and experiences of individuals, groups, cultures and institutions that are primarily people-centred and which describes, explain and interpret human life ways within particular culture context and over short or long periods of time. It is suggested that people in health care and social disciplines search knowledge concerning their clients. In Finland the information concerning Somalis and Somali culture is limited and if available most if it is biased. There are many risks that, this kind of information can mislead innocent health care worker and make difficulties to carry out his duties. The study has found that Somalians suffer the additional stress caused by unemployment. They had problems in integrating because of social status. A few informants mentioned that they are always labeled as foreigners whenever they are applying for a job. If they get a job, mostly it is something they are not qualified for. They feared the media had fuelled their marginalization and hampered their attempts to integrate and make useful contribution to the host society. Sales( 2002) proposes that the social exclusion and stigmatization to which refugees are exposed damages their changes setting, whilst racist discourage against asylum seekers impacts on every one from these communities, whatever their legal status.

“Knowledge available about the Somalis and Somali culture are biased. Many know about the Somalis through the Finnish newspapers Ilta-sanomat or Ilta-lehti, so called “gossiping newspapers” which we all know what they write. Also available scientific researches are not reliable. One day I listened a researcher from one of the health institutions in Helsinki area and according to her, Somali women delivery babies like machines” (Male F)
5.2.5. Sociological understanding

Family size, family culture and what does family mean in Somali culture. Unemployment and its related social and mental problems and how it affected the client’s life. On the other hand it has been known that no patient can be treated according to his or her social status in the society both in public or private health care services.

It is regrettable that language barrier has affected and contributed to the marginalization of the Somalians on the labour market.

One female informant stated: “I think many employers are right, when they are demanding the ability of the instruction language, because you can’t carry your duties without understanding the core idea” (Female A)

Unemployment as a resource stress. While other female in the conversation added on to say: “Here in Finland if you don’t work you mentally and even physically become sick. If you sit home without work you face pressure from everywhere and you are stressed more and you become sick” “Cause of family problems mostly comes from unemployment, both are stressed and can not control their emotions” (Female B)

This study found out that men were more likely to experience difficulties adapting as many of them could not maintain their social status and position in the family. This is how they described their status when asked about keeping their traditions and cultural values. Migration to Finland resulted in considerable downward social mobility to them.

“As the bread earner I was the head of the family, and I had a great respect among the family, but now I am there and my existence does not contribute anything to the family” (male E), another went on: “.... how many men are homeless and suffering from mental problems, because their wives kicked them out and they can not even see their children”(Male B) and he continued saying:

“Also many women have health problems caused by lack of support network. Single mother with at least 4 children may face many mental problems”(Male B)

Employment helps people to settle in their host country. They were aware that when people were employed, they stood better chances in getting good accommodation whilst they got through social office. This meant they were forced to get anything available to them. As one connected to their health problems to poor accommodation.
“Back in Somalia, I was a business woman, and I travelled to buy things to sell to other women and I did tailoring work at home. This gave me a lot of activity, but here in Finland, I can not do anything. They will ask me to be licensed to practice and pay tax. How will I get into the course that is in Finnish language? I am completely disappointed with the whole immigrant life. It has made me to be nothing” (Female B)

Almost all informants mentioned premigration and postmigration experience of stress. They gave reason for their negative experience, saying that the cause might be attributed by lack of family support, homesickness, loneliness, sense of being different from the host population or lack of organized Somali community.

Care that is acceptable to the members of a specific group especially Somalis requires understanding and respect for their lifestyle, community and social cultural orientations as the context for the health promotion, maintenance and restoration. According to Giddens (1996) Sociology is the study of human societies that imply historical, anthropological and critical sensitivities. In the case of Somalian community, it would be helpful for the health care provider to have knowledge of some important issues of the Somali lifestyle, the most important relationships within the family, by whom or how are decisions normally made, the role of the mother in the families and how children are viewed and care for. Here are some issues which some informants had highlighted

“I have no idea what kind of vaccinations my children have, but my wife is an expert who knows who as got what” (male E)

Knowing about these issues is important for all health providers as they all affect health and health behaviour. Complete knowing is not possible but general knowledge about these issues provides a useful framework for action.

