

**Welfare Research into Marginal Communities in Finland:
Insider Perspectives on Health and Social Care**

Kris Clarke (editor)

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Acknowledgements

The migrant community research project proved to be a very rewarding experience. The researchers involved in the project were dedicated to bringing out the concerns of their interviewees. Their enthusiasm and perseverance made this project work. On behalf of the research team, I'd like to thank the Ministry of Social Affairs and Health for believing enough in this project to provide funding. It is a significant recognition of a future multicultural Finland to include migrant voices in assessments of social and health care policies and practices.

We would like to thank all of the participants in these studies who offered their time and, most importantly, experiences – however difficult it was for them at times. Without them, there would be no research.

At the University of Tampere, Department of Social Policy and Social Work, Ossi Eskelinen, Paula Palin, Paula Ristimäki and Seija Pulkkinen helped make the paperwork flow when our Finnish language skills sometimes let us down. We would also like to thank Kyösti Raunio who came through for us when it came time to get this published.

Dr. Kirsi Juhila of the Department of Social Policy and Social Work at the University of Tampere participated in a seminar at the beginning of the project which helped familiarize researchers with qualitative research.

Dr. Ravinder Barn of Royal Holloway, University of London came all the way out to Tampere to participate in the final research seminar. Her comments on the papers were a very valuable contribution towards the completion of the final manuscript.

The members of the steering committee were very important in giving advice electronically. Their support and encouragement were very important.

Many thanks to Toni Vormisto whose computer skills came through at the critical time to get the manuscript ready for publication. We are also

grateful to San Francisco artist Lori Schafer for capturing the central idea of the project with her cover illustration. Warm appreciation is due to John Horn who put the cover together out of the kindness of his heart and with a pressing deadline.

Finally, the language correction provided by Aijaleena Ahonen really speeded up the final process. Her sensitivity with the texts was beneficial to the final result.

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Reader's Note

Each researcher is solely responsible for the content of his/her own article. In the interest of maintaining the anonymity of the interviewees, all names used in the research are pseudonyms. The interviews have taken place throughout Finland, unless otherwise noted.

Foreword

Dr Ravinder Barn

The social and economic landscape of Finland as a country is undergoing considerable change. The process of globalisation is resulting in a society that is becoming increasingly racially and culturally pluralistic. The evidence from multicultural societies around the world is that diversity can be exciting and challenging. Multiculturalism brings with it an important combination of vitality and new ideas, which are essential for the healthy development of societies. However, the possibilities of marginality, alienation and conflict are also ever present.

The problems encountered by minority groups can be many and complex. Generally speaking, problems may arise from a lack of sufficient resources which prevent minorities from functioning as full members of a society. Minorities may also encounter overt or covert discrimination. The ways in which a society responds to minority needs and concerns to reduce negativity and to afford equal opportunities is a sign of its maturity and wisdom.

As Finnish society becomes increasingly multi-ethnic comprising diverse family formations and religious and cultural traditions, it is important that an adequate understanding is developed to make appropriate provision for all its people. This report is a welcome addition as it helps to enhance our understanding of those on the margins of society. Kris Clarke, in her introductory chapter, sets the scene by providing a very useful context in which to understand the empirical findings presented in the main body of the report. The historical, demographic and theoretical underpinnings of Clarke's introductory chapter proffer a useful backdrop. An account of the social and health care services in Finland is a useful reminder of the status quo.

The researchers, Josephine Adjekughele, Arman Haghseresht and Judit Strompl, present excellent 'insider' accounts of groups of people who are on the margins of mainstream society. A particular focus upon user conceptualisations of health and

social care services provides an important understanding of the essential needs and concerns of minority groups. Notions of equality and fairness are raised to help promote understanding of those who have experienced upheaval and disruption and have a desire to make a better life for themselves. The report highlights the need for change at structural and local levels to bring about improvements in policy, practice and provision.

It is clear that the rapid changes in the racial and ethnic composition of Finnish society require parallel change in the provision of adequate help and support. The research findings, in the report, indicate the importance of developing a better knowledge base, adequate training for health and social care professionals, skilled and trained interpreters, adequate promotion of the availability of services, and a sophisticated professional response which takes into account diversity and difference in a variety of important ways.

The veracity and the inherent value of a multi-cultural society have become a recognisable feature of modern contemporary society. There is an important relationship between cultural diversity, innovation and creativity and economic welfare and growth. Unless and until we begin to cherish diversity and difference, we will not reap the possibilities of creativity, vitality and economic welfare and growth. Social justice and equality of opportunity need to be made a reality for the good of the society as a whole.

Introduction to the project: framing welfare and migrants in Finland

Kris Clarke

1. Notions of welfare, belonging and equality in the Finnish welfare state

Often contrasted to continental and liberal welfare state traditions, the Nordic welfare state is renowned for the high quality of its comprehensive cradle-to-grave social insurance. Though the reality is far more complex than this simplistic image, it is undeniable that the fundamental principle underlying the Nordic welfare state has been the notion of universal equality and social rights. Largely created in the post-war era, the Nordic welfare state is predicated on the social right of each member of society to have access to social and health care services regardless of socio-economic status. Welfare systems that ensure maternity, housing, unemployment, sickness and child benefits as well as income support have been an important means of reducing poverty and social inequality in Nordic societies. Indeed, the solidarity embodied by the Nordic welfare state has often been viewed as the essential glue that holds societies together in the best interest of individuals and communities.

There have been significant changes in the post-war international world order in recent decades. Among the important trends have been the massive shifts in income distribution worldwide, the transnationalisation of finance, the informational revolution, labour flexibility, increased human mobility, and an increasingly unstable world order. These changes have produced globalised socio-economic and political pressures that have challenged many of the basic Nordic welfare principles, both externally and internally. Questions have increasingly been raised in many Nordic countries about who has the right to be included in the social welfare net and who should be excluded.

Immigration has become the flashpoint of debates on the boundaries of solidarity and social rights in many Nordic countries. The Danish People's Party, which came to power in a coalition government in 2001, ran for office on the twin pillars of harsher restrictions on asylum-seekers and enforced integration into Danish society through a

carrot and stick approach to social welfare benefits as well as mandatory Danish language and culture courses. There has also been an increase in anti-immigrant incidents in Norway where the Progress Party, which calls for immigrants to adhere to Norwegian culture and values, has received increasing support. Heated discussions over integration have been prominent amongst and within the Nordic countries. Indeed, in 2002, the Danish Minister of Integration Bertel Haarder snarled that the Finnish Prime Minister Paavo Lipponen had no right to criticise Danish policy on immigrants when Finland itself accepted so few (Helsingin Sanomat 2002). The rejection of multi-ethnic Nordic societies is the underlying premise of this political trend that can be seen to a greater or lesser degree in each of the Nordic societies. Though, at the same time, it is important to mention that there have been significant steps in all of the Nordic countries to develop anti-racist networks that promote tolerance towards migrants.

Demographic developments in Nordic societies pose serious challenges to the maintenance of the welfare state. As the population ages and birth rate declines, there is a great need for skilled labour to replace retiring workers, particularly in the post-industrial shift to information-based technology (see, e.g., Raunio 2002). While leaders across the political spectrum have recognised the future need for foreign workers in the face of a declining population, there has been fierce debate over how this is to be achieved.

Public debate on immigration in Nordic countries tends to thrust foreigners into one of two categories: highly skilled global workers, which are viewed positively and thought to contribute to Nordic society, and refugees and asylum seekers which are viewed solely in terms of deficits and as a net drain on Nordic society. This division is clearly based on the difference in socio-economic status and often has a strongly racist subtext. Highly skilled global workers are educated and can often choose where they want to live. They are not subject to overly restrictive immigration laws and are even actively recruited by various national governments facing labour shortages in key areas. Asylum seekers, undocumented migrants and refugees, as well as others forced to migrate by circumstances beyond their control, have few financial means and often have little choice in where they eventually end up residing. These are the most vulnerable of migrants in the world and they face considerable barriers to

mobility across borders. Mobility for these vulnerable migrants is frequently marked by violence and life threatening situations. Security is elusive and residence in a country is often contingent on factors over which they have little influence.

It is the most vulnerable of migrants, those who lack opportunities, depend on social welfare benefits and have a precarious legal status, that have often been constructed as the greatest threat to the Nordic welfare state in public discourse. Refugees and asylum seekers are sometimes viewed as unskilled, lazy malingerers that threaten the cultural purity of Nordic societies. Visible signs of difference, such as the wearing of a hijab (head scarf) by Muslim women, are frequently constructed as negative examples of the refusal to assimilate into Nordic society by the mainstream, rather than viewed as positive signs of cultural identity. Indeed, two young Danish female researchers from the University of Copenhagen conducted an experiment in 2000 in which they walked around the capital city clad in the traditional Iranian chador. They reported the experience as a 'day of hell' during which they were verbally abused and received hateful gazes from passers-by (AFP 2000; Hussain 2000). Integration has thus become the litmus test for access to the Nordic welfare state, though there is no consensus of what this integration means. Growing tensions within Nordic societies regarding the future shape of the welfare state have thus been transposed onto the public debate over the reception of increasing number of asylum seekers entering Nordic countries and what impact this will have on Nordic cultural 'purity.'

Nordic social workers and health care providers have thus found themselves on the frontlines of these difficult questions regarding inclusion and exclusion. Article 22 of the Universal Declaration of Human Rights, passed by the General Assembly of the United Nations in 1948, states that all members of society, not just citizens, are entitled to the economic, social and cultural rights indispensable to the dignity and free development of the individual. The fact that social workers and health care providers are often required to check residence permits, social insurance cards and determine the right to access and eligibility on the basis of immigration law, rather than social welfare law, interferes with their ethical professional responsibility to provide the best possible care to clients and patients. Departing from a law enforcement, rather than caregiver, role ultimately harms the confidential trust necessary to good practice. Hence the political nature of the social and health care

profession is present as never before and Nordic caregivers have an obligation to speak out for the fundamental human dignity of all people, regardless of national origin, as an intrinsic human right of all residents of Nordic societies.

1.1 The construction of Finnishness in the social welfare state

Finland has a unique geo-political history that has had a strong impact on the development of ideas of citizenship and nationhood. After nearly 700 years in the Swedish Empire, and nearly 100 years as an autonomous part of the Russian Empire, Finland became an independent republic in 1917. The Finnish economy remained largely rural throughout the 19th century with a high number of landless agrarian workers. However, as industrialisation came to Finland in the late 1800s, an urban proletariat emerged that, along with landless peasants, was dissatisfied with the grinding poverty they endured. After achieving independence in 1917, there was a bloody civil war over the distribution of wealth and land in the relatively impoverished nation of Finland. Over the course of the Second World War, Finland fought against the Soviet Union as well as both against and with Nazi Germany. In the Cold War, Finland remained a strictly neutral country that trod a careful path between east and west. Finnish national identity emerged as an ongoing and contested project at the crossroads of empires and wars (Harle and Moisio 2000, 55).

Anneli Anttonen has pointed out that historically citizenship in Finland has a communitarian basis that can be seen as a legacy of the unification of the state and the Lutheran church tradition (Anttonen 1998, 357). Though there have always been small ethnic minority groups in Finland, such as the Romanies, Sami, Jews and Tatars, their traditions and cultures have largely been marginalised from the norm of Finnishness constructed by membership in one church, one community and one nation.

Contemporary notions of Finnishness are tied to the nation building legacy of the national romantic movement of the 19th century. At that time, Swedish was the primary language of education and administration as a consequence of Finland's long history in the Swedish Empire. The Fennoman movement, as it was known, promoted the use of the Finnish language and emphasised the unique qualities of Finnish

culture, which laid the foundation for Finnish nationalism. Though Finland remains a bilingual country today (Finnish and Swedish), the continuing societal focus on language and culture as proof of membership in Finnish society reaches back into the emergence of a national consciousness over a century ago. Hence notions of Finnishness have been strongly influenced by the construction of an image of cultural homogeneity that has remained strong despite social class divisions. These cultural factors have shaped ideas of universalism.

Though Finnish social policy in the early 20th century focused on improving the status of disadvantaged mothers and children, it was not until the 1960s that the impetus towards the developing a society that promoted the social equality of men and women became strong. The Finnish welfare state thus arose out of the process of the democratisation and institutionalisation of workers' rights (Anttonen 1998, 363). The welfare state arrived later in Finland than many of the other Nordic countries. However, inclusion in the welfare state was constructed as an intrinsic right of every Finnish citizen through the principle of universality. The greatest challenges to the Finnish welfare state materialised as a result of the deep recession of the early 1990s. Reductions in welfare provision came at the same time that an increased amount of migrants entered Finland. Many of the social policy decisions and cutbacks made then have had a deep effect on sharpening the borders of inclusion and exclusion in the Finnish welfare state as well as hardening public attitudes towards welfare entitlement.

1.2 Belonging and integration

As theories of transnational identity have emerged in recent years, notions of belonging have become ever more complex (Wahlbeck 1998). Though nation states have long been the metaphorical homes for the members of the nation, there is increasing recognition that belonging to a nation is not solely linked to a spatial entity. There are nations that exist which do not appear on any political map. Conversely, there are members of nations that never set foot on national soil. Globalisation and mobility have tended to increasingly deterritorialise nationality and ethnicity. Nations themselves are facing an identity crisis as growing ethnic, racial and cultural diversity

challenges traditional blood and soil stories of the origin of nations through political pressure for recognition.

In many ways, there are unique aspects of Finnish history that have influenced its path as a multiculturalising society in the 21st century. Being on the periphery and historically a subject of other empires, embodying a rather striking level of cultural homogeneity as well as its history of emigration, have all had a strong impact on the development of national attitudes towards perceived otherness. Finnish citizenship itself is based on the principle of *jus sanguinis*, the 'right of blood'. This implies that being a Finn is constructed as a mystified and reified genetic phenomenon. Tied together with Anttonen's argument that belonging in Finland has emerged in the unity between the nation and the Lutheran tradition; we can see that the boundaries of Finnish identity are closely tied to constructions of ethnicity, religion, and language as markers of community membership.

A sense of belonging is closely associated with membership in the state, though it is not required. The recognition of cultural diversity in a society often creates a platform for claims of political rights (Brah and Coombes 2000). Ethnic minorities in Finland have existed in rather small numbers and managed to preserve their cultures despite the fact that the issue of multiculturalism was not raised in public debate until immigration increased in the 1990s. Indeed, until the Alien's Act of 1983, there was very little legislation regarding foreigners. Residence permits had been administrative matters handled by the police. With the introduction of the 1983 Alien's Act as well as membership in the European Council (1989) and the adoption of the European Human Rights Convention in 1990, the legal security and social rights of migrants was more clearly defined. This represented a significant change in Finnish legal culture (Kauranen and Tuori 2002, 15). However, as Kauranen and Tuori further point out, while the Finnish Alien's Act is no more restrictive than laws in other Nordic countries, the practice of administering the law remains very strict.

In the early 1990s, there was broad recognition within Finland that it was 'internationalising' or 'multiculturalising'. This was largely due to the growing number of migrants and membership in the European Union. However, there was little agreement on what this would concretely mean in terms of cultural, social and

political recognition and rights (Clarke 1999). By the end of the 1990s, the policy of social integration became the official government line.

The Act on the Integration of Immigrants and Reception of Asylum Seekers (1999) was intended to enhance migrants' 'personal development' by requiring authorities to provide measures (such as Finnish language courses or vocational training courses) to help migrants into Finnish working life while encouraging migrants to preserve their own cultures. Each migrant was entitled to draw up a 'personal integration plan' in cooperation with the authorities. Usually, integration plans are drawn up in municipal labour offices or social services offices. Failure to follow an integration plan can result in reduced benefits. Hence integration measures are generally targeted at jobless migrants in a lower socio-economic position who require social assistance.

It has been frequently suggested that the main problem with integration measures is the lack of resources to meet the special needs of highly diverse groups of migrants (Heikkilä and Peltonen 2002, 7). There are many migrants who suffer from the consequences of traumatic experiences of forced migration and separation from loved ones. A very high amount of migrants are socially isolated in Finnish society and have little opportunity to practise the use of the Finnish language. Annika Forsander has argued in her dissertation on immigrants in the labour market that the national homogeneity of the Nordic welfare state structures has difficulty responding to growing cultural diversity. Businesses often do not recognise the edge that diversity can bring to a company in an increasingly competitive market. Furthermore, the labour market in Finland does not generally recognise the value of foreign degrees or training and the threshold to obtain employment is high (Forsander 2002). Integration thus remains a confusing concept to many migrants who feel hopeless about ever attaining a foothold in mainstream Finnish society. It can be argued that integration measures will only be successful when migrants feel a sense of belonging and meaning in Finnish society.

2. Cultural diversity in Finland

Due to its geopolitical location and history, Finland has traditionally been a country of emigration rather than immigration. Poverty has been the major driving force which

pushed Finns out to seek work in Sweden, the United States, Canada and Australia. The largest amount of Finnish emigration was to its neighbouring country, Sweden, where Finns remain one of the largest ethnic minority groups. There are still more Finns living abroad (approximately 250,000) than foreigners living in Finland (approximately 100,000) (Institute of Migration 2003).

There are some small minority groups in Finland that migrated many years ago, such as the Roma who came to Finland in the 16th century; Tatars, the descendants of Muslim soldiers who came with the Russian army in the 19th century; Old Russians as well as a small Jewish community. In addition, there are the indigenous Sami people of Lapland and the Swedish-speaking Finns. Each group has maintained its culture to a varying degree and has different experiences of discrimination and marginalisation; however it would probably be safe to say that they all consider themselves to be part of Finnish society.

2.1 Brief history

The first refugees in Finland came in the 1970s from Chile and Vietnam, though they were very few in number. For example, there was a total of 182 Chileans that arrived in Finland between 1973 and 1977. It is, however, interesting to note that most of the Chilean refugees have moved on to another country or returned home (Kauranen and Tuori 2002, 6). Starting in 1986, the Finnish government agreed on a certain number of quota refugees to accept each year, with 100 refugees accepted the first year (Finnish Government 2002, 5).

In 1990, President Mauno Koivisto stated that he thought that Finland owed a ‘debt of honour’ to the Ingrians, a small group of people of Finnish ancestry resident in the former Soviet Union. Koivisto considered the Ingrians to be ‘returnees’, under the *jus sanguinis* principle, rather than foreigners. This meant that Ingrians did not have to go through the same immigration procedures as other groups of migrants. Koivisto’s policy started a chain migration of approximately 30,000 people in the ensuing

decade, though there are currently moves afoot to limit the numbers of Ingrians coming to Finland by instituting a mandatory language test.

Immigration to Finland increased sharply in the 1990s at the same time as one of its deepest recessions in modern history. A growing number of refugees and asylum seekers worldwide contributed to this rise, though overall numbers of migrants in Finland are low. One of the striking facets of the immigration of the 1990s was its enormous diversity. Finland does not collect statistics on ethnicity, but rather on language groups and nationality.

2.2 Population trends in the 21st century

There are several significant population trends in contemporary Finland that indicate a growing cultural diversity. Finland is a bilingual country with 92% of the population reporting Finnish as their native tongue and 5% listing Swedish. However, we can see that .6% now report Russian as their native language as opposed to .3% with Sami as a mother tongue (the language of the indigenous people of Lapland). The next largest language groups are Estonian, English and Somali (Statistics Finland 2003). The increasing linguistic diversity in Finland may have a significant impact in the future direction of multicultural policy.

Another significant trend is the rising number of marriages and cohabitation between Finns and foreign citizens (Institute of Migration 2003). Additionally, there are a growing number of international adoptions. This indicates that Finland is becoming a more culturally and ethnically diverse society from within, not only from without through immigration. This may pose interesting future challenges to constructions of 'Finnish blood.'

2.3 Immigration statistics

The Directorate of Immigration, which was established in 1995, processes matters regarding the entry and residence permits of foreign citizens, refugees and asylum seekers in Finland. All foreign citizens resident in Finland must register at the local police who issue residence permits.