5.2.6. Similarities and variations

Cultural similarities in different societies do not cause difficult on the way to do things and usually allows interacting easily between the people. Variations are always the area both sides needed to be compromised. The health care provider should not forget the culture of caring but he/she needs to explain the level of understanding of client, considering his or her culture into account.

Many informants described the Finnish health care services as far better to that in Somalia. They described negative experiences of health care in Somalia including shortages of health care facilities, poor sanitation in the facilities, shortage of drugs, equipments as well as
updated qualified staff. The informants acknowledged that Finland provided quality health care services than Somalia. However some informants mentioned that lack of family, friends and neighbours to give informal support and care and lack of traditional Somalian remedies in Finland was seen as a negative aspect of living in Finland. A positive expression from female group praised the Finnish health care services as a positive thing;

“There is great difference between health care in Finland and back to Somalia. Here doctors have more knowledge and facilities to help their patients” (Female A)

The health care provider’s attitude towards the client has a lot impact to the care. More the health care provider shows tolerance and understanding to the cultural differences, more the client develop openness and trust to wards health care providers.

“Regardless of our background each and every one of us came from different family and including the health care providers, better not to judge negatively who is who, we are different”(male D)

One informant mentioned that some providers become confused and uncertain for their actions. According to this informant the care providers feel that they are not prepared to deal with culturally diverse clients specially Somali clients.

“I have been in a situation where the health care provider got confused and could not handle the situation. I don’t understand why many health providers get confused when they see somali clients. We are not so special!”(female A)

There are some commonly held beliefs about cold, chills and fever which are widely spread among Somalis and are shared by indigenous people or the mainstream groups.

Rain or damp environments cause cold like in the head, a runny nose, while dry condition causes feeling of cold such as aches, and pains and shivering.

Chills are believed to be caused by careless behaviour such as going out after the shower and being out in draught for too long. One female participant compared her experience in Finland

“…..My problems caused by lack of knowledge, like during the winter time, I went outside for shopping while my hair was wet”(female B)

Usually the victims of this get little sympathy and are expected to take care of themselves by restoring warmth or staying in bed.
Area with high proportion of people from Somali speaking backgrounds need at least a contact person in health care centres to simplify those who can not speak any language.

“whenever I go to the health care centre, nurses on the front desk ask me many questions which I can not answer. It would be great to have a contact person who knows those people in special needs like me” (female B)

5.3. Cultural Competence

5.3.1. Challenging and addressing prejudice, Discrimination ad inequalities

Some people criticise that there are inequalities in health care services which caused by the system itself. The health care provider’s ability to recognize and challenge racism and other forms of discrimination and oppressive practice and develop a broader understanding of around inequalities, human needs and equality rights may promote the development of skills needed to bring changes.

According to the Finnish law, any form of discrimination is a crime in and outside of health care services. In serious cases the health care provider can lose his or her license to practice in health care services. Any expert in some culture can not claim that he or she knows everything in that culture and the process of learning is on going process and prejudice may be found in their opinions.

In reality, being able to read and write in the majority language is an important fact in enabling users learn about and then access health care services. Here is the example of how telephone triage is commonly used to access care. Utilization of such a service demands a reasonable command of Finnish language, including the understanding of and ability to communicate descriptive words and some medical terminology. Without this, one could argue that these clients’ rights of access to these services are not being respected and therefore they are being treated unequally.

“Calling and reserving time is something that is out of discussion, because I can’t even tell my things well enough when I am physically there in health care centre and If I can’t explain means “ I don’t have problem and they send me back home ” (Female D)

Another female in the conversation added on to say “Once you call them they ask you so many strange and medical questions that I am not able to answer”(Female D)
There are some areas in Helsinki metropolitan known for high proportion of immigrants especially Somalians. Informants that came from those areas were wondering as to why there is not even single health care provider from the Somali community.

"I don't know the reason why they don't employ Somali health professionals; they could help us in many ways and avoid misunderstandings" (Male C)

5.4. Cultural Sensitivities

5.4.1. Empathy

The concept of empathy means in this manner how the health care providers are able to share and understand their state of mind. If health care providers are capable of putting themselves in the position of their clients and how they wanted to be served in state of being client. The health care provider has competence to identify cultural sensitivity issues and their influence on delivery of care without ignoring the philosophy of health care principles. In other words, the ability to perceive accurately the feeling of other persons and the ability to communicate this understanding to him or her.

Here is the case of how one informant felt she can get empathic care from the female group described it in this way;

"If only we would have Somalians recruited as members of staff among the health care providers, we would not have this health problems prolonged to the worst. It would be easy and comfortable to talk to some one from the same culture. These people will have deeper understanding our problems, which goes beyond spoken words. It feels comfortable to express yourself in own cultural way of feeling things which are more direct" (female C)

Other informant asked her what she meant by more direct. "I meant, I don't have to hide anything or talk through interpreter who will change some words. My own fellow culture will understand what I meant just saying it once and this way the health institution will save time and money by shortening the gap of interpreter" (female D)

The above case explains how Somalians are having problems in adjusting to the Finnish culture especially in the delivery of health care services. They prefer some one from their own community because of the commonality of culture, and who understands the behaviour of the Somalis as the above informant had described it.
The empathy of the health care providers to Somali clients is rarely mentioned. It’s very difficult for the researchers to know the feeling of the health care providers whether the allegations are valid or not.

“It depends on the person, I met some people in health care centre who are more kindness and understand my situation than my fellow sister” (male E)

5.4.2. Interpersonal/ communication skills
The interpersonal/ communication skills the health care provider develops a trust between him or her and client. In some cases health care seeker may think that he is not listened to or lack of attention. A service received at first time has a lot of impact to the patient’s trust.

When the clients can not communicate in their mother language, clients look up to health care providers as being superior and therefore not value their own ability to make decisions around their care expecting the doctor to take on the role. In turn health care providers can not assess whether their delivery of health care services is indeed respecting their clients’ cultural values. Important symptoms of life threatening conditions could be missed. Here we can see how the client explained her ordeal:

“I can not even reach to the doctor. You have to see the nurse before they allow you to see the doctor. The most of the time the nurse sends you back home. If you demand to see the doctor, then they tell you, the next available time is after two months. One small problems you can suffer for a long time. I tell you good example “ I went to health care centre at 9 o’clock until 13 hours. After that the nurse called me and said your problem is not acute and sent me back home. I could not sleep whole night long and next day I went back to the health care centre, similar thing has happened to me. I went to Puolarmetsä hospital to seek emergency doctor in the evening; the doctor examined me and ordered an injection should be given. The doctor also ordered that my case should be seen by my own doctor as soon as possible. The nurse called me next morning. My problem became life treating health problem. I pray for that doctor because he saved my life” (female D)

In such cases health care providers have failed in their duty of care and thus increased the potential of harm to their clients who could not communicate their needs because of their language deficiency.

The research findings show that it is clear that there is lack of information on how to access the primary and secondary health care services by the diverse minorities.
Some informants described their relationships with their doctors as considerable and as having time to listen to their clients. Here are expressions by some informants on their relationships.

“*My doctor is a nice person; he listens my problems and better explains for care plan precisely*” (female C)

A male from another group stated similar experience by saying “*I even sometimes get better services than I expected, so I am satisfied with the present health care services in our area*” (male D)

Other one mentioned her satisfaction with her doctor, but was negative towards the nurse on the front desk.

“*My doctor is really nice person and if I get into her room I come back with satisfaction, but how can I get into her room, that is the question*” (Female E)

However some expressed their negative views which were sensitive and could lead to negative attitudes towards seeking help from the health care provider, thereby prolonging their health problems.

“I *need to know also why people go to the health care centre many times for one specific problem, I mean why the doctors do not make referral to the specialist after the person comes to same problem may times or even years*” (male E)

More than half of the informants emphasized that how the shared language plays the biggest role in self-awareness and relationship between the provider and client.