Foreigners in Finland

Country of citizenship:	1990	1995	1996	1997	1998	1999	2000	2001
Russia	.	9 720	11 810	14 316	16 861	18 575	20 552	22 724
Estonia	.	8 446	9 038	9 689	10 340	10 652	10 839	11 662
Sweden	6 051	7 014	7 291	7 507	7 756	7 809	7 887	7 999
Somalia	44	4 044	4 555	5 238	5 371	4 410	4 190	4 355
Yugoslavia ¹⁾	75	2 407	2 624	2 755	2 935	3 392	3 575	4 240
Iraq	107	1 341	1 855	2 435	2 670	2 960	3 102	3 222
United Kingdom	1 365	1 865	1 803	1 907	2 058	2 170	2 207	2 352
Germany	1 568	1 748	1 836	1 961	2 072	2 162	2 201	2 327
Former Soviet Union	4 181	6 163	5 187	4 675	3 628	2 966	2 447	2 249
Iran	336	1 275	1 397	1 681	1 706	1 868	1 941	2 166
USA	1 475	1 844	1 833	1 905	2 001	2 063	2 010	2 110
Turkey	310	1 335	1 479	1 668	1 737	1 737	1 784	1 981
China	312	1 412	1 471	1 610	1 650	1 677	1 668	1 929
Vietnam	292	2 084	2 143	2 171	1 965	1 840	1 814	1 778
Bosnia and Herzegovina	.	928	1 342	1 420	1 496	1 581	1 627	1 668
Thailand	239	763	864	964	1 084	1 194	1 306	1 540
Ukraine	.	366	536	654	766	849	961	1 133
Others	9 900	15 811	16 690	18 044	18 964	19 775	20 963	23 142
Total	26 255	68 566	73 754	80 600	85 060	87 680	91 074	98 577

1) Former Yugoslavia and Federal Republic of Yugoslavia.

Source: Statistics Finland, Demographic statistics

The amount of asylum seekers in Finland has fluctuated somewhat throughout the 1990s, but the numbers remain staggeringly small compared to many European Union member states.

Asylum-seekers and refugees

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Asylum-seekers	3 634	2 023	839	854	711	973	1 272	3 106	3 170	1 651
Decisions on asylum ¹⁾										
- Asylum granted	12	9	15	4	11	4	7	29	9	4
- Residence permit granted	564	2 073	301	219	334	277	372	467	458	809
- No asylum or residence	1 344	1 435	492	276	248	278	240	1 330	2 121	1 045

permit granted										
Family reunification										
- Opinions in favour/decisions in favour ²⁾	-	1 208	323	250	226	509	240	185	214	495
- Adverse opinions/decisions ²⁾	-	838	765	880	513	299	769	362	392	785
Quota	500+	500+	500	500+	500+	500	600	650	700	750
- Additional quota	200	200	-	500	500	-	-	-	-	-
Refugees received by municipalities ³⁾	2 349	3 689	1 412	1 415	1 193	1 406	958	1 189	1 212	1 857
Immigrating as refugees, from 1973-	6 361	10 050	11 462	12 877	14 070	15 476	16 434	17 623	18 835	20 692
1) Decisions of the Directorate of Immigration. 2) From 1 May 1999, decisions. 3) Refugees by quota, asylum-seekers having received a favourable decision, persons admitted under the family reunification scheme.										

Sources: [Ministry of Labour](#); [Directorate of Immigration](#)

There is little information about undocumented migrants in Finland, though the number is thought to be low. There are, nonetheless, indications that the amount of undocumented migrants is gradually increasing in Finland, largely due to trafficking in prostitution (Nurmi 2002, 182).

3. Social and health care services and migrants in Finland

Finland has a comprehensive national social and health care system that is implemented by municipalities or federations of municipalities. All migrants with permanent residence status in Finland qualify for a social insurance card which provides access to all social and health care services in the municipality of residence in the same way as Finnish citizens. Foreign students at Finnish educational institutions have access to student health services, while migrant workers have occupational health services. Asylum seekers are provided with health care services at their resident reception centre. In theory, all migrants legally registered in Finland,

even on a temporary basis, should have access to primary health care. However, there is little research on this issue.

3.1 Equality and universalism in social and health care

Universalism is one of the most important basic principles of the Nordic welfare state. In practise, it means that citizens and permanent residents have social rights to access social and health care services regardless of income level or work status. This is tied to the notion of equality which is conceived as the fundamental rights of all citizens to be equal before the law and to receive universal services.

Certain population groups, such as the disabled and children, have so-called 'subjective rights'. Subjective rights are defined in Finnish law as universal rights for individuals that fulfil certain criteria to receive special services. For example, all children over the age of three have a subjective right to a day care placement. This mandates municipalities to provide these services for all children and leaves no room for discretion. Subjective rights in Finland are powerful tools to guarantee the client's equal position in the social and health care system.

For the most part, migrants do not have subjective rights. Language interpretation is a good example of the complexity of migrant rights in the law. While language interpretation is recommended in social and health care situations when the client or patient does not have adequate language skills to understand, this is not a right but a recommendation. The provision of interpretation services thus depends on the amount of existing resources as well as the availability of qualified interpreters. A migrant therefore only has the subjective right to receive interpretation in an official situation or action which is initiated by the state. What this implies is that the right of migrants to linguistically appropriate services is entirely dependent on whether the authorities decide that it is necessary.

In the 1990s, there has been a tendency towards ensuring the rights of clients and patients in the Finnish social and health care system. The Act on the Status and Rights of Patients (1992) is an example of an important piece of legislation that guarantees the right to informed consent, the right to see one's own medical records and right to

lodge a complaint. The development and enhancement of a network of ombudsmen have also served to support the rights of clients and patients in the social and health care system in Finland.

3.2 Equality in practise

Finnish policy towards migrants in the social and health care system is one of integration. Underlying this policy is a notion of equality which tends to be constructed as a normative concept. Special services for migrants in social and health care are conceived by the Finnish authorities as potentially stigmatising and marginalising. Hence integration is conceived as the best way to ensure equality for all patients and clients. The policy of integration in social and health care reveals a culture-blind approach to the question of equality in social and health care services. Indeed, conceptualising equality in these terms constructs it as a passive standard which does not recognise the validity and significance of cultural diversity in the caring encounter.

Culturally homogeneous Finnish notions of personhood, belonging and community have been fostered through the national identity project and tradition of the Lutheran church. This has had a strong influence on concepts of equality. Students of social work and health care rarely have the opportunity to take courses in cultural competence or consider care from an intercultural perspective. Social work researcher Kathleen Valtonen has noted that ethnocentrism means assuming that one's own group is the standard by which all others must be judged (Valtonen 1999, 60). Notions of equality in social and health care services in Finland are often based on ethnocentric perceptions of help-seeking behaviour and means of helping. There are few ways to challenge the cultural assumptions of professional training or practises in the field because there is not a culturally diverse workforce in the caring professions that could raise such questions from a professional standpoint. There are also no patient advocacy organisations promoting the rights of culturally diverse people that could raise these concerns as issues of inequality.

Though the universalist premise that services should be accessible to all is a fundamental human right, it is important to underline the significance of culture, ethnicity and residence status in provision of services. As noted before, migrants do not have subjective rights to obtain culturally and linguistically appropriate services. According to Finnish law, equal opportunities in terms of language are provided only to migrants with a permanent residence permit. Permanent residents of Finland have a subjective right to interpretation and translation services in a specific procedure if the action is initiated by the state or municipality. These types of situations usually involve contact with the police, law courts or infectious disease control. If the matter is initiated by the migrant, such as an appointment at the labour office, health care centre visit or social welfare office visit, then the authorities are not required to provide interpretation or translation assistance. All clients have the right to bring an assistant with them to income support appointments, but the municipality is not required to provide such help. Migrants may not be informed of their right to bring an assistant. The lack of rights to culturally and linguistically appropriate services places migrants in an unequal position.

In Finland, cultural competence is not considered an essential practise skill nor is it a core part of social and health care curriculum in polytechnics and universities. As Kathleen Valtonen has pointed out, social and health care workers need cultural competence skills to work with culturally diverse clients that are often in crisis (Valtonen 1999). Migrants' social isolation and poor help-seeking skills in Finnish society, combined with the lack of culturally competent caregivers and high threshold to gaining entrance to many services, tends to deny migrants access to the social and health care services to which they are rightfully entitled. One of the great challenges of Finnish social and health care policy and practise in the 21st century is to develop culturally competent services that can meet the needs of a diversity of clients and patients.

4. The research process of this project

4.1 Rationale

The most cost-effective way to maintain health and avoid expensive medical procedures is a comprehensive program of culturally competent health promotion information and activities. Preventive health interventions and policies are most effective when there is adequate knowledge of community expectations and needs. Immigration is a new phenomenon in Finland and there is little information from the perspective of migrants and their communities on how Finnish health care services can improve their cultural competence to meet the needs of a culturally diverse population. According to recent research, the amount of migrants in Finland has quintupled since 1987 (Pitkänen and Kouki 2002, 105). This means that the amount of migrants using the Finnish health care system is set to increase thus placing new demands on health care delivery. This project aims to provide general and concrete information to policymakers, practitioners and students of health, both nationally and internationally, on migrants in vulnerable circumstances in the Finnish health care system.

By developing a community research model, this project develops a community health psychology perspective (de la Cencela et al. 1998) with the following intended outcomes:

- Development of concrete information for policymakers and practitioners to improve the health care delivery to migrant communities
- The empowerment of migrant communities in health promotion
- Development of concrete information on how to improve cultural competence in working with migrant communities for policymakers, practitioners and health educators

In the spring of 2002, the Ministry of Social Affairs and Health approved funding for a small-scale migrant community health research project to be co-ordinated by the University of Tampere, Department of Social Policy and Social Work. The idea of the

project was unique: to link key persons in migrant communities with academic support in order to produce qualitative studies on migrant communities' perspectives on social and health care services.

4.2 Forerunner to the project

The idea for this project came from a qualitative study carried out in 2000. The European Project AIDS & Mobility conducted a study on African Communities in Northern Europe during 2000-2001. The aim of the project was to gain a deeper insight into the perception of HIV in African communities in Northern Europe. Two researchers from ethnic minority backgrounds were recruited to conduct in-depth interviews with members of the African community in Berlin and Finland. These researchers were recruited because the perspective of ethnic minorities on their own communities is often overlooked or dismissed. Indeed, the richness of the data collected by these researchers made an important contribution to understanding the need for professional development in the social and health care fields as well as specific information relating to African communities and HIV/AIDS. This study is published by the Netherlands Institute for Health Promotion and Disease Prevention.

4.3 Insiders as experts on their own communities

This project departed from the notion that research on migrants must benefit migrant community. Though there has been greater investment in research on migrants in Finnish society in recent years, very little research has been carried out by migrants themselves. Researchers commonly bring unconscious biases and stereotypes to their research. There is often an ethnocentric tendency to disregard migrants as experts on their own communities who might have the knowledge and skills to do a study.

Therefore, the fundamental question raised by research on migrant communities is: Who has the interpretive authority to represent and analyse information on migrant communities? The primary purpose of this research project was to empower migrants themselves as experts on their own communities in order to better bring out the voice and perspective of migrants on these important issues. Hence this project involved

migrants as the central actors and decision makers in this project as the point of departure.

4.4 Structure and working method of the project: working together as a project team

The project took place over a one year period. An international steering committee of multidisciplinary professionals was convened electronically. Seven migrants applied for the position of community researcher. A summary of each candidate (without names) and his/her research aims was sent to the steering committee. The researchers were selected by majority vote of the steering committee based on the perceived relevance of their topics. Five researchers were initially selected.

There were four seminars that took place every four months over the one year period of research. During the seminars, each researcher had two hours to discuss his/her own work. Other researchers gave feedback and offered advice. Dr. Ravinder Barn of the steering committee came to Tampere from London to participate in the final seminar in which the final drafts of each manuscript were discussed.

When the first drafts of the manuscripts were ready, they were circulated to those members of the steering committee that had time to give comments. This research structure supported the needs of the researchers well and provided a good forum for dialogue.

The path to completing the research was long and arduous. Although the project started with five researchers, due to the huge time commitments and personal reasons, two researchers had to drop out. Doing this kind of research meant that each researcher had to commit him- or herself to an intensive process over a one-year period that often meant reflecting on one's own purpose and meaning in Finnish society as well as one's own feelings as being a migrant in Finland. It meant listening to very difficult stories and making complex decisions about how to represent and discuss painful issues. Through the seminar method, academic support was provided to the researchers as well as teamwork was developed. Researchers had the opportunity to brainstorm and discuss their own work at length which significantly enhanced the research process and quality of the manuscripts.

4.5 The studies

There are three studies in this collection. These studies explore the broader issues of equality and integration on a local level and examine what the Finnish welfare state means to those who are not Finnish. One subtext that runs throughout each of the three articles in this collection is the notion of belonging and the attempt to build a future in a sometimes hostile and non-supportive community. The contested nature of Finnish notions of equality is also an important theme that runs through each one of these studies. Each study provides a wealth of information and insight into migrant communities in Finland and their relationship with the Finnish welfare state.

Josephine Adjekughele's study focuses on the experiences of women from the African continent in the Finnish child/maternal health care system. In her article, we can see the everyday struggles and joys that many women faced during the process of having a child in Finland.

Arman Haghseresh't's study explores the health care experiences of Iranian asylum-seeking families. His work movingly recounts the personal toll that this system has on families that often wait many years for a decision. He shows the difficulty of living with uncertainty on the margins of a society that does not necessarily want you.

Judit Strömpl's study presents the assessments of Estonian and Russian sex workers in Helsinki of the Prostitution Counselling Centre. She opens a window on the lives of these mobile sex workers that are invisible and voiceless in Finnish society.

These studies represent the important first steps towards developing a dialogue with migrant communities on how to enhance and improve social and health care services to underrepresented and invisible communities.

5. References

Agence France-Presse (2000) "Hijab experiment." Reported 22.4.2000
<http://www.sunnahonline.com/film/sisters/0003.htm>

AIDS & Mobility – African communities in Northern Europe and HIV/AIDS.
http://www.aidsmobility.org/frame_research.htm

Anttonen, Anneli (1998) "Vocabularies of Citizenship and Gender: Finland" in
Critical Social Policy. Vol. 56, 18:3. 355-373.

Brah, Avtar and Coombes, Annies (eds.) (2000) *Hybridity and Its Discontents: Politics, Science, Culture*. London: Routledge.

Clarke, Kris (1999) *Breaking the Bounds of Bifurcation: The Challenge of Multiculturalism in Finnish Vocational Social Care Education*. Tampere: University of Tampere.

de la Cancela, Victor; Chin, Jean Lau and Jenkins, Yvonne (1998) *Community Health Psychology: Empowerment for Diverse Communities*. New York: Routledge.

Directorate of Immigration (2003) News and statistics.
<http://www.uvi.fi/englanti/ajankoht.html>

Finnish Government (2002) *Government report on the implementation of the Integration Act*. Government report 5. <http://www.mol.fi/migration/govrep.pdf>

Forsander, Annika (2002) *Luottamuksen ehdot. Maahanmuuttajat 1990-luvun suomalaisilla työmarkkinoilla*. Helsinki: Väestöliitto väestötutkimuslaitos D 30 2002.

Harle, Vilho and Moisio, Sami (2000) *Missä on Suomi? Kansallisen identiteettipolitiikan historia ja geopolitiikka*. Tampere: Vastapaino.

Heikkilä, Elli and Peltonen, Selene (2002) "Immigrants and integration in Finland." Institute of Migration, Turku.
<http://www.utu.fi/erill/instmigr/art/Heikkila&Peltonen.pdf>

Helsingin Sanomat (2002) "Danish integration minister rejects criticism of Denmark's policy towards immigrants." <http://www.helsinki-hs.net/news.asp?id=20020211IE7>

Hussain, Mustafa (2000) "Islam, minorities and media in Denmark." In: *Current Sociology*. Vol 48 (4), October 2000.

Institute of Migration (2003) Migration statistics. (Jouni Korkiasaari)

Kauranen, Ralf and Tuori, Salla (2002) "Mapping minorities and their media: The national context – Finland." National report. European Media Technology and Everyday Life Network, London School of Economics.
<http://www.lse.ac.uk/collections/EMTEL/Minorities/reports.html>

Pitkänen, Pirkko and Kouki, Sari (2002) "Meeting of foreign cultures: a survey of the attitudes of Finnish authorities towards immigrants and immigration." In: *Journal of Ethnic and Migration Studies*. Vol. 28, No. 1: 103-118.

Raunio, Mika (2002) *Suomi globaalitalouden ossajien valintojen kentällä. Ulkomaalaisten huippuosaajien mielikuvat ja todellisuudet suomalaisessa työ- ja kaupunkiympäristössä*. Tampere: University of Tampere. Sente-julkaisuja 12/2002.

Schaffner, Eva Matter (2003) "'Freed from a mental yoke': Denmark tightens its immigration laws." In *Neue Zürcher Zeitung*. (8.3.2003) NZZ Online http://www.nzz.ch/english/background/2002/06/26_denmark.html

Statistics Finland (2003) http://www.stat.fi/tk/tp/tasku/taskue_vaesto.html

Valtonen, Kathleen (1999) *Pakolaisten integroituminen Suomeen 1990-luvulla*. Helsinki: Ministry of Labour.

Walhbeck, Östen (1998) "Transnationalism and Diasporas: The Kurdish Example." Paper presented at the International Sociological Association, XIV World Congress of Sociology, Montreal, Canada.

A Reflection on Finnish maternity and child health clinics from the perspective of mothers from the African continent

Josephine E. Adjekughele

1. Introduction

This is a qualitative report on immigrant experiences in the Finnish maternity and child health clinics based on interviews of women who occupy the margins of the health care system. The study focuses on the experiences of African mothers in pregnancy to under school age child¹ health care. This research is not meant to examine issues that are totally unrelated to health issues of mainstream society, but rather explores the issue of Finnish maternity and child health care from a particular vantage point. The national health care system influences the lives of all females and males irrespective of cultural background and socio-economic status. In economic terms, if there are more sick people in Finland; a larger proportion of the nations' revenue generated from taxes will be needed for the annual health care budget. Hence the perspective of marginalised people on the national health care system is also significant to the mainstream population in terms of developing health care policies and good practice.

Finland has a national health system in which all citizens and residents are entitled to care with a minimal fee regulated by the Law on Client Payments (1992/734). In Finland, the Ministry of Social Affairs and Health provides guidelines to municipalities regarding the provision of health services for both Finnish citizens as well as immigrant residents. The Finnish National Health Service serves a larger percentage of the population than the private health care sector (Ministry of Social Affairs and Health 1996, 31). Finland's health service scheme is directly administered

¹ Under school age child in Finland refers to any child who has not started the primary school. A child below seven years of age, or will be seven during the year in which the child starts first grade, fall under this category.

on a municipal basis (Clarke 1999). In 1995, there were 243 health care centres in Finland. Each municipal health service structure consists of a number of hospitals and clinics situated in separate districts within municipalities or cities “administered by a joint municipal board” (Ministry of Social Affairs and Health 1996, 24).

It is useful to analyse a specific segment of health care users because it provides a vital microcosm to better understand the progressive nature of the Finnish health care system and its connection to the wider social structure. Research on the experiences of mothers is a good point of departure from which to discuss the role of health care providers and the broader social implications of their care. The focus of this research is thus how mothers on the margins are treated and reckoned with, from the mothers’ own perspective. Thus, the study is a reflection on the operations of the Finnish maternity and child health care system as perceived by different ethnic groups within the all-encompassing term ‘African communities.’ Immigrant² dwellers are marginalised groups and tend to be the most vulnerable set of people in any country. Nevertheless, what is paramount in this enquiry is that it paved the way for the voices of minority women to be raised by allowing the women to narrate their own experiences without fear, favour, or manipulations.

One cannot write holistically about maternity and child health care systems if one withdraws from listening to the experiences of those who are using the services provided by the system. Therefore, it is essential to take into consideration how people have experienced the services irrespective of country of origin, race, cultural background, religion, socio-economic status, and level of education. This is in line with the idea that “...one cannot write about homelessness without hearing about it from the homeless.” (Granfelt 1999, 94) The users of the maternity and child health clinics comprise both majority and the minority groups. Immigrants and their families are sometimes not regarded as an integral part of the Finnish social and health care system. There are communities that have not been fully considered or studied in analyses of specific health care issues in many countries in Europe (Edubio 2001). It is important to point out that the only way to give health care providers and other

² Immigrants and migrants are used interchangeably to designate the African community and African ethnic minority groups.

ancillary workers to feedback about the quality of their services as perceived by diverse communities is to listen to the stories of those who receive health care services from precisely these minority communities.