“To be confident and have direct contact with the health care providers depends first your knowledge of the spoken language and opens the doors of knowing how the health care service works. Once you know how the system works you can demand your rights as well you can be aware of your responsibilities” (male D)

The study showed that the informants believed that speaking the mother language gave them several meanings and advantages. The informants believed that by speaking Somali language, they would be able to communicate perfectly with the health care providers. This meant that they would feel secured because they would be certain that they have been understood correctly, which facilitates comprehensive communication and feeling of trust by being
understood and considered in a care situation henceforth given the congruent care. Male c remarks

“The interpreter was young and grown up in Finland. His Somali language was not enough and I decided to come back to health care centre with my relative. The information was completely different as I suspected” (male C)

The above remarks revealed that language is significant barrier to the effective communication in the health care services. The informants narrate how their communication abilities are limited hence the reasons for prolonged health care problems. Their language inefficiency hinders information transmission to the health care providers.

Cultural biasness was revealed in the study by the informants. They complained on the delivery of the information especially information pertaining to their prescribed medication which many found as strange that they received no information on the side effects or what kind of drug. Male E discussed the need for information:

“I think most people especially the old generation prefer advice with the medicine and if they get prescription without explanation, they think the doctor did not like them and he or she wanted to get rid of them” (male E)

5.4.3. Trust

Trust goes side by side with above concept of communication skills. The ability of patients to trust their health care providers is one of the most important aspects of health care delivery. Understanding factors that influence how patients develop trust in their health care providers and being able to measure patient-provider trust in a simple, consistent way are important first steps in improving health care delivery now and in the future.

The meaning of the mother language and shared language with the health care providers was a recurring issue in the themes. Most of the informants lacked adequate skills in either Finnish or English language and this resulted in a suspicious attitude towards the care they were given. They were also suspicious about the medications which are prescribed for them as informant explains:

“When you can not speak Finnish or English, you are really in trouble. It happens many times that the interpreter speaks either language less. Sometimes he may be a young person grown up in Finland and whose Somali language is not complete or a person whose Finnish language is not good at all. It is difficult to deliver the client’s message to the doctor” (male D)
Another male in the conversation added on to say “I think the interpreter I got knew less Finnish language than me and I even told to the doctor that the message was not proper and I started speaking English. Can you imagine if you give wrong instructions to a person with diabetes? That is what has happened to me” (male D)

Language skills were significantly associated with a feeling of satisfaction with health care services among the informants who had visited the health care centres. This suggests that when health care providers and the clients do not have a shared language, satisfaction with health care services decreases.

For example male B remarks “Communication is very important, the problem I face in Finland especially in health care centres is when the doctor is not native Finn, and me and doctor used broken Finnish, I don’t know if whether the doctor understands my message or not” (male B)

Some informants expressed disappointment with the health care services as being against the expectations they held when they were coming to Finland. They had high hopes that their health problems would come to end, as one informant expressed her hope.

“When I was coming to Finland, I had a feeling that all my health problems will be solved but nothing has become true. In fact they haven’t tried enough to help, I don’t know is it because of my background” (female C)

Those visible minority most of the time experience some forms of racism and discriminations, which creates loss of trust among minority. It is up to the health care provider to develop positive environment, which can assure the minority person that he is not left out. Language and cultural barriers may cause misunderstanding between the client and health care provider. This kind of problems can be partially solved to achieve provider-client trust, which the key components are being polite and showing respect. This is how a male informant said:

“.... How can I trust a person who has no respect for me?” (male G)

Many clients who seek health care services have difficulties to communicate to the health care provider. They may come to the health institution with their relatives or friends to assist with the language problems. The person or family member might not be fluent in Finnish; might not be familiar enough with medical terminology, diagnoses or treatment to interpreter effectively or the person knows the language but does not know how to interpret.
The use of official interpreter is strongly recommended by Finnish Ministry of health and social welfare during the reception to receive care. Many of those complained about “wrong” interpreter, these situations were when the interpreter “official” was opposite gender or young adult who has grown up in Finland and inefficient both in Somali culture and language. The client may ask something to the health care provider but interpreter feels shame to transmit the message because it was inappropriate in Finnish culture. This tells how those young adults who are grown up in Finland have strong belief in Finnish culture than the Somali.

“She was so young and lived whole her life in Finland. We don’t have same mentality and I am not sure whether she transmitted my complete message. She is culturally biased in Somali culture and her Somali language is not enough to be interpreter” (male A)

5.4.4. Acceptance
Skills related to acceptance are of two kinds: Those that help us develop self acceptance and those that help us accept others. Knowing and accepting ourselves enables us to accept others, a necessary component of interpersonal communication and relationships. The attitudes of the health care providers some times can make others or their clients lose their human rights as one informant stated:

“They always tell me to go to a practitioner (immigrant doctor) and we all have problem with the Finnish language. I don’t know if I have right to go to the normal doctors” (male G)

Some informants claimed that they were not accepted as a client or they felt that they were not expected clients as one of the informant explained;

“I was operated and my situation was unstable. I called for help and when the nurse came to my room, she did not ask me what my needs were, instead she said to me “don’t call us every time” we are busy with people” and left the room. She did not say she was busy with other patient. I think she did not accept me as patient” (male B)

5.4.5. Appropriateness
“I have been sent to hospital for gastro-copy examination and after examination the doctor told me to go back to my doctor in health care centre to listen the result. I waited contact form the health care centre but no body did it. Almost a year after the examination I contacted to hospital and they told me the result was sent to the health care centre. When I met with my doctor in health care centre one year later, he told that I am suffering for helicobacter and prescribed medication. I don’t think Finnish people get their results after one year” (male F)
From the above description of some events one can conclude that the informant had very little knowledge on how the health care services are delivered. He expected the doctor to contact him on the results. He had no knowledge that he was to follow them up by himself. It is one of the barriers to qualify health care. Clients need all the information they need on their subsequent care. Information dissemination is the biggest problem and creates the gap to equal services.

“...............My knowledge of health care services is limited and if I would know perfectly about it, I wouldn’t wait one year the result of my gastro-copy examination” (male F)

The study found that the informants preferred experienced health care provider than inexperienced who is a same gender even-though female informants expressed their wish to have female care provider its more culturally appropriate.

“It is really difficult for me to see male doctor and even sometimes male interpreter. I can not talk my things freely” (female A)

Another one contributed to the conversation by saying “If male doctor, I expect my husband would be allowed to come with me, because some doctors say only clients can come in” (female B)

These ladies mentioned that they were forced to delay their problems and cure at home with over-the-counter medications just to avoid to see male health care providers.

“Instead of going to a male doctor, I prefer to use home remedies or to discuss the pharmacist to buy over-the-counter medication” (female B)

The study has highlighted some inappropriateness in the delivery of health care services by the professionals. Some of the advice or information could be offending to some cultures especially to the Somalians. Here is one case of inappropriateness which emerged from the interview.

“My wife just got our 5th child; some nurses were already asking her if she can do sterilization a form of permanent contraceptive method. My wife was so offended because she thought the nurse thinks that my wife has no choice but to obey my husband and she did not like to get help from that nurse” (male F)
Family planning is considered a private matter in some cultures and it is up to the couple to decide. In addition to this big family is seen as a blessing and motherhood, child rearing is a highly valued activity in the Somalian culture, big family is seen as prestige.

5.4.6. Respect
Some of the informants said that they have great respect to their health care providers especially to their doctors and according the doctors show great respect to client’s culture, which made easier to develop culturally congruent care as stated informants below.

"I have a good doctor and she showed as patient a great deal of interest in me until now" (female D)

"The people I met respected me and treat me well and in my opinion providers in health care services should accept and respect other cultures because Finland is becoming more and more a diversity society" (male F)

The concept of respect is addressed in different ways. Health care provider have many times been in cultural clash with their clients, others will show their disappointment whilst others will not. It is worth it asking a client from Somalia or any other ethnic background client on how they would want to be addressed or if by first name or surname. We can see in this case how the client lost her name as she describes it.