The study deals with cultural, social, and administrative phenomena that influence the manner in which public health care services are rendered and received. Public health can be viewed as “...a social enterprise with a community orientation.” (Schlesinger 1985, 129) Schlesinger argues that the boundaries of traditional public health are expanding:

This definition anticipates the continuous extension of public health boundaries. These boundaries have grown from an initial focus on gross environmental sanitation, to preventive medicine, to a focus on the behavioural aspects surrounding health behaviour and care, to assuring the availability of comprehensive health services for all (Schlesinger 1985, 128).

This study departs from a community-based viewpoint. The data comes from interviews in which I discussed the main issues regarding the respondents’ maternity and child health care encounters, social-legal status and the environmental conditions surrounding their experiences. Finally, I derive the health care needs and policy recommendations presented at the end of this report from the totality of the analysed interview data.

2. What is the Finnish maternity and child health care system?

There is an extensive child and maternity health care system in Finland. Clinics are divided into child health clinics (*lastenneuvola*), maternity clinics (*äitiysneuvola*), and family planning clinics (*perhesuuniteluneuvola*). There are also family counselling centres, which I will not consider in this study because they belong to the field of social work. All of these clinics play vital roles in the Finnish national health care system. The Finnish child health clinic renders a broad spectrum of health services to both Finnish and immigrant families. Finnish health care policy emphasises equal access to health care services by all residents of Finland. Maternity and child health care clinics provide services free of charge.

These clinics are intended to help expectant mothers and their families, to learn and attain skills, as well as to be aware of the competence needed to support the growth and development of the child. These services create opportunities for healthy families to better understand and cope with their health problems by giving appropriate counselling, health screening and providing treatment for health related problems. Thus, the objectives of these clinics include care of the expectant mother and foetus, to prepare the family for the delivery of the baby, and supporting parents in coping with health related issues (National Research and Development Centre 2000).

All pregnant women resident in Finland must register at their local maternity health clinic by the fourth month of pregnancy to receive maternity benefits from the Social Insurance Institution. Approximately 99% and 97% of all children are registered at maternity and child health clinics (Kolimaa and Vallimies-Patomäki 2002).

3. The aims of the research

It is an indisputable fact that health is one of the most important issues in all human lives. On the local, national and international level there is a great need for government health care policymakers, health care providers, planners, and medical educators to better understand the complexity of health issues surrounding different migrant groups in their respective countries (Edubio 2001, 22). One way of enhancing understanding of migrant health and social conditions can be achieved through research conducted by an *insider* within a particular community. An insider perspective reflects deep reserves of cultural understanding of the community in question which are often unavailable to outsiders.

This study aims at listening to the health care experiences of women from Africa to better understand how they consider their position in the Finnish health care system and to bring out the maternity and child health care needs of the marginal migrant communities. Since this is a collaborative research project with other community researchers, we have agreed that all the researchers ought to have the same research questions but developed different analytical approaches. We came up with the following two common research questions:

- How do these respondents assess their position/situation in the Finnish health care system?
- What expectations/needs do these respondents have regarding the Finnish health care system?

The specific questions used in the interviews are in Appendix 1.

4. African communities in Finland

In 2001, the percentage of foreign nationals living in Finland was approximately 2% of the total population of 5.2 million (Sorainen 2001). Russians and Estonians are the largest immigrant groups in Finland (Korkiasaari 2002). It is impossible to obtain exact figures regarding the composition of the African community in Finland. This is due partly to the fact that some of these people have already naturalised as Finnish citizens while others have left the country. This makes the African community, like all other immigrant communities, complex in terms of comprehensive statistics. The largest number of Africans live in the Helsinki metropolitan area while a small number live in Turku, Espoo, Tampere and a smaller number in the northern part of the country.

It must be stressed that the African community includes people who have migrated to Finland as Africans from all areas of the continent. Hence these people have different cultural backgrounds, religions, and speak different languages. The most widely spoken languages are English, French, Somali, Swahili, and Portuguese. Thus the African community is heterogeneous in nature. Official statistics show that Africans have immigrated from Somali, Morocco, the Democratic Republic of Congo, Ethiopia, Ghana, Mozambique, Nigeria, Cameroon, Egypt, Algeria, Kenya, Tanzania, and South Africa as well as other parts of Africa (Institute of Migration 2002).

The African community in Finland is very diverse. African nationals in Finland have a variety of legal statuses including refugees, asylum seekers, workers, students, spouses, and so on. Recent demographic data in Finland indicates that people born in Africa are the third largest continent group (Institute of Migration 2002).

Foreign born population by continent of birth³

Europe	102,156
Asia	20,256
Africa	10,256
America	6,555
Oceania	796
Unknown	4,685

Korkiasaari 2002

It has been estimated that only 36% of African citizens residing in Finland were female in 1999 (Institute of Migration 2002). However, it is important to be cautious in interpreting these statistics because they do not reflect those people who have become naturalised Finnish citizens. Nonetheless, the statistics do suggest that the majority of African migrants in Finland are male.

In summary, the African community in Finland can be characterised as highly heterogeneous in terms of culture, nationality, legal and socio-economic status.

5. Defining the target group for this study

The target group for this research study constituted African women resident in Finland who have used maternity and child health care services. They could be pregnant women, mothers or nursing mothers. All respondents were women born on the African continent, which included women from the northern part of Africa as well as from Sub-Saharan African. The women were drawn from a limited number of towns in Finland: four big towns and one sparsely populated municipality. Moreover, it seems pertinent to indeed mention that most of the respondents have lived in more than one municipality in Finland.

6. General research orientation

It is worth emphasising that the research orientation of this study embraced and incorporated elements of the gender approach utilised by the World Health Organisation (World Health Organisation 1997, 83). The gender approach used here dismisses the idea of separating women and their position in society from their health:

³ The categorisation of continents was devised by the statistician.

...[the gender approach] brings into the analysis how the different social roles, decision making powers and access to resources between women and men affect their health status and the access to health care. It examines how these differences [affect] access to the benefits of technology, information and services, and ability to protect oneself from disease and ill-health. (World Health Organisation 1997, 83).

The research approach is also formulated in such a way that there is representative data from nationals from the northern, southern, western, and the eastern parts of the African continent. Implicitly, each of these parts has diverse cultures, languages, and histories, which were not underestimated when considering the variety of experiences related by the respondents. Sub-Saharan African communities as well as North African communities are most strongly represented in this study. The core focus is to explore the social status of the women and their families, their education levels, their length of time in Finland, and their experiences in the Finnish maternity and child health care system.

7. Methodology

7.1 Data collection and paths to enlisting participants

The course of finding the respondents for the study was an interesting, but a non-linear process. Most of the respondents I have seen on the streets, in shops, churches, in the university buildings, as well as in African shops. One of the respondents, Angela, is a friend whose shop I have patronised for years. I first told Angela about the research and she declared her willingness to participate. She was the first lady I interviewed. She told her customers, who fell within the target group of the study, about the research and gave their contact numbers to me if they were willing to participate in the study. Thus, through a kind of snowball effect, I began to gather participants for interviews. I called each potential interviewee individually and explained what the research is about.

I knew a few of the respondents before starting this study, in that way some of them were familiar faces. I stopped African mothers when I saw them at popular meeting places and told them briefly about the importance of the study. Many of them complained that it would not be of any benefit to them. I tried to tell them that

community based research creates social avenues for them to voice their health experiences and problems. A few of them impatiently replied that the maternity and child health clinics were very good.

Two of the respondents were willing to disclose their identities (names) while the others refused to have their identities revealed. I assured them that it would be kept confidential. In other cases, some of the women refused to be contacted and thus did not give their contact numbers. I was very surprised to see that one lady whom I knew very well refused to be contacted about the research. Nevertheless, she did not say 'no' directly but rather in the African way.

Without a doubt, being an African woman myself was one reason that it was possible for me to have the confidence to approach the women, especially to introduce myself to the unfamiliar faces and then tell straightaway about the research. Of course, they asked many questions about me and I had no choice than to reply to them in a friendly way. The fact that I am an African woman who can speak both English and Finnish served as the greatest advantage in enabling me to find the respondents. I approached many men from the northern part of Africa on the streets, and at the university. I introduced myself and told them what I do for a living as well as about the research. They thought it was interesting and important. I said that I would like to interview their wives during the months of June and July and they gave me their telephone numbers. Unfortunately, when I contacted them during those months many of their wives were on holidays either in their homeland or in another city in Finland.

As I had difficulty contacting some women during the summer months, I had no other choice other than to go to the mosque on a Friday. In the mosque, I found only men and I was kindly told that the women are away on holidays. They recommended that after the summer, I should come back and I would find women. On the whole I was in a position of contacting seven other women who either refused to participate, or were away on holidays, or just did not want to be contacted.

7.2 The respondents

There were eight African women who participated and were, at the time of the study, already biological mothers. Two Finnish public health nurses were interviewed as well. My aim in interviewing the nurses was to obtain information about how they deliver their services, the various kinds of information they offer to their patients, and also to hear about their views on working with immigrant patients in general. This enabled me to compare and contrast the research findings. The respondents were assured anonymity. Hence the following pseudonyms were used:

<i>Angela</i>	<i>Jane</i>	<i>Claire</i>	<i>Rachel</i>	<i>Tina</i>
<i>Cherry</i>	<i>Asha</i>	<i>Stella</i>	<i>Nurse Tuula</i>	<i>Nurse Anna</i>

7.3 Conducting the interviews

In this study the researcher positioned herself as a ‘conversation mate’ with the respondents since she is an ‘insider’ in the community. I used individual face-to-face interviewing in the form of a conversation. I came to an agreement with the respondents regarding the most comfortable place and time for them to be interviewed. At the start of every round of interviewing, I asked if I could record the conversation on tapes. Six of the eight African respondents refused to be tape-recorded. Two of the participants were interviewed at my home; one of them at her home; while the others preferred the coffee break room of a shop. I interviewed the respondents individually, though two of the respondents had special needs. These respondents had French and Somali as their native languages. One of these respondents wanted and chose somebody who knew her well to translate very difficult expressions to me. The other respondent was interviewed with her husband present. The remaining respondents were interviewed using either Finnish or English language. This also was the case with the two public health nurses interviewed.

I used an open-ended structured questionnaire to serve as a reference. This made it possible for me to focus on issues surrounding the questions. The respondents first narrated their experiences. When they finished, I realised that some issues in my

questionnaire remained open. What I did was to throw questions from my questionnaire, which I had on the table. That in turn, stimulated their thinking and they answered all questions and raised other issues as well. We had enough interview time. On average, I spent two-and-a-half hours for each interview. I had to write down the discussions when I was not permitted to record the respondents' voices. Refreshments were provided during the interview by the host and the respondents suggested that they would like me to prepare Nigerian food for them someday after the research is completed. One of the women from North Africa promised to make Moroccan food as well. They see this as a means to socialise and to get to know about each other's national dishes and to talk informally about other socio-cultural life issues. Many of the women complained that the social life in Finland made them sick. They felt that people looked cold and overly serious.

7.4 Interview data analysis

Before I started collecting the primary data I prepared a questionnaire which comprises four parts of interview questions:

- background information
- questions concerning maternity clinics
- questions about postnatal clinics and child health clinic
- questions that sought to identify information needs, socio-cultural gaps and problems (See Appendix 1 for the detailed structure of the questionnaire).

I collected the primary data for the study from ten women who were interviewed during a period of three months. Most of the interview data was written down because very few of the respondents felt comfortable having their voices recorded. Afterwards, I carefully documented the written texts and the recorded information were all transcribed in a sequential order on paper and electronically. I rearranged the transcribed information where I endeavoured to match research questions with the appropriate replies of the respondents. I selected the information needed in analysing the research outcomes and combined it with the secondary source material directly produced by the social and health institutions in Finland and other literature.

When transcribing the interviewees' replies, I have tried not to alter their notions and misrepresent their replies. In the interpretation of the research outcomes I felt that it

is my responsibility as the researcher to report respondents' experiences in a simple and clear manner understandable to the reader. I have therefore modified some sentences to render the meaning unambiguous. In a number of cases I replaced the names of places in Finland with another city or municipality to preserve the confidentiality of the participants.

It must be mentioned that not all of the participants were able to respond in ways that are easy to understand. Some of the respondents exhibited difficulties and annoyance when telling about unpleasant medical encounters and the various complex environmental and cultural factors that influenced their family relationships as well as the process of raising children in Finland. At one point, two respondents on separate occasions became distressed when narrating their stories. One told of a negative experience with a male doctor who handled her roughly. I felt bad about it but was consoled by the fact that the research will be for the benefit to my community.

8. Findings

8.1 The respondents

The people I interviewed raised issues during the data collection conversation about parenting, inequality, vulnerability, language problems, socio-economic and cultural issues. It is obvious that when human beings migrate to a new environment they have to adapt to the new environment in order to survive and develop, these adaptive processes are very challenging (see Germain 1979). Migrants might have to learn a new language, environmental culture, and in general to try to become acquainted with a new and unfamiliar social and health culture. In trying to cope with the systems that control their lives and learning to do things in ways considered 'proper' in the new environmental setting, migrants can be in a dangerously vulnerable position.

Although a few of my respondents were naturalised Finnish citizens, all the respondents identified themselves with the African communities and in the wider class of immigrants who are among the most vulnerable people in Finnish society. The respondents included immigrants who have both permanent and temporary residence status. However, it became clear that for the majority it was not their legal

status that mattered but the community to which they felt themselves as having a true sense of belonging. They felt that they were strangely disassociated from the social aspects of life in Finland concerning doing what they are trained to do, integration, human rights questions and not having extended family members around them to help them cope with social issues. For example, one of the qualified nurses was unemployed and depressed. A tiny percentage of the respondents have residence permits that directly hinder the degree of health treatment they and their children can have.

At the moment my child is denied rehabilitation services because I do not have KELA card⁴. I was told by the KELA [Social Insurance Institution] officials that I can't have the KELA card because of the type of residence permit I have. I have not experienced the health care services of other European countries. However, the city still supports my child at day care where my baby receives occupational and activity therapy. The hospital pays for therapy services for my child. (Cherry).

On writing the research plan I thought that the respondents would likely encompass women ranging from intellectuals to illiterate. But to my surprise there was not an illiterate among them. Only 20% of them did not have a high school education, though they had some sort of vocational education; while the remaining 80% had higher education. This meant that they all had basic education and professional training. Two of the respondents who received additional professional education here in Finland are unemployed, the others are students and one was a nursing mother. The ages of the various respondents ranged from 27 to 37 while the average age of the mothers interviewed was 32. All of respondents have lived more than three years in Finland and five of them have already spent at least a decade of their life in the country.

The psychological well being of people can be enhanced through the recognition of their cultural value system. The informant below thinks that getting pregnant can augment a woman's psychological state because the woman has something to look forward to. She has responsibility ahead of her that can keep her busy and secure. This shows that security means different things to different people. As Jane pointed out:

⁴ A KELA card is a social insurance card that is generally available only to migrants with permanent residence status. Migrants with a temporary residence permit can sometimes receive a fixed-term KELA card that corresponds to their work contract or the duration of their residence permit.

In my first antenatal visit to the refugee health nurse, I was told that my urine test was positive and that I am pregnant. The nurse asked me "Are you really prepared to have a baby?" She did not encourage me to keep the pregnancy. It is a very political issue when a refugee woman gets pregnant. You are diplomatically discouraged so that you can take the decision to undertake an abortion. She will use say for example, "Are you able psychologically to handle the pregnancy?" I think that many people's living conditions in Africa are worse than the situation in the refugee centre. Why can't refugee women here in Finland, who have no legal residence permit, still have babies? It should be mentioned that it is a great relief for an African woman to have a baby. It is more than money for the women. It is a better psychotherapy treatment for them. It gives them hope and a reason to live and to be happy. (Jane)

It was traditionally believed in many African countries that having many children is a sign of great achievement and large families were highly respected by the public. However, by the 1990s having many children did not enhance social status as much largely due to the increased cost of living, which placed great economic demands on parents to maintain their families. Hence there have been some shifts in attitudes towards large families though children are generally highly valued in African societies.

The respondents are categorised in two groups based on the time range in which they have encountered or made use of maternity and child health clinics discussed in this report. The groups were divided on the basis of time frame in order to analyse policy and practice changes over the past decade.

Table 1. Period of use of health care

<u>1990 – 1996</u>	<u>1997-2002</u>
Angela	Jane
Claire	Cherry
Rachel	Asha
Tina	Tina
Stella	

Reflection on the changes that have occurred over the past 12 years is a significant part of this study. The experiences that are related can thus be seen in the context of their time frame.

The function of the maternity clinics in Finland is similar to those in other parts of the world. However, the respondents saw the standards of the Finnish maternity services as being of very high quality. One of my respondents put it this way:

The Finnish health care procedures for treatment automatically made me feel secure and I had no fears that I was going to die. I felt secure at once with the Finnish maternity care system. (Angela)

The conversation mate: Why?

...because the environment is clean, the system is well organised, there were no queues, they have advanced technology, and effective workers. It was eleven years ago that I started using the health care services.

I think the system is just good and normal. I used the child health clinic last, about 5 years ago, so now I am thinking that there is a different way of welcoming individuals depending on their social class, the kind of partner the woman/man has, and the colour of skin may be taken into consideration when the health professional renders their services. Although, I did not experience any discrimination neither did I notice receiving discriminatory treatment. I think the element of discrimination is always there even though it is not clearly seen or shown. (Angela)

Here we can see that while Angela was very satisfied with the level of medical care, she felt in retrospect that social and cultural factors could have been taken into greater account by the staff. The fact that the respondents were highly educated could be seen as having an influence on their ability to verbally analyse their experiences in the context of socio-economic and cultural differences. Furthermore, respondents' strong sense of African cultural values was a significant factor in providing psychological and emotional support in Finnish society.

8.2 Maternity care

Generally, every pregnant woman in Finland uses the national maternity and child health care system. The first time an expectant mother visits the maternity clinic she usually goes with her partner and is given the handbook *We're having a baby* (National Research and Development Centre for Welfare and Health 1993, 2000). Normally, the first visit takes place when the woman is about 8 weeks pregnant. The expectant mother receives a thorough health check-up. It is voluntary to take blood

tests, but haemoglobin is checked during every visit depending on the case (Nurse Tuula). Patients have many possibilities to see a physiotherapist, nutritionist or psychologist for health and social reasons depending on the case. It is also possible to request for either a female or a male medical doctor.

On the one hand, it is voluntary for an expectant mother to undertake blood test, but the thing is that many of the Africans do not know that it is possible to refuse the test. Although, it is not a punishment to have one's health properly examined, a large number of immigrants do not know their rights. On the other hand, health professionals should encourage expectant mothers to take all required tests, as it will enable the professionals to better assess the health conditions of the mother and the foetus. It will also enhance preventive measures in terms of discovering and treating disease in its preliminary stage if it is curable or preventable (World Health Organisation 1997). In the following section, I describe the research findings concerning the core obstacles affecting the delivery and coordination of maternity and child health care services.

8.3 Barriers to good care

8.3.1 Language and communication

All of the interviewees professed that the way the maternity and child health care services are provided is generally good. It is a thing of joy to discover the great variety of services rendered by health care providers to help expectant mothers and their families to improve and develop their abilities as parents. However, Claire and Rachel mentioned that language was a major barrier in their encounters with the system. One would imagine that learning a new language like the Finnish language, which is ranked among one of the most difficult languages in the world, would not be an easy task for any immigrant. This is especially true in situations where the learners do not have the opportunity to interact with others and thus cannot use the language after language classes. Many immigrants are marginalised from the mainstream of Finnish people. The lack of social interaction is thus the main reason why immigrants are unable to use Finnish as a means of communication. Communication is an important part of social life, it affects how social roles are understood and played out

in the society. Social isolation and marginalisation ensues when people are unable to communicate.

Communication is more than just fluency in a language. Communication involves social and cultural factors. Rachel went for regular check-ups at the maternity clinic during pregnancy. The doctor recommended that she come to the hospital and after the check-up and ultrasound that day, the doctor told her that she was to receive a caesarean section when the time was due. Rachel refused and said that she wanted to have her baby normally. The health care providers did not explain in detail what a caesarean section meant and how the procedure was going to be done.

I was so scared and I cried at home that I want to make the baby normally.
(Rachel).