"I was in hospital emergency department and everybody was called by their names and pronounced correctly. My name was called and pronounced wrongly and did not know that the doctor was calling my name. After waiting for too long, I decided to go and ask the nurse on the bench. She told me I have been called twice and now the doctor is busy with another client. The doctor took me in after a while. They decided to observe me overnight in the hospital. To my dismay, I lost my name, I was addressed as Somalian. I never heard my name all I heard was “somaliainen potilas” behind the curtains. I would have love them ask me how to pronounce my name properly than just run away to my nationality" (female C)

From the explanation of this informant we can conclude that the name is an important part of identity and we all have preference as how to wish to be addressed. If the name is difficult to pronounce it would be helpful to get the person repeat it or ask the person to write it down phonetically. This way you show that you really respect the client.
6. DISCUSSION

6.1. Ethical issues

Talbot (1995) argues that the ethical issues emerge in every phase of the qualitative research process from the beginning throughout every step of the methodology. Talbot (1995) states also that the qualitative researcher must attend to potential ethical dilemmas when data collection involves participant observation or when interviewing includes sensitive topics.

Nursing progress is based on research which ultimately must rest in part on experimentation involving human subjects. As researchers, we were aware of the ethical, legal and regulatory requirements for research on human subjects in our own countries (Finland) as well as applicable international requirements. No national ethical, legal or regulatory requirement allowed to reduce or eliminate any of the protections for human subject according to National Institutes of Health, Office of Human Subject Research, World Medical Association (Helsinki declaration 1964, Revised June 23, 2005).

The research aimed at helping the Somalian community benefit from it as well as the health care providers. The informants were volunteers and informed informants in the research project. The rights of research informants to safeguard their integrity were respected. Every precaution was taken to respect the privacy of the informants, confidentiality of informants’ information.

Informants were informed of the aims of the study, methods, sources of funding, and any possible conflicts of the interest, institutional affiliations. Informants were informed of the right to abstain from participation in the study or to withdraw consent to participate at anytime without reprisal. After explaining and ensuring that the informants had understood the information, an informed consent was obtained in writing and formerly documented and witnessed.

All ethical guidelines of researching on human subjects were applied to them and they were not taken as friends but partners in research. In this study, any sensitive issues that emerged, the researchers had to analyze whether the information could be included in the findings.

In the final phase of the analysis process of this study, the informants were consulted for the feedback and to ensure that the findings accurately reflected their views.
6.2. Trustworthiness

The researchers’ need to establish effective trustworthiness four objectives should be achieved. These are Credibility, transferability, dependability and confirmability (Talbot 1995).

Credibility “ensures that the researcher has developed plausible interpretations and conclusions” (Talbot 1995).

Transferability “allows someone other than the researcher to determine whether the findings of the study are applicable in another context or setting” (Talbot 1995).

Dependability “enables someone else logically to follow the process and procedures that the researcher used in the study” (Talbot 1995).

Confirmability “guarantees that the findings, conclusion and communications are supported by the data and that there is an internal agreement between the investigator’s interpretation and actual evidence” (Talbot 1995).

With one of the researchers being a Somali (an insider) of the community, and the second one being from another immigrant ethnic group, made this study credible and trust worth to the informants. They used their mother language and expressed themselves honestly without fear or reprisal.

The informants trusted the researchers in a way that the information given will not be used in a negative way but as a base to development of cultural congruent care for their community. The informants could rely and depend on researchers to deliver their expectations and needs to health care providers in unbiased way as one of the researchers was an insider and another researcher being an African immigrant. The problems or limitations to the methodological approach may probably include the possibility that the interviewers as one being an insider might have taken some information for granted without probing, which an outsider interviewer may have pursued.

6.3. Discussion of findings

The study has highlighted a number of barriers to culturally congruent health care delivery to the Somali minority in Finland including the stigma of being refugee, difficulties in finding employment, living in poverty, feeling socially excluded, marginalized, having poor command of Finnish language and experiencing difficulties in understanding the mainstream culture.

Finland is increasingly becoming multicultural, which challenges the provision of health care services. According to Anderson and Kelley (1998) culture is thought to be a major element of how persons view the world and interact within the health care settings. Therefore an
understanding of how culture influences peoples’ behaviour is a necessary first step in comprehending what Anderson and Kelley’s call “ethnic context of intercultural encounters. Khan and Pillay (2003) however, argue that differences in health beliefs and values, when comparing ethnic minority groups to the white indigenous population, are not addressed adequately. Being knowledgeable about culture does not necessarily guarantee sensitivity in patient care.

Although awareness has increased about the role of ethnicity and culture and their impact on health care practices, and preference to the way in which health care services are organized and delivery is mainly mono-culturally based on western ideologies that can easily become ethnocentric Khan and Pillay (2003). Papadopoulos and Lee (2002) argue that notions of cultural sensitivity and cultural awareness are not sufficient to provide culturally congruent care. Since the relationship between colonialism, dominant ideologies and caring practice are either underestimated, overlooked or left aside.

Gerrish (2000) argues that ethnicity and culture are offered as an explanation, meaning that cultural differences lead to health differences among populations. This ethnocentric perspective identifies ethnicity and cultures as the key question and problem. Despite the usefulness of nursing cultural theories in understanding immigrants’ health beliefs and practices, the extent to which health care experiences have been stereotyped, ignored or mislabelled need to be questioned.

To overcome the risk of mislabelling health care providers need to be sensitive too, and respect the attitudes, beliefs and values of ethnic minority groups. It is therefore important to be aware that because every person belongs to an ethnic group, all provider-client interactions are inherently transcultural (Andrews 1999).

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

When encountering people from different ethnic groups, it is important to be aware that in these encounters, every person has notions of ethnic stereotypes and biases (Andrew and Kelley 1998). It is also essential that the assessment process includes an examination of one’s perceived biases and expectations of care from both the client and the health care provider’s
perspective. These biases and expectations can be based on ethnicity, and will be revealed particularly through behaviour and expectations of behaviour.

According to Khan and Pillay (2003) there is growing evidence that being familiar with the culture of a particular group and developing effective partnership with group members are essential strategies in promoting health, especially in avoiding communication difficulties.

Heikilä (2004) claims that if synergy between ethics and caring is translated to practice, then it should reflect and include customs that fulfil the needs of all members of society. This is of crucial moral concern because it is difficult to talk of a “caring ethics” when research indicates that members of certain communities feel alienated and isolated in their health care experience.

In order to provide culturally congruent care for the immigrants, health care providers should include members of their own ethnic group who speak the same native language.

The findings of this study should therefore be taken into account by health and social care policy makers and practitioners. Services should be provided which breakdown the barriers to culturally congruent health care.

This study highlighted that the delivery of the health care services without bilingual workers to whose first language is not Finnish can not be effective. Bilingual health care services should not be regarded as special; they make good financial sense. This study has also revealed that health care providers are not able to gain the confidence from the Somalian clients hence the reason for avoiding or delaying in seeking health care. In the process, they become anxious, distressed or depressed and take longer to recover.

Provision of culturally congruent care requires a thorough understanding of the factors that influence health care provider’s decisions to provide care that fits with the values, beliefs, and meanings of care for the diverse clients and families. The findings of this study support the development of health care delivery models, education initiatives, and practice expectations that can guide and influence health care providers’ thinking, actions and decisions related to care of practice for the culturally diverse clients or patients like Somalis.

The findings of this study can assist health care policy makers in integrating the principles of cultural congruent care into the overall infrastructure of the health care service delivery systems.
Finally this study also revealed cultural beliefs that should be understood by the health care providers specifically with the Somali clients or patients to ensure that they are able to provide culturally competent care that is, care that is based on cultural awareness, knowledge and sensitivity that takes into consideration the Somalis’ health beliefs, practices and needs. The findings of this study also serve to illuminate the requisite antecedents that fuel cultural desire for provision of holistic culturally congruent care provided by culturally competent health care providers which is the wish of the informants of this study.