Her baby was delivered normally and she thinks that the reason that the delivery and communication was so difficult was because she disobeyed the doctor's orders. Rachel had no previous knowledge of how a caesarean section is performed and no one explained to her in a way that she could weigh the advantages and disadvantages of having an operation. What made Rachel so sad and afraid about the idea of having a caesarean section? What were the consequences of Rachel's behaviour and what lessons can be learnt from her case?

Human beings are naturally afraid of something they do not understand. When a patient does not receive an adequate explanation about his or her health condition and the reasons why health care providers recommend certain kind of treatments to the patient are unclear, the patient inevitably experiences discomfort, fear and confusion. It is important for health care providers to inform patients of the disadvantages and advantages of a proposed treatment or delivery, particularly when the situation is new to the patient.

There is a communication problem. When you are getting a baby the service is very good, but when you are sick they just give prescription. The most difficult thing is that you must learn the language. Without you knowing the language things don't work out. In the child health care clinic their service is good. Sometimes they don't take time to learn. In the past three years or so, after Finland joined the European Union, things have changed in Finland that Finnish people have started speaking English. (Tina)

It was also clear that all the respondents believed that it is important to learn the Finnish language. All of the respondents said that it has been very difficult, as 'newcomers' in this country because they could not speak Finnish properly and, in turn, were unable to explain inner pains or feelings. Sometimes the women felt embarrassed, ashamed, and a sense of inferiority crept into their social interactions with staff. This unpleasant situation affects African migrants' family relationships, where important health issues can be overlooked by either of the spouses. Language is important in terms of transferring and communicating information. When a person is not sure of how to say something the last resort may be not to say anything at all.

A nurse was all the time speaking French to me and I mentioned to the nurse that I speak Portuguese and not French. During all antenatal check-ups my husband was with me every time and one can call if one has a medical problem. Things went well and there were no serious problems, the health professionals tried to educate the expectant mother a lot so that the child remains in good health...During my visits to the child health clinics and to the hospital there were always language barriers. The pamphlets and handbook given were all in their language. But on one hand, I think it would have been better to have it in one's own mother language. On the other hand, it is good that people are encouraged to read and learn the new language. (Angela)

Angela continued:

The biggest problem in my opinion in Finland is the language and I could not speak English. Thus I could not communicate with Finns or with other foreigners. (Angela)

Tina underlined the generally high level of maternity and child health care services by contrasting her experiences there with the general health care system.

The information in the health care handbook was useful. Three years ago when I was pregnant I was given 'We're having a baby' and it was in Somali language. I was very happy when I read the information in my language. (Asha)

Asha also underlined the importance of receiving information in her own language. From this we can see the significance of language in communicating with patients. Rachel's negative experience with the maternity clinic largely came about through the fact that her doctor did not attempt to communicate information to her about the procedure. Tina, though, noted that health care providers have become more willing to

communicate in English in recent years. Communicating to patients in a language that they can understand is thus of great importance in the caring encounter because it reduces unnecessary distress and enables the patient to make an informed decision.

Cherry discussed the importance of communication when dealing with difficult health issues:

It is necessary to take time to prepare the patient when unpleasant health information is about to be transmitted or told to the patient. ...For example, the people who rehabilitate my child do not talk much. Each time they come to work they do not say what is on the record or even the progress. The translating services which the system allows is limiting me and my communication capabilities are interrupted and made inefficient. (Cherry)

By marginalising Cherry from the rehabilitation process of her child, Cherry's role is diminished.

The analysed interview data revealed that language was a significant barrier in the effective communication of medical information between health providers and their patients. The consequences of communication crash can be felt from the respondents' own stories that it limited their ability to communicate personal health problems and questions. Obviously, they could not get the adequate feedback about their health and their children's health. All of the respondents claimed that language is one of the core problems that hinder information transmission. The respondents' personal experiences with the system were initially negative.

Regretfully, the language barrier has affected all other social aspects of migrant lives in terms of integration and getting a job. A few of the respondents mentioned that when applying for job you are first labelled as a foreigner which automatically means that you do not fully belong to the society. Secondly, your language competence and skills are considered to be deficient. Employers are not willing to train you for a job that will benefit you in the long-term. Hence migrants often face a vicious circle of marginalisation in Finnish society.

I did not get the handbook, We're having children. It is important to employ foreign nurses in the maternity clinic and in the health centres

mostly because of the language problem. I was not given the handbook on we are having children may be because I did not know any Finnish then. It should be compulsory to give the book to all expectant mothers.
(Claire)

The employment of nurses with a migrant background could significantly assist with language and cultural barriers. Furthermore, it could help reduce social marginalisation in migrant communities.

8.32 Cultural issues

During the interview sessions, the respondents raised a number of pressing socio-cultural problems connected to the manner in which health services are rendered and received. These issues reflected on the ways immigrants are cared for. Each individual is unique and therefore peoples' attitudes are not same. People behave similarly at certain times and at other times differently. One interviewee noted that some health professionals hold stereotypical beliefs in the sense that they generalise and assume that all Africans are not punctual. These health care workers then tend to see the lack of punctuality as a cultural phenomenon in Africa. It must be stated that there is a clear distinction in the African context as to what is a formal and an informal appointment. Health care workers must know and understand that it is important to let their clients know their rules and communicate this information in an understandable way. Coming to a new country where the system is different from what one is used to, requires that health care workers should inform newcomers how the system works in early encounters. This should be done in a culturally appropriate manner and communicated clearly. We can see the result of miscommunication in the following case:

I remember my visit to the dental clinic in 1994, where I had my tooth extracted about 8 years ago. I had to see the dentist and for some important reason I could not make it. I did not know that I was supposed to call the clinic and inform that I could not make the appointment, neither did I know that I would be fined if I did not call. I went back the following day to the clinic and I was told that I had to pay 150 FIM. I was dumbfounded and complained that I was not aware of the procedure. The dental worker said it was too late and that she could not do anything to help me. This is learning the hard way and many migrants have found themselves in this sort of situation, in most cases even in worse situations. (Stella)

People must be treated respectfully whatever their culture is. Some of the respondents told me about their bitterness about their names being shortened and sometimes written wrongly. Asha described how she and her fellow migrant friend were treated:

Sometimes the public health nurses call their clients with one finger up. It is dogs that are usually called in that manner and never a human being in my culture. They call us the way dogs are called in Africa. Can you imagine! (Asha)

She continued:

They all the time spell some people's name wrong, at least my friend has complained about that. They make our names short and we cannot shorten their names. (Asha)

Here we can see how cultural insensitivity can have a great impact on patients. The significance of being recognised as a person entitled to equal respect is paramount in the health care encounter.

Jane also tells of her impressions of the reality of living in the reception centre. She felt that residing in the reception centre greatly reduced her social contacts and restricted the kinds of health care she was entitled to receive:

When I was transferred to the 'city' I was examined. No initial detailed explanation was made to me as to why my blood sample was taken. They will call your name and do what they want to do with you. Generally the first impression was not good...I went to the maternity clinic alone for the first time. In the refugee centre when the pregnancy test proves positive the nurse will deliver the announcement to you and you are given a week to decide if you want to keep the pregnancy or not. So immediately you declare that you will keep the baby. General information about how your first visit to the maternity clinic will proceed is told. They will explain the procedure to you, usually the nurses are good but a few are racists. (Jane)

The conversation mate: How do you know a racist?

Jane said: They are not efficient in the way they communicate. A racist is impatient, lacking in giving proper information, responding in ways that make you feel you are stupid.

Often misunderstandings in the health care encounter are attributed to cultural differences, but Jane points out that racism can also be an important factor in

preventing proper health care delivery. Tina also suspects that her foreign status might have an influence on why her child has not been properly treated:

The doctors should take lessons on how to treat foreigners so that they can learn more. Sometimes when one is in pain the minor problem is not treated well. My daughter is allergic to pollen and she has never been sent to a specialised doctor for proper testing. In most cases you have to ask for proper check-up in order to get it. They wait too long before a problem is seriously looked into and they keep prescribing medicine. Appropriate testing should be done. Health problems should be tackled immediately as fast as possible. (Tina)

Claire told about the influence of one's own cultural perspective and how it affected health care. My interpretation of the information from this respondent confirms that immigrant men in general should equally be educated about the usefulness of health information and the system. The health care system in Finland is different from the system back home. The importance of knowing that general health information is meant for sharing and not for keeping to oneself is an important idea to communicate.

The public health nurses did not come to visit me at home after my delivery. When we moved to another city then I heard from friends that it was possible for the nurses to visit after delivery. The man was the only one to decide what I ought to do. The African culture and way of life influences my reactions and decisions because it is the man who makes the ultimate decisions. My husband's behaviour confined me to always staying at home with our child, without letting the child and me to communicate or play with other children or people. (Claire)

Jane thinks that it is good for nurses to ask patients how they want to be treated when they are admitted to hospital. Nurses should get more information about cultural differences and should not generalise about cultures. In other words, they ought to get more information about multiculturalism. It is necessary to have foreign doctors and nurses working together if it is possible, so as to enable foreign patients both males and females to be more relax in such ways they can express their medical needs and wishes.

The maternity and child health service is very good. The main problem I encountered was with the hospital. I met a woman who spoke Finnish very fast and I did not understand what she was saying and the information she was trying to get across. The Finnish nurses in the hospital do not pay attention to foreigners, as they should. Attention is needed and touching is needed in some cases. When a patient is from the refugee

centre, it influences the behaviour of the nurse. Anyway, it depends on the nurse on duty as at that time because the social security number with an A tells something about the client's or the patient legal and social status in Finland. Some nurses do not give respect to such people. (Jane)

Asha faced a tragic situation where she received culturally sensitive treatment:

Once I was pregnant, and after 6 months of pregnancy a health screening was performed and the doctor declared that the baby should be aborted. The reason was that the baby would be born with many deformities. We refused, owing to Islamic religious grounds because in the sight of our religion it means that we are killing the baby. When the baby is conceived, it is considered human life and as Muslims if we abort the baby we are guilty. But the doctor agreed with our plight and we took the risk. Consequently, the baby died inside my belly. (Asha)

Relating these experiences stimulated me to think about power relations. Does power have something to do with domination? For example, it is locally acknowledged among Africans that men have more power than women do in many respects. Whether this is domination, oppression, or discrimination is beyond the scope of this study. Nevertheless, issues that pertain to the cultural influences of gender relations and roles were highlighted in many interviews. For it is not only the health care system that causes cultural problems, but also the cultural practices of the respondents as well as the institutional structure of health care. When discussing this, some women pointed out the Finnish custom that males (that is, soon-to-be fathers) are supposed to accompany their expectant wives to maternity clinics. Most of the African men found this to be inconvenient. In contrast the women thought it was a great idea and a good health care practice. They related the importance of letting the men know the importance of their presence.

Respondents discussed gender roles in the context of maternity health care provision. Asha affirmed: "Our culture does not allow a male doctor to treat females". This can be very problematic in the Finnish cultural context where the gender of the health care provider is not considered when assigning patients to caregivers. Rachel noted:

Some male doctors are very aggressive and I have experienced it, they tend to touch and examine their patients roughly. The power they exercised in rendering their duty sometimes overrides the care that ought to be shown when treating a female patient. (Rachel)

The respondents from the northern part of Africa felt more comfortable with a female doctor. One informant stated: “It feels easy, and I get along better and communicate better with a lady doctor”. During Asha’s subsequent visits to the maternity clinic she requested a female doctor because she was told that she has the possibility to choose between having a female or male doctor.

Most of the participants from the northern part of Africa prefer to have female doctors treat them. The findings revealed that the reason was not solely religious grounds but also because they felt more comfortable with female doctors. The idea and practice that a doctor has the power to tell you what to do should be questioned and patients should know their rights and limits. Cultural preferences for a health care provider of the same gender should be respected and considered a fundamental aspect of the patient’s human rights.

The lack of communication can also be seen in routine health care encounters:

Since I have been living in Finland until today I have not had anything to do with the maternity clinics, only with the child health clinic. When my children came to be united with us in Finland, I was told by the KEELA [Social Insurance Institution] office to take them to the child health clinic. I took them to the clinic, and they were physically examined there and samples of their blood were taken for various tests. I asked what the tests were and the reasons for the test. The health nurse on duty told that the test was to check if they were infected with HIV, hepatitis B, or other types of diseases. She continued that it is the procedure when people come from Africa to Finland for the first time they must be medically tested. I asked who made the law? She replied that it was their big boss. Included in the health law, African migrant parents are also supposed to take these tests if they live in Finland. The health authorities have decided that all parents and children must be tested for these very serious diseases. (Stella)

Stella continues:

I was not given any information on paper. The message was transmitted orally by word of mouth. It was good information and in my experience with child health clinics, the nature of the health care service received was okay. On the one hand, I felt and understood that I am from a continent where people are thought of as having lots of diseases. On the other hand, I saw and experienced prejudice in a frightful way that the nurse and the health authorities think that Africans do not know how to take care of themselves and their children. It was absurd to me, because in my country, since the early

1970s, parents know the importance of giving vaccinations to their children. Child immunisation is taken seriously in Finland. (Stella)

The stigmatising way of informing the patient about health tests thus hinders the development of trust and good communication between the health care provider and patient. However, health screening is a good policy.

A slice of Cherry's story reveals similar problems with obtaining health information:

When I came to Finland my baby was sick and I went to a private clinic in order to get health care services. I was not registered in the social insurance scheme. After I got a residence permit then I was able to use the child health clinic services. My baby received the appropriate vaccinations. My baby has had developmental and growth problems from birth. (Cherry)

The conversation mate asked Cherry if she had been given information about child development. She replied that she was given a handbook about child development but she could not understand it because it was in Finnish. She complained that medical terminology in Finnish is not easy to understand and the information is not available even in English. Perhaps if Cherry had been properly informed she could have better supported her child with his developmental difficulties.

My respondents also drew a clear line between the high quality of maternity and child health services and hospitals in Finland:

The maternity and child health service in Finland is one of the best health services in the country. The health care providers there support you, encourage you, they take time to check you, they prepare you for the future, when you come back after delivery you want to see them. They also treat women from the refugee centres very well. In the main hospital, they do not want to learn about people's culture, they feel bad when they have a foreign client or patient. Doctors there do not take time to explain your diagnosis if you do not understand. In hospitals they are afraid of differences and refuse to understand other people's cultures and to learn about other cultures. (Jane)

These statements demonstrate that in the bigger hospitals there are problems that these respondents perceived to be partly cultural orientation problems. They felt that health providers did not want to learn about other cultures and did not know how to deal with migrant clients. The story does not end here, the interviewees also complained

about long queues in hospitals, series of communication breakdown that occurred due to language barriers, and the fact that they received insufficient information about their diagnoses. Health providers have a stipulated amount of time allocated to each patient and it is difficult for the provider to exceed the time. This time restriction might be one reason why enough attention is not paid to clients in the hospitals and there is a shortage of professional staff. This can be linked to the lack of resources in health care. Nonetheless, it is important to recognise, and even underline, the salience of cultural issues in the health care encounter.

8.33 The lack of culturally and linguistically appropriate health information

The respondents related a number of aspects concerning health care information delivery patterns that mirror gaps in the kinds of health information available to them. The gaps exist due to the reality that most of the information is available only in Finnish and/or in Swedish, but only a small amount of the information can be found in English. However, the amount of available health information in various languages has increased in comparison to the situation five years ago. Currently, the handbook *We're having a baby* is available in Finnish (*Meille tulee vauva*), Swedish (*Vi väntar barn*), English, Russian, Somali, and French (National Research and Development Centre for Welfare and Health 2000; Interviews Asha, Rachel, and Jane). *Having children in Finland* is published in at least seven languages and is available at maternity clinics in Finland. These health clinics are situated both in the cities and in the municipalities irrespective of the population of the municipality (Hoppu et al. 1997).

Jane discussed her need for information:

The maternity information handbook (We're having a baby) is not enough, the health service providers have to find out if the women understand the information in it. I understood it because I got it in the language I understand and it was okay. (Jane)

Jane's statement demonstrates the importance of having health information in a language one understands. She received the maternity handbook in French, one of the languages she understands.

The handbook, *We're having a baby*, contains detailed, well-written information about Finnish health care and social welfare. Many of the mothers I interviewed said that they were not given the handbook during antenatal visits. *We're having a baby* covers issues on pregnancy, disease prevention, caring for the child, and child development. It is usually given to an expectant mother on her first visit to the maternity clinic. This is intended to promote healthy family patterns and to help families and improve their children's health. All other information, such as pamphlets, leaflets, and booklets are given free of charge.

In *We're having a baby*, (National Research and Development Centre 2000, 42) there is one paragraph which explains that parents should talk to their baby because it enhances child development, but little detailed information. Nonetheless, after going through the information in the handbook one comes to the conclusion that to a large extent it covers panoramic information applicable from the period of pregnancy to when a child is a year old. Other relevant information in smaller leaflets and advice pertaining to child development are available only in Finnish.

Each Finnish family having a child from one to six years old normally receives *Vuotiaan vanhemmille* [To the parents of pre-schoolers] depending on the age of the child. Parents who do not understand Finnish cannot read the information and in most cases they are not given the pamphlets at all. The nurses I interviewed recognised the fact that these pamphlets are indeed very useful and ought to be made available in languages other than Finnish and Swedish, which are the two official languages in Finland. In order to disseminate the information equally to all the parents who are entitled to have them, the information ought to be made available in English, French, Somali, Russia, and other languages deemed necessary in the particular municipality. This will ultimately be very useful to health care providers because communication barriers can be bridged if the information is available in other languages.

My interviews with Finnish nurses confirmed that some vital information gathering forms used for obtaining an individual health history are only available in the Finnish language. For example, when a woman is eight weeks or more pregnant she goes to the maternity clinic and she is given a form to fill out called *äitiysneuvolan esitiedot* [maternity clinic preliminary information] which is not in any other language other

than Finnish. This form contains very important health questions that the client ought to understand in order to be able to fill it out correctly.

The respondents repeatedly came back to the issue of communication difficulties. However, whenever the language obstacle was resolved, the respondents were always happy with the information obtained and the health care services received. Two of the respondents saw it as positive for Finland, as a member of the European Union, to have a variety of health information brochures available in international languages.

8.34 Getting social and health care information across

The manner in which medical care information is discussed and understood by both the health care providers and patients touched issues that revolved around misunderstandings of information transmission. Generally, the women I interviewed felt that the health leaflets they had received were useful. However, they strongly felt that the ways of giving health and social care information by professionals should be changed and improved. Efforts ought to be made to inform patients better about their health condition and the implications of decisions made about health.

When I was pregnant, I was bleeding and the nurse asked how many children I have and I told her two. The nurse brought a paper for me to sign, so that I will never have a baby again. I said to the nurse that I want to know more about how it works. The decision to be sterilised should be taken by the mother. Before a medical decision is allowed to happen, the mother should first be educated properly about the merits and demerits of, say, sterilisation. The nurse and the doctors can sometimes decide to sterilise you depending on the case. (Jane)

It is the basic human right of patients to be provided with adequate information in their own language regarding health care procedures in order to give informed consent. Health care procedures, such as sterilisation, can only be done with the clear consent of the patient otherwise it becomes a violation of the patient's human rights.

The lack of proper health information can have long-term effects on patients' health, well-being and family relationships:

During my first antenatal and postnatal visits to the maternity and child health clinic with my first child who is 8 years old now, I did not get enough advice and I lacked experience about child development complications. The health service providers should improve the way that they give information and assistance about child development and growth. Women should be told why the pamphlets or handbooks that are given are important and necessary. There are differences between towns as to the way health care is offered. More information should be given to new mothers. They need support in understanding the information given to them and they should learn to talk with their baby. (Claire)

Claire mentioned that she did not receive the handbook *We're having a baby*. Information about child development and areas of concern, signs of development, signs of deficiencies, and how they should be tackled outside hospitals and clinics should be provided to migrant clients. Information about the stages of child development is particularly important. Child development information can be best understood if it is in the language one understands. Notions of child development in various cultures have different characteristics. The research findings show that there is a lack of comprehensive information about child development, which in turn has resulted in child development problems. This has contributed, for example, to speech impediments among migrant children in Finland. It is important that migrant men are educated as well about child development.

Rachel went to the hospital when she was pregnant. She did not understand nor speak Finnish eight years ago when she was pregnant. During Rachel's visits to the maternity clinic, she could not communicate directly with the health providers and her spouse acted as the interpreter. Finnish was thus a barrier to communication. If health policy is geared towards saving lives, to promoting healthy living and reducing illness and disease in various communities then endeavours then it should be made in such a way that it gets the health messages across to the patients.

The pamphlets I received about child development were in Finnish and the nurses could not speak English clearly. The pamphlet has information about the growth of child, length, weight, etc. The hospital services are complicated. My child has many types of sicknesses. The language is the problem especially when the information is given in Finnish to somebody who does not understand it. I have not met a real doctor that can explain fully to me the disabilities of my child. It is good that health care services are available to all but it is also important that the doctors are able to speak an international language.

If they really value life they should know the importance of proper medical communication between medical providers and the clients.
(Cherry)

The cost of providing rehabilitation services for children with speaking abnormalities could be reduced, if prevented at the initial stage so that they do not become severe. The socio-cultural environment in which the African families are living communicates messages about practices and what they know about child development. A crucial part of the difficult problems of immigrant mothers and their families' is that they are here without extended family members. It is a common knowledge that most women in the world learn about child rearing and development from extended family members. When people have their relatives around them, such as aunts, parents, cousins, and nephews, they have the possibility to discuss, exchange information as well as the possibilities to make comparisons. This is very significant for those mothers who are having their first child here in Finland. This also shows that the environmental settings in which immigrants live can affect the development of the child. For example, Claire did not know that when there is a health problem that deserves attention, it was possible to call for an appointment and make an appointment to see a doctor. She realised that her child had problems with speaking when he started day care. Consequently, migrants are in a vulnerable position with regard to health information because they lack family members in their new countries. The public health nurses stated that there ought to be additional endeavours by the health care system to make available and to disseminate health care information.

8.4 Post-natal check-ups and family planning

Family planning plays a significant role in controlling the reproductive patterns of modern society. Through family planning birth rates are controlled, diseases are prevented and families are given the possibilities to ask questions, learn more about new demands and challenges of bringing another child to this world. Families are stimulated to think of the future of the unborn child and themselves. The Finnish family planning clinic offers advice on contraception and methods of family planning.

All countries have their own systems and differences that cannot be changed so easily. I had no culture shock. My husband had lived with me in Africa and we got married there and had one child before we moved to Finland. And I had visited Finland many times before. From

prenatal care to the time my baby was 2 years I went with my husband to the child health clinic and to the hospital, when our child was sick or I needed to go for check-ups from time to time. When my child was 2 years I went to child health clinic alone. Since I could speak Finnish by then. But after sometime I started having back pain almost every day and headache, after doctor's consultation I was told that I needed a lot of rest. My husband had to take care of our child. (Angela)

The message of this respondent's story was that she was happy to see that it was possible for her husband to take care of the baby while she was sick. In Africa she had house helper and relatives around who could help her. If it were in her homeland, her husband would not have taken such kind of responsibility.

8.5 Changes over the years (1996-2002)

One question that arises here is: has the quality of services rendered by *neuvola* improved or deteriorated since 1996? The research findings suggest that since 1996 the quality of health care services rendered by the maternity and child health clinics has continuously improved. However, there are still elements of communication barriers between health care receivers and health care providers linked to language and cultural factors as well as structural problems.

A few times when I have had an appointment, I have mentioned to the receptionist beforehand that I need an interpreter but no interpreter was present and the appointment was not kept. The hospital management do not ask or check how long the expectant mother has been living in Finland. Nowadays those in charge of booking appointments ask you beforehand whether you need an interpreter or not, or do you have your own? Now they have improved the system. It is not very good for us to have an interpreter when talking about personal medical issues to a health worker. Actually, it depends a great deal on the case. I want to keep my medical information and files private. (Asha)

Thus, we can see that many of the respondents reported a steady improvement in maternity and child health services for migrant patients over the years. Though there is still much room to develop services.

9. Respondents' assessments of their position in the Finnish health care system

The interview data provided information on how the respondents perceived their position in the Finnish health care system. I asked the question: 'How do you think you are seen and understood by the health care professionals?' The responses varied according to individual opinion and social status. The majority of the interviewees thought that there are acts of racial discrimination that are not so obvious. This sort of discrimination is often attributed to the fact that the patient does not speak Finnish and thus the patient is seen as belonging to a lower social class. Respondents believed that being an immigrant puts families and their children in a different class and indirect efforts are made to belittle some immigrants' self-esteem. The respondents described their position as follows:

I assess myself as among the low class of people in Finland, even though my husband is a Finn. If a person does not speak the Finnish language in Finland that person is treated and assessed as belonging to the lower social class. Especially, if one is an African, but when one speaks the language the person is valued. For example, I received the handbook about having children in Finland and it was helpful because I could read and speak English. Some health care providers think we do not know anything about life. They think we want to find security and we don't find food in our country that is why we are here. They call us 'maahanmuuttaja/siirtolainen' ('immigrant'). I think that 'ulkomaalainen' ('foreigner') is better than maahanmuuttaja. (Rachel)

One problem that some of the respondents are worried about is the ridiculous popular way of addressing all migrants as *maahanmuuttajat*, which can be translated as migrants or immigrants. It is just a way of representing and categorising people who are not Finnish nationals. However, one reason that this term is problematic is that the second-generation people, for example, those who have both Finnish and African parents are called migrants or immigrants as well. The lack of not having a clear term or word for this group of people is a cause for alarm because it makes these people feel alienated from their own society or nation. This will definitely cause serious psychological, social and health problems in the future if not dealt with as soon as possible. It might lead to acts of rejection where people cannot identify themselves with the broader society where they suppose to belong. As Angela said:

For example, the word 'maahanmuuttaja' (immigrant) is very controversial. I prefer that my children and I were called foreign nationals. They think that they can strip our confidence and sense of self-worth from us, especially from our children. There is too much differentiation among and between immigrants-Finnish people's origins. (Angela)

It is also important to mention that most health professionals sometimes do not believe what Africans say pertaining to taking care of their health and that of their children.

On a visit to the child health clinic with my children, the nurse asked if my children had been given vaccinations back home. I told her that they have taken all the necessary vaccinations for their age. The nurse did not believe what I told her and she said that I should bring the official proof. I explained to her that I left them back home but I remembered vividly that they had received the vaccinations before I came to Finland. And the vaccines left had been given to them while I was away because my mother took care of them, and she has confirmed and explained to me all the vaccines they had taken. The public health nurse still insisted that she did not believe my story, and I mentioned clearly that I would not allow them to be given twice those vaccines because the side effects are drastic. I even told a story to her about the consequences of given a double dose of vaccination to show her that I knew what I was talking about. Then she agreed that they would be given the vaccines that children of their age take in Finland, and I agreed. I noticed that the nurse did not trust what I said to her not until after, I insisted on not having my children re-immunised. It means that we Africans, and perhaps all foreign nationals who cannot provide a paper to prove what we are attesting are easily disapproved of our claims. (Stella)

Health service providers should discuss more with foreign people. It would be important to have more nurses who could speak other languages. This would be useful for both doctors and patients because effective communication is the cornerstone of good health care practice. The opportunity to communicate in one's own language leads to effective ways of communicating which consequently saves time. Many health professionals speak English but when on duty some of them do not want to speak an international language.

10. Respondents' needs and suggestions concerning Finnish health care services in general

This study is devoted to hearing the voices and concerns of a marginalised community in Finland. The basic health care needs perceived by these women revolved around issues of how people are to be treated, the question of privacy, aspects of bridging communication gaps, open-ended possibilities for learning, providing culturally appropriate health care services, and equal access to health information and health care services.

These concerns and needs are summarised:

- All health services should be made available to all residents irrespective of the individual's legal status. This would be in line with the World Health Organisation's health policy recommendations in *Health for all by 2000* (World Health Organisation 1997).
- Respondents explained that the system allows minor illnesses to develop into severe and more painful illnesses through the lack of preventive medical practice. Hence, there is the need for the system to be reformed. Two of the respondents emphasised that allergic problems are sometimes overlooked. Respondents with children living with allergies think that such problems ought to be taken more seriously.
- Medical professionals should be prompt in treating patients. One explanation for this is that there is a long list of patients awaiting surgery and other procedures in hospitals and only very urgent cases are handled quickly. Nonetheless, patients should be informed of the reasons for delay.
- Economic problems among the respondents were a major reason that they infrequently patronised private clinics. The immigrant population in most cases is the ones in the inauspicious economic conditions. As a result, they are not in a good position to use the private health care services.
- There is a need for more specialised doctors who understand tropical diseases. A few of the respondents noticed the lack of specialised tropical doctors in hospitals. For example, there are some prevalent tropical skin diseases in Africa which Finnish medical practitioners are not familiar with which has made diagnosis and treatment difficult..
- There is a need for applying culturally appropriate approaches to health and social care. As Schlesinger notes: "Of equal importance are the values concerning how people are to be treated. In health care these naturally

generate questions about the relationship between the way health services are organized, available financing, and attention paid by health care providers to dignity, privacy, and culturally derived disposition to care” (Schlesinger 1985, 42).

- There is a need to improve emergency services, especially in the summer months and during holidays.

11. Conclusions

11.1 Good policies in the Finnish maternity and child health care system

Based on the research findings, the following list of good policies is presented:

- The possibility to choose either a female or a male doctor is culturally appropriate.
- Health screening and all kinds of immunisation schemes against infectious diseases are excellent practices.
- In the maternity and child health clinics, adequate time is taken to treat pregnant women and their children as well.
- People feel that the Finnish health care system in Finland is far better and less expensive than the health care system in their home country.
- Health care services are provided without much discrimination. Although the system is not perfect regarding how people of different races and low social status are treated but there are possibilities for improvement considering the openness of the system and the prevailing spirit of cooperation.
- There is equal availability of health care services to almost all residents, but a small proportion of immigrants are deprived of certain health services if they do not have the Social Insurance Institution card (KELA card).
- The implementation of the use of advanced health technology coupled with well-trained health professionals has consistently guaranteed high quality health services.
- Maternity and child health clinics and hospitals have good environmental conditions, which have facilitated health care safety and an unpolluted environment.
- Before each child is born in Finland the mother receives what is called the 'Finnish maternity pack.' This is a special gift from the state containing items such as jacket, clothes, socks, pants and other items. This is done only in Finland and approximately all the items in it are made in Finland as well (see National Research and Development Centre for Welfare and Health 1993, 37)

11.2 Problems with the Finnish public health care services

- If one does not have KELA card one cannot have access to using the Finnish public health care services. This makes it very difficult for those immigrants who do not have the KELA card due to their legal status. Consequently, these migrants who lack KELA cards are not able to get health treatment from the public health care services in many areas. Furthermore, those people who lack a KELA card are unable to receive the state subsidy on prescribed medicine. Cherry commented that because she does not have a KELA card when buying medicine she has to pay 100% for all her purchases. Taking into consideration the condition of her economic situation, she often does not have the means to purchase medicine for her child.
- The medical staff does not smile and tend to be very serious. Health care providers are not relaxed when rendering health care services. Health workers are sometimes too shy and rigid when communicating health information.

They often exhibit stereotypical attitudes about race and think, for example, that Africans always have problems with punctuality. This also applies to taken-for-granted approaches that do not clearly inform patient about rules on how to make and cancel appointments.

- Health care providers distance themselves from people from other cultures. There is a need for training in culturally competent methods of health care.
- Many patients experience problems in understanding the information in some of the available health material due to the fact that they are only in the Finnish language. More information should be given to patients about their diagnosis.

11.3 Policy recommendations

- Equal health care opportunities: Health care services should be available and accessible to all irrespective of residential legal status. This would mean a health care policy based on equality.
- More health information in languages other than Finnish: There is a great need to have more health care information and forms in English, French, Somali, Arabic and other languages.
- Development of community legal and information advocates: Community advocates are needed for migrant communities. There is a clear need for advocates who could give general advice to immigrant clients. Migrants need health, social and other types of advice to know their rights.
- Culturally appropriate health care delivery: Cultural competence should be a core element of professional health care education. Health care providers should be aware of the various kinds of cultural reservoirs that immigrant communities have (Adjekughele 2001). This would mean, for example, sensitivity in relaying negative health information to patients.
- Lessons on child development: Additional and prompt attention ought to be paid to infants and children with signs of disabilities. More information about child development should be given to new mothers.
- Immigrant workers should be absorbed into the system: There are many recent graduates of Finnish nursing colleges and medical schools with an immigrant

background. There should be a greater emphasis on hiring a culturally diverse staff at maternity and child health clinics that have a large number of immigrant clients.

12. Final remarks

This study explored the experiences of African mothers during pregnancy to under-seven year-old child health care encounters. The study described the cultural, legal, social and administrative phenomena that influence the manner in which services are provided.

I obtained rich information from two Finnish public health nurses, who are not migrants, to comment on the data collected from the African community respondents. This was done in order for me to have knowledge of how the health care providers render their services, the different kinds of information they give to clients/patients and to hear about their views on working with migrants. The research results derived from the research analysis has been carefully looked into and utilised as store of important information about the community. This research method has proved effective in revealing areas of policy and practice implications. The findings suggest that health care services available to the African community resident in Finland are lacking in some respects. Among the main problems and barriers that were cited about access to health care are restrictions on people without a KELA card, language obstacles, communication barriers, cultural factors, lack of trust and respect for the marginal communities.

The study is useful in many ways. It is based on pertinent, reliable and adequate data (Ghosh 1985). The findings provide a wide ranging view of the knowledge and thoughts African women carry with them which are rarely heard in the public arena. This data can help health care providers gain a better picture of the African community and how it experiences maternity and child health care. This work stresses the need for health care workers to learn more about cultures, to treat people with respect and to learn to transfer bad health news in a culturally appropriate manner.

There have been a considerable number of achievements attained by the Finnish health care system over the period of time studied. Maternity and child health care services have continuously improved in many respects and more health information is available in many languages. A general assessment of the results of this study shows clearly that the services rendered by maternity, family welfare clinic and family planning clinics care are very good while that of the hospitals are unsatisfactory.

Finally, I shall conclude by citing Elfriede Schlesinger skilful message to health and welfare workers:

Racism and discrimination are very much with us. So many of the young mothers whose infants die are considered 'lesser' persons by the society. Avenues for positive identity and a sense of worth are still not available to many. Medical workers personnel, physicians, and social workers often approach people from the perspective of their own experiences and views of life and fail to recognise the extensive fear, insecurity, and lack of resources experienced by many of these groups. (Schlesinger 1985, 15)

Acknowledgements

My thanks go to Kris Clarke who was always ready to answer and to listen patiently to all the puzzling questions I had during the research process. On the one hand, she was the one who informed me about the project. On the other hand, without her support, which cleared up my thinking this report would not have been possible. Thanks also to Dr. Ravinder Barn who gave her time to read through my research drafts and the manuscripts and gave valuable suggestions and insights. It would be a mistake not to acknowledge the contributions of the other community researchers, who were also involved in this project. Their comments and questions were useful for the study.

I am indebted to all of the respondents of this study for their discussions, openness and the good humour exhibited throughout the interviews. The data collected from them was undoubtedly the harvest that was ploughed. I am grateful to them and the project co-ordinator for their help and cooperation.

13. References

Adjekughele, J.E (2001) Climate Change Mitigation: Clean Development Mechanism and Cultural Reservoirs. In *Every Human Has An Equal Right: Equity Problems In Climate Policy and Politics*. (Ville Haukkala ed.). [2nd ed.] Tampere: University of Tampere, Department of Regional Studies and Environmental Policy.

Bauman, Karl E. (1980) *Research Methods for Community Health and Welfare*. New York: Oxford University Press.

Clarke, Kris (1999) *Breaking the Bounds of Bifurcation: The challenge of Multiculturalism in Finnish Vocational Social Care Education*. Tampere: University of Tampere, Department of Social Policy and Social Work.

Edubio, Abigail (2001) A Study on Sub-Saharan African Migrant Communities in Berlin, Germany. In *African Communities in Northern Europe and HIV/AIDS: Report of Two Qualitative Studies on the Perception of the AIDS Epidemic in Selected African Minorities*. [pp. 15-54] (Kris Clarke and Tarja Pösö eds.) Woerden, The Netherlands: European Project AIDS & Mobility, NIGZ.

Germain, Carel B. (1979) *Social Work Practice: People and Environments: An Ecological Perspective*. New York: Columbia University Press.

Ghosh, B.N (1984) *Scientific Method and Social Research*. [2nd ed.] New Delhi: Sterling Publishers Private Limited

Granfelt, Riitta (1999) Stories about Homelessness and Marginalisation. In *Reconstructing Social Work Research*. [pp 91-110] (Synnöve Karvinen, Tarja Pösö and Mirja Satka eds.) Söphi: Jyväskylä.

Hoppu, Ulla et al. (1997) *Having Children in Finland*. Helsinki: Ministry of Labour, Migration Division.

Institute of Migration, University of Turku (2002) Emigrants and Immigrants by Sex, Citizenship and Country of Emigration/Immigration in 1980-1999. Available at: http://www.utu.fi/erill/instmigr/eng/e_22.htm

Juote, Mari et al. (2002) *A Home in Finland: Information for Immigrants about Living, Studying, and Social Security*. Helsinki: Ministry of Labour.

Kolimaa, Maire and Vallimies-Patomäki, Marjukka (2002) Health Promotion in Maternity, Child and School Health Care. Available at: <http://virtual.finland.fi/finfo/english/women/sostueng.html#mate>

Korkiasaari, Jouni (2002) Statistics on Foreign Born Population. Turku Institute of Migration. Available at: http://www.utu.fi/erill/instmigr/eng/e_16.htm

Matthews, Janice R; Bowen, John M; and Matthews, Robert W. (2000) *Successful Scientific Writing: A Step-by-step Guide for the Biological and Medical Sciences*. Cambridge: Cambridge University Press.

Ministry of Social Affairs and Health (1996) *Health Care in Finland*. Helsinki: Government Printing Office.

National Research and Development Centre for Welfare and Health (1993) *We're Having a Baby*. Helsinki: Painatuskeskus.

National Research and Development Centre for Welfare and Health (2000) *We're Having a Baby*. Helsinki: Painatuskeskus.

Schlesinger, Elfriede G (1985). *Health Care Social Work Practice: Concepts and Strategies*. New Jersey: Times Mirror / Mosby College Publishing,.

Sorainen Olli (2001) Ministry of Labour, Finland in OECD Trends in International Migration. Available at: www.mol.fi/migration/finrep2001.pdf

Taylor Cox Jr. (1994) *Cultural Diversity in Organizations: Theory, Research and Practice*. San Francisco: Berret-Koehler.

World Health Report (1997) *Conquering Suffering Enriching Humanity*. Geneva: World Health Organisation.

Appendix 1

Interview questions

Framework for background information:

- How old are you?
- How long have you been in Finland?
- What is your legal status (this information is strictly confidential)?
- Do you have a partner? (Finnish, the same nationality or another nationality)
- How many language(s) do you speak or understand?
- Do you have children? If yes, how many?
- What is your level of education and your occupation?

Regarding antenatal clinics:

- How did you first get health information in Finland?
- In your first antenatal visit to the maternity clinic did you go with your partner or a relative?
- What can be said about your first visit to the health centre? Narrate pleasant and unpleasant experiences
- Did you experience any form of uneasiness because of the antenatal questions asked by the medical professional/s?
- What kind of socio-cultural barriers were encountered in the communication process?
- Recall and freely narrate your experiences during all antenatal visits/check-ups?

Regarding postnatal clinics and child welfare clinics:

- Did you attend postnatal check-ups with your partner?
- How easy or difficult was it to discuss about family planning with health professionals during postnatal visits?
- Did you have lots of reservations because of your cultural backgrounds?
- Did your spouse advice you on how to behave during postnatal visits?
- Do you think culture plays any role in these kinds of discussions?
- Tell me about pleasant and unpleasant experiences during postnatal care encounters?

Identifying information needs, socio-cultural gaps and problems:

- Tell me in your opinion the usefulness and problems associated with maternity care/ pre-school child age health care guidelines manuals/booklets provided by the health centre?
- How easy or difficult was it to follow and understand the information in it?
- What can you say about the effect of language on the distribution of health information?
- How would you generally assess the nature of the health services and information received?
- As an African woman how do you think you are seen and understood by the health professionals?
- What is lacking and missing in the system?
- What kind of studies would be pertinent and important to expand on in the future?

Iranian Asylum Seeker Families in the Finnish Health Care System

Arman Haghseresht

1. Introduction: opening up hearts

The objective of this research was to find out about the experiences that Iranian asylum seekers living in a certain Finnish city have had within the health care system. As the researcher and a fellow Iranian, I was also interested in learning about what the informants thought and felt about their experiences. I wanted to know if and how they acted upon these feelings.

1.1 My own story

When I was still living at home in Iran I had no reason to give much thought to migrants, especially refugees. Things generally worked well for me. As a member of the mainstream, a person with a middle-class background, I didn't need to worry about my basic rights as a citizen, although I lived in a country ruled by a religious dictatorship. Those rights included the right to reside in the country, work and study. Due to my own socio-economic status in relation to other Afghan refugees, I did not need to worry about receiving proper health care services. I didn't bother to think about how migrants were managing in terms of their basic needs in Iran. When the situation changed over time, I ended up being a migrant and a member of a minority group in a society myself. Consequently, I became much more aware about what it means and the difficulties connected with it.

I see myself as being different from the Iranian asylum seekers I know in Finland in certain decisive terms. After twelve years of living in Finland and having an active social life I have integrated into the Finnish society rather well and adopted its norms, values, customs and mentality. However, since my informants tend to feel their cultural identity threatened by the dominant culture of the host country their social circles are quite small and limited. Thus, they mostly interact only with each other,

and naturally strongly hold on to their own cultural values and norms, which further isolate them from mainstream society. This gives me contradictory feelings. On the one hand, I see how well I have managed to adjust to the new society, but on the other hand, I feel I have become a stranger to my own origin.

I did not come to Finland as an asylum seeker, but as a refugee through the UNHCR (United Nations High Commissioner for Refugees) programme. Refugee status provided me with more rights than asylum seekers have, and also entitled me to receive a broader variety and higher quality of different public services, such as health care. With the exception of some small groups of refugees that arrived in Finland in the 1970s, I entered the country among only the second group of refugees accepted in Finland as part of a UNHCR quota. The officials I encountered were friendly and cooperative in comparison to the current situation. It is my general opinion that because of years of experience in receiving a variety of migrant groups and having to work in a difficult position, many officials are now less motivated and there is more indifference in their attitude than at the time I arrived here. Consequently, due to my different experiences and more established status, I felt differently than the asylum seekers that I interviewed for this research. I knew I could stay in Finland, and therefore had the opportunity to make long-term plans for my future. I had legal rights that made it possible to follow through with those plans of building a life in Finland.

The situation for asylum seekers today is totally different. I can say that in respect to what they have been through it must be hard to have positive feelings, such as hope, motivation or the ability to act.

If I consider all of the changes that have taken place since I came to Finland twelve years ago, I would say that the new law called the Integration Act (*kotoutumislaki*), even if practiced poorly and inadequately, has been the one positive development that has also had an influence on the position of asylum seekers. It has provided opportunities for migrants to study and to gain entrance to the labour market which can lessen social isolation. However, these opportunities are indeed limited to generally low-level jobs in places such as kebab shops. Furthermore, the increasing cuts in services, poor financial situation and inadequate resources that affect all public agencies obviously also have a strong negative impact on asylum seekers.

1.2 To the reader

Even if the reader of this article has not been an immigrant herself, there is no guarantee she will never experience migration in the future. I faced the experience twice. The majority of Iranians who are now refugees could not have imagined such a thing back in 1978. Whether we like it or not, we are all bound together with the forces of life itself. I therefore consider the issue of migration extremely important and feel it is important for every member of every society to learn what it can mean and what it has meant for all those who are migrants now.

Even if we never have the experiences of being a migrant, we may nevertheless be caught in the turmoil of living in a society in which social stratification increases through various discriminatory practices towards certain social classes and groups, including migrants. Thus it is important to study the different migrant groups more closely and listen to what they have to share and really hear their voice. Asylum seekers in particular are a significant group in this connection because they are in one of the most vulnerable positions in society.

2. Getting into the research

Until recently, I thought that social care is my specific area in the field of social and health care. However, since these two areas are interwoven, and may even overlap, I found this research project a very useful opportunity to get more involved with health care issues. I am happy that I had the opportunity to choose the target group myself. It is certainly expedient to study a social group about whom the researcher has a fair amount of knowledge, a group which he is concerned about and to which he feels a commitment. Of all Iranians living in Finland, I decided that it was important to study the most vulnerable and stigmatised group.

It was not difficult to get in touch with the informants. However, some difficulties appeared in terms of understanding each other. I personally have changed a lot since moving away from Iran, and similarly people who have recently migrated from Iran are different from the Iranians I used to know when still living in there. Some of my

close non-Finnish friends often describe me as being more than 50% Finnish already. I dare say that Iranian asylum seekers in Finland are 150% Iranian -- due to the need to protect their cultural and ethnic identity that they experience as being under threat - and hence, obviously, there were significant differences between us.

3. Research aims

The aim of this research was to investigate the target group's ways of thinking, feeling and acting towards the services provided by the Finnish health care system. There are two main research questions:

- How do the informants assess their position/ situation in the Finnish health care system?
- What expectations/ needs do the informants have in regard to the Finnish health care system?

In order to appreciate the positive experiences and assess shortcomings as well as to be better able to improve the services in the future, it is essential that the target group's own voice is heard.

4. Methodology

Gaining access to informants was not a difficult task. Before I came to Finland, I had already worked with refugee children included in the UNHCR programme and pursued studies in the field of social care. I also actively sought and established contacts with other foreigners in Finland in order to try to be of help to them in adjusting to Finnish society.

Being of Iranian origin, I have stayed in close contact with Iranian refugees and asylum seekers in Finland and consider myself to be part of that community. On the other hand, I am now a Finnish citizen and have both studied and worked in the field of social care for years. This has provided me with practical experience and skills as

well as familiarity and understanding of Finnish society and its public service sector. When I began collecting data for this research, I already knew my target group on a personal level, and they were aware of my studies and work history in Finland. All of this helped to create an atmosphere of trust between us, and encouraged people to feel confident enough to freely and eagerly participate in interviews. The interviewees also had no objection to being tape-recorded during the interviews.

I chose a qualitative research method to implement the study for several reasons. Firstly, it is well-suited for the main research objective of finding out what are the actual real life experiences, thoughts and feelings of the target group concerning the issue of health and health care in Finland. In-depth interviews help to reveal these experiences and thoughts in all their complexity. The interviews concentrated on a few issues but in great intensity.

5. The Iranian asylum seeker community in Finland

In Finland, the Iranian community includes people with a wide-range of socio-economic situations: diplomats; students; migrants who have come to the country for work, marriage or family reunification; refugees; and finally, asylum seekers. In recent years, the number of Iranian refugees and asylum seekers has decreased corresponding to the changes that have taken place in Iran. Moreover, the revision of Finnish policies that allow asylum seekers to be deported after an accelerated procedure has also affected the situation. Unfortunately, background information about Iranian asylum seekers in Finland is not easily available, though some of the primary reasons that people from Iran have sought asylum in Finland over the years include religious freedom, political and ethnic persecution.

Statistics on migrants in Finland (2002)

102,723 = Number of foreigners⁵

21, 791 = Number of refugees⁶

2440 = Number of **Asylum applications** by 30.09.2002 in Finland⁷

⁵ **Monitori Magazine, 4/2002**, Ministry of Labour, Helsinki

⁶ **Monitori Magazine, 4/2002**, Ministry of Labour, Helsinki

2243 = Number of people with Iranian nationality resident in Finland ⁸

2089 = Number of Iranian refugees⁹

85 = Number of **Iranian Asylum applications** by 30.09.2002 in Finland¹⁰

When an asylum seeker enters Finland, he must immediately contact the closest police officer or police station. The police authorities then conduct a preliminary interview in order to clarify such facts as the asylum seeker's identity, the way of entering the country, and the basis for applying for asylum. Officials also ask about the financial status of the applicant's relatives at home. A more thorough interrogation is conducted later that may last for hours and include several meetings with the police authorities. This interrogation forms the basis of making the final official asylum application.

After an asylum application is submitted to the Finnish Directorate of Immigration, the asylum seeker is placed in one of the reception centres in Finland where she must wait for a decision. The waiting period varies according to the asylum seeker's country of origin, but usually takes several years. If the application is rejected, the applicant has the right to appeal to a regional administrative court and is appointed legal counsel which is subsidised by the Finnish government. It is also possible to hire private legal assistance, but this is rare due to the poor financial situation of asylum seekers. Increasingly, there has been an emphasis by the Finnish authorities on the use of accelerated asylum procedures. Complaints have been made regarding the efficiency of state-provided legal counsel. Some people feel that they are not sufficiently competent in their work and, for various reasons, do not always have the client's best interests as a priority.

If the regional administrative court rejects an appeal on the first negative decision by the Directorate of Immigration, then it is sometimes possible to further appeal to the Supreme Administrative Court. The Supreme Administrative Court itself grants leave for appeals. If the Supreme Administrative Court does not grant leave to appeal then the asylum applicant is deported to the country from which she came. If the asylum

⁷ **Monitori Magazine, 4/2002**, Ministry of Labour, Helsinki

⁸ **Monitori Magazine, 4/2002**, Ministry of Labour, Helsinki

⁹ **Ministry of Labour, 2002**, Helsinki, **Monitori Magazine, 4/2002**,

¹⁰ **Monitori Magazine, 2/2002, 4/2002**

seeker refuses to leave voluntarily, he is taken by force and accompanied on the flight by two Finnish police officers who deliver the individual to the officials of the target country. If it can not be established from which country the person arrived to Finland, the asylum seeker is deported to the country of origin. Currently, most Iranian asylum seekers in Finland are rejected for asylum.

6. The informants

For this study, I conducted in-depth interviews with three Iranian asylum seeking families living in Finland, each of which consisted of a father, mother and a child or children. The families were selected both because of their status as asylum seeker which makes them among those most vulnerable of migrant communities, as well as their Iranian nationality which I identify myself. The chart below provides brief background information regarding the families.

Family 1

- Khosrw (32 years) father
- Parvin (32 years) mother
- Kambiz (4 years) son
- 2-3 years living in Finland

Family 2

- Bizhan (47 years) father
- Manizheh (37 years) mother
- Arzhag (under 1 years) son
- Zhaleh (7 years) daughter
- 3-4 years living in Finland

Family 3

- Farhad (32 years) father
- Shirin (27 years) mother
- Sara (6 years) daughter
- 1-2 years living in Finland

Note: The names are pseudonyms and ages are approximate in the interest of protecting the identities of the families.

6.1 Family 1

This family consists of three members. The parents are in their early thirties and the son is four years old. They have stayed in Finland two and a half to three years. Both of the parents' native language is Persian (Iran's official language). They also speak a little Finnish and English. The family considers itself belong to the upper middle class in Iranian society.

The mother, Parvin, told that she had six credits left to complete her B.A degree in psychology before she had to flee the country. She has a diploma in economics and accounting as well as a technical diploma. In addition to being a housewife, she used to work as a cashier. Parvin is not employed. She is also aware of the limited possibilities for asylum seekers to study in Finland. At the moment she is not studying, but will start a Finnish language course in the autumn.

Asylum seekers face obstacles to getting jobs, which include discrimination and suspicious attitudes by employers. The long period of uncertainty when awaiting the decision on the asylum application, the sense of not being able to have any influence on one's future combined with not having a proper home; often results in asylum seekers adopting a passive attitude towards learning the Finnish language or motivation to study and work.

The father of the family, Khosrw, had worked as a goldsmith, chicken farmer, and automobile parts salesman in Iran. He had completed a diploma in a vocational school. He was also aware of the very limited possibilities to work and study in Finland. Currently, he neither works nor studies. Khosrw was present during Parvin's interview, and fully agreed with his wife's account of the experiences they had had with the Finnish health care system.

6.2 Family 2

There are four people in the second family: a father, mother, daughter and son. The father is forty-seven years old and the mother in her late thirties. The girl is seven years of age and the son a little under one. The family has lived in Finland for about three years. They consider themselves belonging to the upper middle class in the Iranian society.

The mother, Manizh, speaks Persian, English and a little Finnish. She has a B.A in nursing, and worked in Iran as a specialized nurse. The father, Bizhan, is an architect. He has worked as a visual artist as well as a jeweller. When I asked whether she could work in Finland, Manizh said no “...but if we can ourselves find a job and an employer who is willing to hire us, we can be granted a work permit. The rule is that we can earn 100 euro or less per month. If we earn more we can't receive any benefits from social services.” All asylum seekers in Finland are entitled to basic income support. However, income support benefits are reduced if earned income exceeds a certain limit.

Manizh pointed out that she and her husband had done voluntary work for two years as supervisors of summer camps organized for migrant families in Finland. Manizh said that she is aware of the possibility for her to study in Finland and explained that by the end of August she will start to study nursing in English. Bizhan has no plans to study, but when his wife begins her studies he will stay at home taking care of the children, improve his Finnish language skills and work with his art.

6.3 Family 3

The third family consists of a father, mother and daughter. The mother is pregnant with the family's second child. The father, Farhad, is thirty-two, the mother, Shirin, twenty-seven, and the daughter six years of age. The family has stayed in Finland for one and a half to two years. Persian is their native language, and they also speak a little Finnish. The father studies English.

Shirin went to school for eight years in Iran. She was educated as a hairdresser and tailor, and worked as a hairdresser. She considered her family to belong to the upper middle class of the Iranian society. When asked about the possibility to work in Finland, she answered that there is a new law which allows her to work, though she was not working at the moment. When she was asked if she could study, Shirin replied: “Yes, but not everything, there is the exception of university education.”

Farhad went to school for 9 years and had his own shop in Iran. He considered himself to belong to the middle class of Iranian society. He knew about the possibility to work in Finland. At the time of the interview he did not have a job, but he was planning to start working very soon. He knew about the possibility for asylum seekers to study in Finland and was learning the Finnish language.

7. Findings

7.1 The reception centre

7.11 General information

Most commonly, the first contact with the Finnish health care system by asylum seekers takes place in the reception centre clinic, except in cases of medical emergency or an urgent medical need when the clinic is closed. In this particular reception centre, an asylum seeker can obtain the services of a physician and a nurse. For procedures that require more professional expertise or special equipment, such as dental or laboratory facilities, the asylum seeker is referred to specialised health care units. Asylum seeker patients must first visit the reception centre clinic to obtain a written referral for specialised care.

This is the process for asylum seekers to gain access to Finnish health care services:

During the regular office hours of the reception centre clinic:

- Patient → Nurse in reception centre clinic

- Patient → Nurse in reception centre clinic → Physician in reception centre clinic
- Patient → Nurse in reception centre clinic → Physician in reception centre clinic → Specialised physician, dentist or radiologist in specialised health care unit or hospital

When the reception centre clinic is closed:

- Patient → District hospital emergency room → Nurse in hospital → Physician in hospital → Specialist
 - Dentist
 - Radiology
 - Laboratory

Before discussing asylum seekers' views of health care services provided by the reception centre, I would like to present the views of one interviewee regarding the general state of hygiene in the centre. It appears to be difficult to maintain an adequate standard of hygiene in reception centres (often called 'the camp' by asylum seekers) due to the fact there are a lot of people living in a relatively small space – 80 people in 40 double rooms. The residents come from many different parts of the world and, in the interviewee's opinion, therefore have different standards and customs of cleanliness themselves. The interviewee continued by explaining more about the reasons for this problem.

Definitely there is not enough toilet facilities, and after daily cleaning, very soon (less than half an hour), the place is dirty again. In addition, part of the dirt is not new but has built up during many years of use and naturally difficult to clean. Basically asylum seekers themselves are responsible for the problem since they don't care about the cleanliness of the centre. (Manizh)

The interviewee blamed other asylum seekers for being irresponsible in maintaining cleanliness as well as the officials for their apparent lack of interest in renovating the building and improving the living conditions for asylum seekers.

7.12 First health screening - an accepted routine

One of the first medical experiences an asylum seeker has, aside from the exceptional treatment of symptomatic illness or urgent cases, is the first compulsory health

screening by the reception centre clinic. This screening includes taking certain blood tests (for syphilis, hepatitis and HIV), an electrocardiogram and lung x-ray for adults. In general, the interviewees accepted the preliminary health screening without complaint. Some found it useful because they were used to having regular check-ups in Iran and wanted to continue doing so in Finland. Others had most of the test taken already in Iran and found this to be unnecessary. My informants believed that health screening for asylum seekers was required by law, but no force was involved regarding how quickly they were expected to present themselves.

7.13 Basic medical needs of informants

According to my informants, their basic medical needs included the treatment of different diseases, maternal/child clinic services, psychological counselling, and the services of dentists, ophthalmologists, and the laboratory. When an asylum seeker needs to see a doctor, he must first visit the nurse at the reception centre clinic, who then decides whether a doctor's appointment is necessary or not. The biggest problem was that the nurse's hours for meeting patients were way too short: they are only from 9.00 a.m. to 10.30 a.m. If there was a need to see a specialist or use the laboratory or radiology services, or any other services not available at the centre itself, the centre's physician gave the patient a referral to other units of the Finnish health care system.

7.14 The medical staff and complaints

The nurses at the reception centre are the first health care provider that the asylum seekers meet. Informants made more complaints about the services of the nurse. However, this does not mean that the asylum seekers are more satisfied with doctors, but rather this indicates that they have considerably fewer contacts with them. It is natural that the primary health care provider that asylum seekers have the most contact with is discussed more frequently and in greater detail.

The main target for complaints was the health care services provided by the reception centre itself, and only secondly the mainstream health care system in general. Excerpts of the interviews illustrate some of the reasons why many of the informants

found the services inappropriate and inadequate. The following is from Manizh's interview:

I'm not satisfied with the health care provided by the reception centre at all. ...In the reception centre, in contrast to hospitals, the doctor is largely absent for several reasons. So we don't have the chance to meet the doctor properly. I had to meet the nurse who was a nursing student doing her practical training and sometimes was unfamiliar with the problems we had. Often they have to check a book to find the answer to a simple question and usually the answer was not found there. They had to ask each other and finally they had to ask the oldest nurse who works there permanently and she would make the final decision. I don't mean they are bad people but the problem is the lack of experience, which is very important. In addition, I don't trust a practitioner who uses books in order to make a diagnosis during the patient's visit! That I can do myself too¹¹.

Manizh was generally unsatisfied with the quality of the services the reception centre clinic provides. She made a comparison between the services of the centre and the hospital. Her criticism focused on the absence of doctors and the reception centre's use of unqualified nurses. Nonetheless, Manizh did not question their good intentions.

Manizh told her own story about visiting a health care centre, and how she felt that the nurse treated her with inexperience and carelessness. She contacted the reception centre clinic because of unusual and heavy bleeding. A very relaxed and carefree nurse told her that this was very normal for a woman, but should the bleeding continue, she could always come back. During the time she was waiting she lost a lot of blood daily and felt very weak and dizzy. Finally, she went to see the same nurse and explained that she did not think it was normal to feel the way she was feeling. This time the nurse had a different attitude and ordered laboratory tests, which showed that she was pregnant. The symptoms were signs of a miscarriage. The interviewee explained about the way she was treated, her feelings about that, and her physical and emotional condition during that time:

There was a possibility to prevent the miscarriage. It may have been possible to save the baby if the matter had been taken care of early enough. It could be possible that even if I had received the treatment right in the beginning I still would have lost the child, but what happened shook me up emotionally and I ended up losing a lot of

¹¹ Manizh is a professional nurse herself.

blood. The worst of all was the feeling that I was treated carelessly. I didn't know, at that time, how to get help through another channel and when I found out, it was too late. (Manizh)

Whether it was possible to save the baby or not, receiving proper care from the very beginning would have saved the interviewee from unnecessary physical and emotional suffering.

Certain common themes could be found in the interviewees' descriptions of their experiences when seeing a physician. Doctors were generally seen as having an indifferent attitude towards patients at the reception centre. They were also perceived as having a lack of experience particularly with the different types of diseases and complaints that people coming from different parts of the world may have, but which are not common among the Finnish mainstream clients. One interviewee had heard that the doctors working in the reception centre had not yet graduated, but were working in the reception centre to gain practice experience. In other words, asylum seekers saw themselves as guinea pigs. Visiting a doctor at the reception centre clinic was considered a difficult process that involved several steps of going back and forth to the clinic in pursuit of convincing the other nursing staff that an appointment was necessary.

In order to understand the information given by the interviewees in its context, it is important to remember that the nurses and doctors who work at the reception centre have a difficult and stressful job to do. The vast majority of patients they see at the centre are in varying states of crisis. The work significantly differs from that of the staff in an ordinary health care unit.

Some informants pointed out that the reception centre clinic provided only the primary health care services of a nurse and a GP. In order to see a specialist, a patient had to go through a complicated route of visits and convince the clinic staff to give a written referral to gain access to mainstream specialised health services. Manizh told me about how she tried to prevent unnecessary damage to her daughter's ear:

In her case, based on my own first negative experience of miscarriage, I insisted on seeing a specialist in order to avoid further damage to the ear. After visiting the ear specialist we found out that there already

was a hole in her eardrum, even though I had thought that through my insistence I had managed to prevent it. In general I hardly remember meeting a specialist in Finland. (Manizh)

Manizh's daughter had a recurring ear infection. It took a long time to convince the centre's medical staff that an examination by an ear specialist or a paediatrician was necessary. Nevertheless, she was unable to prevent the damage. Even though the family had various serious medical complaints, Manizh said that she hardly saw a specialist in Finland. In another interviewee's opinion there was a lack of specialists in Finland compared to Iran.

7.15 Other influential factors - use of time, language barriers, dissemination of information

In addition to the experience of medical staff, there are also other factors that affected the quality of health services; such as the use of time, language barriers and dissemination of information. First, the time available for patients to visit the nurse and make appointments with the doctor is very short, especially when considering the amount of people living in the reception centre. The time allotted is only 90 minutes during weekdays. This needs to be extended. The actual appointments are also quite brief.

The medical staff, however, speaks English. The clients also have the right to use an interpreter. Miscommunication problems are more related to the use of interpreters. The interpreters use Persian, which is the official language of Iran and spoken by the mainstream Iranian Farsi people. However, most interpreters are Iranian Kurds and Persian is their second language. Most of the interpreters are also not familiar with the medical terminology used by medical professionals. The majority of interpreters are not familiar with medical terms either in Persian or Finnish, and consequently there are a lot of misunderstandings between patients and service providers, which in an extreme case can even be harmful if not dangerous. One of the interpreters used by the reception centre had studied medicine in her own country before coming to Finland, and people felt more secure and trusting in dealing with matters concerning

health when she was available. When the question ‘is the quality of the interpreters’ work satisfactory?’ was asked, one interviewee answered in the following way:

No. If the matter is important I have to ask for a good interpreter. In the beginning when we didn't know about this shortcoming, I noticed that when, for example, I was explaining about the pain I was feeling, the interpreter just repeated to the staff that I have pain. By that time we didn't understand exactly what was happening. Now that I understand more I always ask for a better interpreter. (Shirin)

Shirin thus began to ask for a better interpreter in urgent medical matters.

Aside from Manizh, who is a nurse herself, none of the interviewees had received any written material concerning their rights as patients, the Finnish health care system or available services in general, child care or legislation. Manizh was given English and Persian language material that was limited to medical care. The nurses at the reception centre clinic had only given brief oral information to the patients. One interviewee mentioned that she had received information mostly through her relatives who had been living in Finland longer. Another had collected pieces of information whenever there was a contact with health care personnel outside the reception centre clinic. A pregnant mother was missed information in Persian concerning pregnancy. Moreover, Manizh explained the general practice she had learned regarding the benefits she was entitled to and other awareness about one's own rights:

There is a basic rule that if I don't ask for a particular service they don't let me know about my rights. One can only use the benefits if one knows and asks about them. (Manizh)

The residents of the reception centre used the services of ordinary pharmacies. Generally, no medication was provided in the reception centre, and the services of the pharmacies were found to be expedient:

We don't have problem concerning medicines, if the doctor prescribes the appropriate one in the first place, which is not always the case. Usually there are good medicines available. Like others, we pay the first ten euros of the cost of the prescription and the rest is covered by the reception centre. (Parvin)

The reception centre uses the services of only one dentist in town. If an asylum seeker wants to see a different one, he has to pay for the expenses himself. Hence this is not

an option for people in the underprivileged circumstances. The interviewees did not have the opportunity to compare dental services they received in Finland to anything else but the experiences they had in Iran.

I can say that in Iran dentists' work is more developed. Here first of all they have such long waiting times to get an appointment (e.g. three months). Also, for one tooth we may need to visit the dentist five times. Last time I had a cavity the dentist put a temporary filling in it, but it came loose in two hours. Today when I went back they fixed it in three minutes. I don't know whether the filling this time is temporary or not, since I didn't understand what they were trying to tell me. It doesn't look like a temporary filling. My next appointment is in two months. (Shirin)

I'm unsatisfied with the reception centre clinic. You are not given an appointment with the dentist unless you have an acute toothache, even if your tooth turns black. I'm afraid that if I get sick I won't get proper attention and care from them because I'm not accepted as a refugee yet. (Parvin)

Many asylum seekers were also in need of the services of an ophthalmologist. As one interviewee explained, the reception centre can pay part of the costs for new eyeglasses once every two years, if prescribed by a professional. Manizh told what had happened to her:

I've had eyeglasses prescribed twice. The first glasses didn't improve my eyesight and I didn't use them at all before my next visit two years later. I heard that also other people were unsatisfied with the work of the person who prescribed the glasses. In my second visit that person was not working there any more, and the new glasses were fine. (Manizh)

The first prescription for the glasses was obviously incorrect. It took the interviewee two years to wait for the correct prescription. She assumed the mistake was due to the one individual professional, about whom also others had also complained. Consequently, the interviewee found the level of professionalism to be random and had no reason to think otherwise.

7.2 Experiences in the health care system

7.21 Psychologists and psychotherapists - cultural differences

It is very important to have psychologists and psychotherapists that are familiar with the culture of their clients. The ideal situation would be to use the services of a professional from the same ethnic group. Where this is not possible, professionals of the host country should be trained in culturally appropriate practices. Manizh tells about her experiences with a psychotherapist:

In the beginning, I went to see a psychologist for six months because of my fears. I was afraid of being attacked. We lived in the ground floor of the reception centre's accommodation unit, which didn't have any security. I was afraid that someone would break the window and come into the room. I was told that I had no reason for such fears, and that I should visit a psychologist. Once a week or every other week for six months I went to see the nurse, and finally I got an appointment with a psychologist. During the sessions I was talking and that person just listened to me without saying anything. I was expected to say the same things that I already told to the police concerning why I came to Finland. Having to repeat the same things all over again put me under great emotional pressure. After each session I had strong headaches and started suffering from sleeplessness. The psychologist said anybody lives in the ground floor has similar fears. My headache and sleeping problems were solved by sleeping pills and painkillers. I decided not to visit them anymore after that experience. (Manizh)

Manizh didn't find help from the psychotherapist. Whether her fears were grounded or not, it can not be denied that she did suffer. It is important to realize that the simple fact that a psychologist acknowledges the fears may be a crucial factor in the treatment. This doesn't mean that a therapist should encourage those fears.

The last topic I would like to mention is the confusion over what confidentiality in service provision exactly means. Confidentiality appears to be an obvious ethical principle of social and health care professionals in Finland. However, it can be questioned whether it is actually practised with asylum seekers. Personally I am aware that officials regularly discuss the private lives of clients in meetings in one Finnish city. Hence the fears that private information given by asylum seekers to social and

health care providers might be revealed to outsiders appears to have some basis in reality.

Trends in new asylum policies are more strongly oriented towards deportation which has caused grave emotional and psychological stress for asylum seekers. Iranian asylum seekers belong to the target group of the new changes in policy. This stress discourages them from living an active normal life that includes plans for the future. Due to the impossibility of planning the future, uncertainty takes a heavy toll.

7.22 Family counsellor and the crisis centre - cultural differences

Manizh describes her visit to a family counsellor in a crisis centre:

Another time was when my daughter and husband became sensitive to each other and argued frequently. I asked help from a family counsellor. This was a similar experience¹². We were not told what to do in order to improve things. There was someone who just listened to us. Maybe it works for Finns who don't have anyone to listen to them but not for us. We talk with each other regularly every day. (Manizh)

She didn't find it useful to ask advice from a family counsellor because cultural differences became an obstacle. Here the need for the culturally appropriate services of a family counsellor who is able to help the clients with a deeper understanding and means of influencing the client is apparent.

8. Hospitals and clinics for all?

I noticed two different kinds of experiences the informants had with hospital care. There were many positive experiences, noted at the end of this section, however, there were also many negative experiences. Manizh explained about how often she encountered a doctor and punctuality at the hospital.

During the time I was in the hospital I didn't meet a doctor at all. A night before delivery an anaesthetist was supposed to visit me and give me some instructions. She came very late. In the morning I was told

¹² Similar to the experience with psychotherapist.

that I'd go to delivery room at 6.00. Actually this did not happen before 9.00. (Manizh)

Manizh complained about the lack of punctuality. She also felt she did not get any attention from a doctor when she was in labour. Manizh also emphasised the difficulties to get to a hospital in a case of emergency, as well as the long waiting period and the limited opportunities to actually see a doctor. She criticised the whole routine of the system:

In the district hospital I've seen that in the reception part there are seven rooms but only three of them are in use. I've noticed that for those who went to radiology the waiting time was at least one hour. So in my case if I could have had an x-ray taken, which I could not because of breastfeeding, I would have had to spend altogether five and a half hours in order to find out what was wrong, how they could treat me or what prescription to give. I can't imagine what would have happened if my situation had become more serious during that long time of waiting. For example, I could have gone into shock because of the pain since there was nobody to check my situation. In some cases it could be even dangerous if there is nobody doing follow-up on the condition of the patient. I am not talking about my own case only but it concerns everyone who has to wait there, including Finns. (Manizh)

In Manizh's experience, a long time of waiting at the hospital without receiving any care is potentially dangerous. She thought that resources, such as space, were not used properly.

Parvin, the mother of the first family, explained more about issues related to equal treatment in the regional hospital in addition to the long waiting time:

In the hospital they initially listened to me eagerly and said that you have to visit us a few times and gave instructions about what to do, but when they found out I was an asylum seeker their attitude changed to be negative and they said that I had to visit the doctor in the reception centre. The last time I had a serious situation, I had to go to hospital. I had to wait for a long time. I think it is the same for Finns too but they don't give us the same careful services they give to others. They try to cut us out of everything. For example, in my case they said that I had to come back for an ultrasound after three months and if there was still the same problem, I would need surgery. The doctor sent me the same response in writing. Now it has been six months since then and nothing has happened yet. I think they don't care enough to make an appointment for me. In other words, the hospital services are good but they avoid giving treatment for us as much as possible. In special cases

they say that that this time it is OK, but next time they don't accept us anymore. (Parvin)

Parvin felt she was treated as a second class resident. At hospital they were trying to avoid providing services because of her residence status. However, later in her interview she spoke about how satisfied she was with the services and attitudes she experienced at a dentist's appointment as well as in the central hospital. The biggest differences were found between the hospitals and the reception centre health services. The different experiences of the interviewees may be purely coincidental. On the other hand, perhaps the fact that Manizh was a nurse and therefore more familiar with issues concerning health care and illness, she was more able to demand better service.

8.1 Dentists' limitations

Parvin compared services provided by a dentist and the health care services at the reception centre:

Of course they, at the dentist's, only do the very necessary procedures for asylum seekers because they say our situation in Finland is not stable and clear. This is their policy, but dentists do their job properly. ... They want to help but just don't have enough experience to do it as well as in Iran. For example they don't have the experience to win the patience's trust. Compared with Iranian dentists their knowledge is also much more limited but compared with doctors in the reception centre they work better. It is also possible to make an appointment with a dentist quickly. (Parvin)

Parvin talked about the limitations of dental care in Finland, which must not be confused with the quality of the treatment itself that she considers high. She mentioned that, compared with the reception centre, she found dentists cooperative and quick, if not as experienced as Iranian dentists.

Manizh noticed a change in the quality of dental care:

We've had to visit a dentist several times. In the beginning it was very interesting to see that they checked the teeth very carefully and regularly, but then I felt that as time went on it became more difficult to get an appointment and they didn't do such a careful job anymore. I had an old bridge on my teeth, which was made in Iran. One tooth connected to it started to be ache. The Finnish dentist didn't know what the reason was even after taking an x-

ray. In order to find it out she broke that bridge and after that my healthy tooth, which was working as a stand for the bridge, was left without cover... They said that they don't understand what is wrong. So the situation was even worse than in the beginning. When I asked what we do now, they didn't do anything, not even to return the how the teeth were before. They claimed that since I was an asylum seeker they couldn't do anything...This situation continued for one year because after what happened, I got pregnant and I didn't want to visit dentist during that time. I just tried to keep my mouth clean by using disinfecting mouthwash. A few months ago I visited them again because the pain became unbearable and I could only use part of my teeth...I asked if I could change my dentist. I was told that it was impossible. I also was told that if my asylum application will be accepted they may make a new tooth for me instead of the one they had broken. I'm not sure if this offer is still valid or not. (Mainzh)

From Manizh's point of view, seeing a dentist just made matters worse. In her opinion, the quality of Finnish dental services has deteriorated. By this she means the quality of treatment, the level of taking the patient's needs and expectations into account, and limitations to getting access to proper treatment on the basis of the patient's legal residence status.

8.2 Positive feedback

One of the main questions if the interviews was 'How do you assess your position/situation in the Finnish health care system?'. Responses varied from positive to negative experiences. Those interviewees who had a positive attitude towards the health care system felt that the public health care sector did not make any noticeable difference between them and other patients, including Finnish citizens. If services are provided efficiently and in the spirit of good practice, everyone benefits from them equally regardless of their legal status in Finland. If there are shortcomings to the system, everyone suffers from them in the same way. The main source of complaints was the quality of health care services provided by the reception centre clinic.

In one interviewee's opinion she trusted nurses better than physicians within the health care system. In her opinion, nurses were better able to understand the needs of the patient due to their willingness to both listen carefully and ask questions to make sure that everything is clear for both the nurse and the patient. She also praised the quality of the services of laboratories, where she and her son had test taken at several

occasions, in addition to her feelings regarding the equality in the provision of the services.

They are very fast and we get the test results mailed to our address. I think that like in pharmacies, we are treated the same as others and don't have any reason to complain. (Parvin)

In general, the interviewees were satisfied with the services of laboratories and radiology department.

Parvin also had some positive comments about the speed of the services in the child and maternity clinic:

I had contact with them too, since they gave me an appointment to treat my son's skin condition. Their services are all right. The best thing about them is that when I ask them for a visit they respond quickly, which is very important. For example, when I asked for a psychologist I got an appointment immediately and after visiting the psychologist twice I got a referral to a psychotherapist. In the meeting with the psychotherapist I asked to meet a family counsellor for matters related to my child and again they made the appointment immediately. (Parvin)

She was also pleased with the services and the quick response from the family counselling centre.

Manizh began to tell that her best experiences in regard to the health care services came from the hospital and its nursing staff. However, she soon started to complain about other parts of the health services. It appeared that she had had so many negative experiences that they obscured the few positive ones. I noticed the same phenomenon in the interview with Parvin, the mother of first family.

The father of the second family, Bizhan, mentioned punctuality and the high quality of various equipment in use by health care providers as positive examples of the Finnish health care services. However, he made a comment concerning recent changes in keeping to the set times for appointments:

Punctuality was one of the most important values of the Finnish health care system but not anymore. Before, when a patient arrived at the health care centre the services were immediately provided, but after three years, things have changed in a negative way. The waiting time

for a set appointment is now 10-15 minutes and can be even a half an hour. (Bizhan)

Informants observed a shift away from punctuality in keeping to appointment times. This could be the consequence of interaction with less punctual clients, too much work and burnout amongst the staff. Bizhan's initial focus on the positive sides of using high technology in the Finnish health care system thus changed into negative criticism over the course of the interview.

The father of the third family, Farhad, expressed his surprise about the high quality of services in Finland by saying that he has become very much interested in the management systems in Finland in general, including health care services. He said that in Iran this could not be found. However, he reminded me that the reception centre was an exception to this system.

No gender difference concerning health care services and treatments were noticed by any of the interviewees. Children received better care than adults, which their parents were happy to see. I was told that health care services are free of charge for children. Finally, Shirin, the mother of the third family, told me that the health care staff "has peace of mind while working". She meant that she did not detect manifestations of stress at work. In Shirin's opinion, Finnish health care health care providers were also friendlier in comparison to Iranian service providers.

The interviewees did not find it difficult to comply with prescribed regimens of medicines. My informants experienced good service at pharmacies. However, Parvin, mentioned that there are no problems concerning drug treatment if the physician actually prescribes the appropriate medicine from the beginning, which was not always the case.

Feedback was largely positive in regard to hospital services, with a few exceptions. Farhad used to word 'excellent' to describe his family's experiences with hospitals. Manizh emphasised the equal way asylum seekers are treated in hospitals:

The services we receive in the hospital are given as routine work and differently [than in the reception centre]. That is because they do not

care whether I'm a Finn, a refugee or an asylum seeker. They just do their job properly for everybody. (Manizh)

On the basis of Manizh's own experience, there was no difference in the quality of treatment depending on the legal status of the patient at hospitals. Since she herself was a specialised nurse by profession and was experienced in working in hospitals, she was able to assess the hospital services in Finland professionally. She described her experiences in a Finnish hospital when she delivered her child:

If I talk about the delivery of my son at the hospital I can only say that they had an excellent team there. The maternity wards has midwives. Even though some are students, the service they provide is excellent. For instance, when a nurse visits you, she also stays with you until you do not need help anymore. Sometimes, for example when I was in pain and the nurse couldn't help me, it was still very comforting to know that whenever I needed help she was available for me. Sometimes I apologized to them for bothering them in the middle of the night, but the reply was a smiling face saying "this is what we are here for"... When my son was sick he was treated with care and responsibility. I remember I was told by a nurse that my son had fever and she ordered a blood test in order to find the reason for it. I became angry that they wanted to take blood from a one-day-old baby. Later on I thought what a good thing she did for my baby through this careful act. The result was that an infection was found which was thought to be caused by the delivery. After two days, a cure of antibiotics was started and he got well. If this matter had been ignored, it could have caused him to be a physically weak person for the rest of his life. It was a painful experience but at the same time I appreciate what the nurse did for me. Each time, after each three hours, they took blood from him. I used to cry but I knew that it was for his good. (Manizh)

Manizh was quite satisfied with the quality of the services at the hospital during the delivery with an emphasis on the preciseness, friendly attitude, and strong responsibility of the staff. Generally, we can see that my informants reported a high level of satisfaction with specialised health care services.

9. Areas which need development

Most of the negative experiences and criticism had to do with the health care services provided by the reception centre where the families stayed. The interviewees felt they were not taken seriously, and even if they were, there were strict limitations to

services due to financial reasons. The two issues discussed below were considered to be the most significant barriers by the informants.

9.1 Language barriers

If an asylum seeker sees any other health care provider other than that of the reception centre, she has no access to an interpreter. When asked about language problems in terms of health care services, most of the responses from the interviewees were related to the reception centre clinic and the interpreters it used. Manizh said that it was very rare to find an interpreter who was familiar with medical terms. She knew only one interpreter who had these kinds of language skills, and also trusted him the most. Most of the time, both at the maternity clinic and paediatrician's surgery, she had noticed that they were not familiar with the professional terms she used in English. The staff used either Finnish or Latin terms. She did not use the help of interpreters and felt that many important issues were continuously left unclear, both for her and the health care providers. Manizh continued by giving a few examples from her experiences and emphasized the importance of the role of linguistically and culturally appropriate care:

One time my heart beat was very fast. I was still waiting for my pregnancy test result and I insisted on having an interpreter because it was a very serious matter for me. I was told that the interpreter was on sick leave. Nobody else came to substitute for the interpreter. Later I had the same problem because I wanted to know whether my physical problem was harming the foetus or not, but I didn't get any answers to my questions. This problem is very common. Thus I am trying my best in order to develop both my Finnish and English language skills. I think in the future I will be useful for Iranian and Afghan patients as a kind of mediator between them and the medical care system here.
(Manizh)

Qualified interpreters play a crucial role in the process of interaction between the client and the service provider. Particularly in this field of work even a small linguistic mistake can cause huge and permanent physical and emotional damage. Thus, interpreters should be selected carefully and trained well to develop their language skills in different sectors of social and health care services together with culturally appropriate training. As Manizh points out in her interview, medical terms are used differently in different countries: the child/maternity clinic personnel and

paediatricians in Finland were not familiar with the English-language medical terms she had learned as a professional herself.

9.2 Lack of information

Some interviewees were first informed about the health care system in Finland in the reception centre. Some others claimed they didn't get any information from the reception centre, but when they first had to deal with the public health care provider, they were given advice either by a relative or a friend who had already stayed in Finland for some time. Most of the interviewees said that they had never received any health care information (such as brochures or booklets) provided by health care centres. The only exception was Manizh, who was a professional nurse herself. She had been given some material both in Persian and English about HIV/AIDS and children's health when she first came to Finland. She found the material useful and easy to understand.

In general, informants were of the opinion that they had not been adequately informed about their rights, legislation, and health care services. Some even said they had not been in contact with any other health care facilities than those provided in the reception centre. It is quite logical that when one does not know about one's rights, one tends to demand less. This is an expedient strategy particularly when resources are cut, or amidst a more fundamental change in the society such as what is currently taking place in the Nordic countries, which are shifting from the traditional welfare state towards a more market-oriented society. The excerpt below illustrates how one informant feels about the level of knowledge she has about her rights, and the role of authorities in providing this information:

I can not say anything about it and because I don't know about the law, I am not sure if I have used enough my rights or not. I know there is a basic rule that if I don't ask for a service they don't let me know about it or my rights. For example, whoever studies in Finland has the right to get a discount for travel expenses. But one can only use the benefit if one knows and asks about it. It happens often that people don't use their rights. I know that in the eighth month of pregnancy mothers have the right to get an extra financial benefit in order to have better nutrition. It is about 800 Finnish old marks. I didn't know about it so I didn't use it. So it feels like my right has been taken away from

me. Still I haven't got any material concerning the rights of asylum seekers. (Manizh)

Manizh feels helpless about her lack of knowledge of her rights and believes that there is no intention by officials to improve the situation. As a result, the interviewee has experienced legal and, consequently, economic disadvantages. There is a great need for legal advocates for vulnerable groups of migrants such as asylum seekers.

10. What is the future going to bring?

The informants share quite a mixture of expectations and forecasts for their future in terms of health care services. Unfortunately, some are not very hopeful and don't expect to see a brighter future ahead of them. Some even predict that their situation will become worse due to their experiences in Finland up until now. Some believe that one may make positive changes for oneself, through learning from earlier experiences, but the situation as a whole will remain the same.

Manizh talks about the future as she sees it:

If nobody does anything about the future nor cares about improving the services, naturally no change will happen. I have decided to be involved and active, but I don't know how much life will allow me to do so. I also don't know how many concerned people like me are around. At least there are a few who have made a commitment to be active about this issue in future if and when our position will change from asylum seeker to refugee. We would like not to forget about the situation we have had and want to be influential. (Manizh)

Manizh feels very responsible and would like to have an active role in helping make positive changes in the health care system for migrants. On the other hand, she is aware of the fact that she can not do it all alone. She has the promise of help from some people, but does not know about the obstacles she will face.

Farhad, the father of the third family, had quite a clear vision about the future:

The future for us will be better because we will know Finnish and adjust to the society more. For example when we understand Finnish better we will seek for extra information independently and naturally we will know more. (Farhad)

He had a more optimistic attitude and believed in a brighter future. However, he thought that this would occur through individual development: independence, language skills and knowledge would be the tools to access better services.

Parvin felt optimistic about the future, but she placed more emphasis on the role of others in accomplishing positive changes in comparison to her own input:

Since I think that they [authorities] have humanistic beliefs, we could have a better future if a Finn or another foreigner who is in a more stable position in this society helps our voice to be heard. I believe that they don't want to provide less good services to anybody intentionally, but the present situation is mostly caused by their limited knowledge about the circumstances and the culture of the foreign clients. They think most foreign clients are liars and come from a poor country where they didn't have what they have here, and think this is heaven for them. I find this attitude a very significant factor.
(Parvin)

In Parvin's opinion, Finnish authorities have good intentions and through having more insight and knowledge about asylum seekers and their situation, they would be willing to improve the present state of the health care system. Other people who have a more stable position in the society could have an important role as being mediators between the authorities and asylum seekers, and help in getting the voices of asylum seekers heard.

Bizhan, the father of the second family, mentioned that there were already some positive changes taking place within mainstream Finnish health care. First he said that he knows there are good Finnish nurses who live abroad. He said that based on what he knew, more attention was paid to the situation of nurses nowadays. He found it a good sign, which meant that qualified nurses had fewer reasons to leave seek work outside Finland.

10.1 How informants saw their role in making change

I found it very important to find out ask how my interviewees saw their role improving the health care system in the future. In most cases the interviewees saw themselves as powerless to make any difference. One person mentioned there was nothing he could do except to talk to me because he had no other chance of making

his voice heard by decision-makers. Another interviewee thought that he could not have an influence over anything but could only try to improve things for himself and his family. By being able to work he would have less need for psychological counselling of any kind. Parvin expressed her role and its dependence on her social and legal status:

I can't have any role in improving things. When we are told that we are not from here, don't belong here; we are not registered not only in this city but also in Finland; when we feel that we are seen as parasites here; I don't think our voice could be reflected anywhere. I don't even bother to make any suggestions. (Parvin)

It becomes apparent in her comments that she felt hopeless and powerless due to a sense of alienation and disengagement in Finnish society. As a consequence, she has lost her motivation as well.

Manizh thought her attitudes and role were more independent of her present position in Finnish society:

With my own family I can try to avoid any sickness or injury in order to reduce the need for health care as much as I can. I can also try my best to give health care advice to people around me. Concerning Finnish health care system I have planned to use this issue as the topic of my thesis while I study here. I hope that it will result in some positive changes because I think my knowledge and experience could be useful. (Mainzh)

Manizh was the most hopeful of all the interviewees. She was also the only person who felt that she could have influence, and she even had plans and taken action in that direction. She focused her hopeful attitudes towards prevention on the levels of both her own family and Finnish society at large. This signifies that there are migrants in Finland with a lot of potential and motivation who are planning to make a practical shift towards being a part of the social and health care system. If their expectations and expressed needs are met with cooperation they, they can be a very useful force to improve the quality of the services in this domain.

10.2 How the informants saw appropriate and culturally appropriate care

I found it important to ask whether the informants had their own suggestions with regard to how it would be possible to improve the health care and medical services of the reception centre. Particular emphasis is put on the special needs of asylum seekers.

One of the asylum seekers had a recommendation concerning the treatment of children on the basis of the health care that her own child had received.

My child has always been checked by a general practitioner. I think it is important to have a child specialist (paediatrician) or even a student specialising in paediatrics. I believe that the diagnosis of a disease or any other health problem is very important since it will prevent difficult and more expensive treatment in the future. Proper diagnosis is not possible if the practitioner is not skilled or experienced enough! (Manizh)

Manizh's emphasis was on a correct diagnosis as the basis for prevention of complications and the importance of having a skilled practitioner in treating children. In her opinion, the present situation would be significantly improved if there was a paediatrician coming to the centre regularly to see patients, or even a post-graduate medical student specialising in paediatrics.

A doctor's psychological skills are also extremely important and valuable. Moreover, the doctor's attitude towards non-Finnish patients is crucial. Many foreigners in Finland, particularly asylum seekers, have difficulties in trusting authorities in any field. Understanding the patient's background and possible special needs is decisive in good treatment. One interviewee expresses her feelings about this matter:

We, asylum seekers, would like to know right from the beginning which way of thinking the practitioner has towards us. It does matter to me if he thinks I came here to eat from his table or if I had real problems and reasons to come here and that's why I am her. (Parvin)

There is a limited annual budget allocated for the health care of asylum seekers. Because resources are not always used expediently and the initial health screening is not necessarily carefully conducted or proper diagnoses made, there are many

unnecessary expenses. One interviewee complained about the channels she had to go in order to find a remedy for her sickness.

For example, if I go and tell a doctor that I have headache I am told that maybe the problem is with my eyes, and the doctor refers me to an eye check-up which will cost a few hundred old Finnish marks. This happens a lot. This could be prevented by a few more investigative questions, which would help the doctor to find the source of the problem. By saving that money I can benefit more in another occasion where I am more in need of specialist's services. (Manizh)

She criticised the costly way of diagnosis and suggested that a better budget saving alternative could be a more precise diagnosis made by skilled professional asking carefully targeted questions.

Another interviewee explains about her daughter's sickness and how their needs were met by the health care system.

My daughter's ear is sensitive which means that it gets infected easily if she has a head cold. The reason for this was the highly polluted air in Iran's capital city (Tehran). Since the beginning of my life in Finland I informed the health care personnel about it. Fortunately here, because of the better air, it has been less problematic but here nobody showed any interest to find out what is behind these constant infections which, I think, are caused by an allergy. There has been no allergy tests at all. If I could find out what my daughter is allergic to then we can save many visits to the doctor. (Manizh)

Manizh felt that there was a lack of interest in finding out what was the real reason for her daughter's constant ear infections. In her opinion, many needless visits to the doctor could be avoided if there was a proper diagnosis had been made and proper tests, such as allergy tests, taken.

A pregnant mother suggested that there is a need to publish material concerning medical care in Persian. The material should include, for instance, information about pregnancy and the services of the maternal/child clinic as well as the health care services of the reception centre. Another mother pointed out that she would very much like to have material about health care and the health care system in general in order to make sure she is doing her best to keep her children healthy.

I need information about the common children's diseases that occur in day care centres. Mostly I don't know about them. Even if I ask I don't

understand what they try to explain to me. It makes me very frustrated and worried because, for example, I don't know whether a particular disease is an epidemic or not. I would like to know that what the children's diseases are and what to do about them. (Shiirin)

She needs information about children's diseases, especially infectious ones, which occur in the Finnish day care centre where her child is in order to be prepared for them instead of just being worried.

10.3 Training in cultural competence and community workers

The suggestions that the interviewees gave could be very useful in solving certain individual problems they had faced. However, some interviewees also said that in order to gain a more fundamental change in the system of providing health services for asylum seekers a whole new model and way of practice is needed. This kind of a new model, which I here call culturally appropriate care, includes training in cultural competence and using community workers. A community worker would be the best possible medium between the Finnish health care system of both the organisations and agencies themselves and their employees and foreign-born asylum seekers. Through training in cultural competence it is possible to enhance the skills of medical professionals in a way that ensures interaction and communication in which both parties understand each other, as well as to ease biases, tension and other obstacles for high-quality care. Such training should focus on finding out and learning to use both linguistically and culturally appropriate means approach to clients who come from other but the mainstream culture.

The use of a community worker as a mediator who is either from or in very direct contact with a particular minority group and is familiar with topics related to health care would be needed and very useful. Members of different minorities should also be trained and employed in the sphere of social and health care.

A good starting point to begin fruitful cooperation between the patient and the health provider would be a change of attitude. We have two groups who are in interaction with each other. One is in need of health care, and the other provides that care as her profession. The common goal to develop and improve that interaction should be based

on the equally strong motivation of both these groups to strive for better communication and working together. The health care providers would benefit by having less stress and a better opportunity to provide minority clients with appropriate care, which as professionals is their overall objective, and the clients would receive culturally appropriate and best possible care at the least possible cost.

11. Summary: The main factors in leading a healthy life, gaining access to health care and assessing health among asylum seekers

11.1 Primary factors

- Limited social life with Finns

Unfortunately, in comparison to refugees, the asylum seekers I interviewed did not have much contact with Finnish people. This has a negative influence on their level of Finnish language skills as well as their general knowledge about Finland and Finnish culture. These are strong preconditions that cause asylum seekers to isolate themselves and reinforce their already existing marginalisation. In the future, if and when the legal status of asylum seekers allows them to have more permanent resident permit in Finland and raise their families here, marginalisation and isolation results in difficulties between generations. Second generation immigrants adjust better to the surrounding society than their parents due to broader social circles and daily exposure to the host country's culture in day care centres, schools and through peer groups and friends.

- Difference between singles and families

Asylum seeking families live an emotionally and physically healthier life because they enjoy the company and support of their family members. Families usually have better nutrition because mothers are more careful about the quality of food they give their children. Single people tend to eat less regularly and less nutritious food. Most single Iranian asylum seekers are men. Parents feel a heightened responsibility to look after for the well-being of their children, and hence the health of the whole family is

better cared for than in the case of single asylum seekers. Moreover, a family usually creates an emotionally healthier environment because of expressions of love and caring. Children play, learn and develop everywhere in the world. However, it is important to bear in mind the special risk factors for asylum seeker children which can seriously harm their development and should receive particular attention.

- The special needs of asylum seekers

In general, the target group of this study attempted to take good care of their health. Prevention was one of their main concerns. While living in the reception center and using common toilets and bathrooms, they were very careful about hygiene in order to avoid getting sick. Another important means of prevention was good nutrition. With regard to physical exercise as a preventive health care method, men were more active and therefore in better physical shape. The target group was well aware of basic health issues and did not learn any fundamentally new knowledge about it in Finland. Nonetheless, asylum seekers have a great need for information particularly about childhood illnesses and pregnancy.

When discussing treatment, the interviewees felt they needed more and higher-quality health care services, but only one person had been active in making changes for the better in her own and her family's lives. Unfortunately most of the others were not hopeful of seeing any positive changes in the future and did not think that they themselves could play any role in having an impact on possible improvement of health care services for asylum seekers in Finland. Stress, insecurity about the future and fear all placed enormous pressure on the asylum seekers. There needs to be a greater emphasis on culturally appropriate services of counsellors, psychologists, paediatricians, and maternal health specialists to help asylum seeking families cope with the emotional turmoil of the asylum process.

- *Gender and age*

The informants did not find any significant gender-based differences in the quality of the health care services they received in Finland. Gender differences in Iranian health

care system did not come up in the interviews but this may have been due to the fact that health care is provided separately to each gender due to religious customs. However, the interviewees felt there was a difference between the quality of health care services provided for adults and children. Children were treated with higher amount of care and thoroughness, but this was viewed positively by their parents rather than with feelings of inequality in treatment.

11.2 Informants' assessment of the Finnish health care system for asylum seekers

- *Health care*

Generally, the informants were more satisfied with other health care institutions than the reception centre clinic. They felt they were treated equally with other residents in the mainstream health care institutions. The quality of service in mainstream institutions was considered to be good and the staff was seen as calm and friendly towards the patients. However, there were several matters which the interviewees would like to see improved. The main concerns and complaints were expressed in regard to the reception centre clinic. It was the wish of Iranian asylum seekers that they would be treated in the reception centre clinic in the same way as in other health care centres; namely, on an equal basis with others.

The difficulties that the interviewees experienced can be divided into two main parts. One was the inefficiency of the Finnish health care system with regard to certain kinds of care and treatment for asylum seekers. The lack of professional training in culturally appropriate practices, health care providers' limited knowledge of both the different cultures of the clients with foreign origin and diseases uncommon in Finland, as well as their overwhelming workload which results in long waiting times and falling behind schedule, presented a problem. The second, and more sensitive issue, had to do with the primary health care services provided for asylum seekers in the clinic of the reception centre itself where the interviewees lived. The criticism of the reception centre was quite severe. The interviewees felt that they were not in an equal position to Finns in regard to access to health services outside the reception centre. They felt this access was limited and strictly monitored. Unless it was an urgent case, asylum seekers were required to first contact the reception centre clinic, which was in

control of assessing their need to see a specialist, and the reception hours were very limited. More importantly, in many cases they were not entitled to use outside health services at all.

The interviewees thought that the reception centre had poor sanitary conditions and a low level of hygiene, which acted directly against the principle of preventive health care. The nurses and doctors working at the reception centre clinic were not skilled enough, and their attitude towards the clients -- in comparison with that of the staff of other health care units -- was less cooperative, less friendly and less client-oriented. Inefficient policies of saving on expenses, influenced by the budgetary limitations of the reception centre, caused more health problems for the client and more expenses in the long run for the centre itself. One element of saving in costs was the use of inexperienced nurses and doctors. Language barrier was a decisive barrier to expedient care due to the use of unqualified interpreters. The interviewees were greatly in need of important information regarding different aspects of health, illnesses, the health care system and their legal rights.

Since it is well-known that prevention in the long run is less costly than treatment of illness, the asylum seekers also felt that the issue deserves a strong emphasis. A case of a common childhood diseases, chickenpox, was given as an example: a qualified nurse can assess the situation perhaps only through a superficial examination without needing to send the child to a doctor. The parents would thus be less worried about the symptoms and know that there is no need for, for instance, antibiotic treatment. Sending the parent with a sick child from one place to another is time-consuming, costly and only inconveniences the child further.

Language barriers existed mainly because of inefficiency of interpreter services. Either the interpreters were not qualified enough to adequately interpret issues concerning health or the interpreter's native language was different than the patient's which caused further confusion, or both.

Asylum seekers need more general health care information as well as information regarding their legal rights. The service providers need to gain knowledge about the culture of their patients. This would decrease the tension or conflicts caused by

cultural differences. The interviewees felt strongly that they were not adequately informed about their legal rights, and could therefore not claim the benefits and services they had a legal entitlement to receive.

It was suggested by the informants that by using more skilled employees in the reception centre clinic it would be possible to avoid several unnecessary visits to other sectors of the health care system. In this way save resources could be better used for other important needs of the client. Prevention is a policy, and when properly carried out cuts down unnecessary expenses. In times of economic hardship and lack of resources it is very tempting to ignore this. As was mentioned before, one of the interviewees pointed out that a flexible cooperation between the decision-makers, administration and practical health care work in which the voices of the patients and the experiences of the practical workers are heard produces the best results in times of financial cutbacks.

- *Why changes are important*

There is a need for a shift of direction in order to develop and improve health care services provided to asylum seekers in general, and in the clinics of reception centres in particular. Improvements in the quality of the services consequently improve the health outcomes of patients. This, in turn, has a positive effect in all aspects of the lives of asylum seekers. When people in such a vulnerable position in this society as asylum seekers experience a positive development in their lives, they feel more in control of their daily lives; they think, feel and act more positively towards themselves, each other, the people who work with them, and the society as a whole. Being respected as people and patients in health services enhances the motivation to interact in a more harmonious way with the surrounding society and gives people a better position to choose an active and productive life for themselves, whether or not they are allowed to stay in the country on more permanent basis or not. The position of vulnerable groups reflects the attitudes of society as a whole. A society in which all resident groups are treated well and provided high-quality services is a healthy society.

In this connection, we can not overlook the crucial role that social issues play in the well-being of all of the members of the society. The consequences that social and emotional difficulties have on asylum seekers and the negative reflection of these in Finnish society, the reception centre employees, and decision-makers as parts of that society can not be denied. When asylum seekers are under tremendous emotional pressure due to uncertainty and fears for the future and can not have an active life in society through studying or working, it is difficult to develop healthy human relationships and interactions with others.

- Looking Towards the Future

Asylum seekers themselves can play a very important role in changing their lives for the better. By maintaining one's integrity and self-respect, trusting in one's own resources, setting goals, planning how to reach those goals, they can have better opportunities in future. The question is whether there is enough motivation and strength left to do all this. The role of authorities in making improvements and empowering people to develop their potential should not be overlooked. Very recently, as I was finishing this study, I received the news that one of my interviewees, Manizh and her family, were going to be deported back to Iran by the end of December 2002. Manizh was worried about her daughter, whom she saw as the most vulnerable member of the family, now that a sudden turn of events was again going to change their lives for good. Finland is going to lose one active, intelligent, responsible and innovative nurse who could have made a difference.

12. Final words

Since the end of the 1990s, certain fundamental changes have taken place that have had an impact on the situation of asylum seekers. Firstly, there has been a noticeable decrease in public and official interest in receiving more migrants in Finland. Both national and international shifts in policy have had an impact on this development. The so-called 'accelerated asylum procedure' policy has been adopted which allows deportation in a very short period of time and after a very superficial investigation of

the case. It largely depends on the country of the asylum seeker's origin whether he is instantly turned back or has to sit in a reception centre for many frustrating years waiting for the final decision.

Secondly, there are more financial limitations for asylum seekers