The findings revealed some reason why mainstream health promotion is ineffective in service delivery to Somalis because mainstream administrators, planner and health care providers lack the cultural competence for designing and implementing services that appeal to members of Islamic faith. Islamic knowledge should be considered as relevant to the delivery of health care services by the administrator and other health care providers. Some informants thought administrators and planner of the health care regarded the Islam and culture as vague intangible that is irrelevant to the health care services, and focused on their administrative efforts on managing budget, staff and service delivery.

Somalian health needs can be achieved through targeted health care services that are designed with the regard to their cultural aspects of Islamic faith. They believe such services will be effective in meeting their health needs of their community or otherwise, without such aspects, their health needs will be markedly compromised.

Failure to provide translation and interpretation, not providing for, religious Halal or ethic dietary regulations, not providing community services, not allowing minority ethnic professionals to practice in health care services is seen by many informants in this study as indirect racism.

The expectation that the people from other communities should speak Finnish, eat the same diet, know the services which are available means that the services may not be accessible or suitable for people from the minority ethnic groups; However, much of the difficulties experienced by the Somalis according to the transcultural model used in this study, result from ethnocentricity and institutional racism. The informants believe the health care services are intended to meet the needs of a largely homogenous Finnish culture.

Some cultural or religious practices some times require adjustment to treatment or care regimes in order to comply with religious or cultural norms; for example, fasting during Ramadan, hospital visiting, death and dying rituals.
Lack of cultural competence can cause misunderstanding and can see religious practices as signs of mental health disturbance. Avoidance of eye contact may be seen as dishonesty, depression or other mental disturbance. Speaking in a loud voice especially if accompanied by gesticulation may be misinterpreted as aggression and may result in some form of restraint.

From the findings of this study it can be concluded that the nursing diagnosis on the admitted patients are not only ethnocentric but can be dangerous as in most cases they fail to take account of cultural characteristics of the patient.

Based on the above conclusions, the researchers wish to recommend the following proposals.

6.4. Recommendations
- Cultural, ethnic and religious background aspects should be the focus to the greater extent in health care and caring sciences.
- Information leaflets in all health care sectors to be written in Somali language too.
- Information for health care providers on traditional healing practices amongst ethnic groups.
- Cultural competence training for all health care providers to avoid culturally insensitive health care services.
- Appropriate assessment of needs and evaluative studies should be conducted on ethnic minority groups and findings should be used in strategic planning of health care services.
- Anti-discriminatory principles can redress some of the failures of the past by recruiting and ensuring the development of staff, when adequately empowered, can contribute to the culturally sensitivity of health care system.
- Equal access and opportunities are essential if Somalians are to become equal partners in health service provision.
- The language that is used in the health care sectors needs to be that empowers people rather than one that reflects or perpetuates inequalities.
- Equal opportunities initiatives are needed that focus on ensuring that barriers to access health services for the Somalis and other minority groups are removed; information provided for these groups needs to be in accessible formats and in their mother language as recommended by the UN on human rights.
- Health researchers should address the development of cultural competency in the Finnish health care system in order to deliver high quality care for minority groups.
- Interdisciplinary cultural competency education must be incorporated into the orientation programs, on-going learning activities to maintain cultural competency, documentation systems, patient rounds, seminars and use of expert consultants to
increase awareness of the care requirements of culturally diverse clients and the dynamics of culturally diverse health care providers.

- Finnish health care policy makers must incorporate cultural competency and the provision of culturally congruent care into their vision and mission statements, policies and standard operating procedures, goals, and performance outcomes, all of which reflect an awareness of the diversity of the external community by the organization.

- Creation of multicultural affairs manager’s post, to deal with all issues related to cultural diversity and language services within primary and secondary health care services.

- Ethnic mental health consultants are needed to improve mental health care delivery to culturally and linguistically diverse clients.

- Transcultural committee should be created in Helsinki metropolitan areas. This committee will consist of representatives from all hospitals, health care centres, mother care clinics, dental care clinics and representatives from the biggest ethnic minorities and representative from ETHNO (the Advisory Board for Ethnic Relations).

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Appendices: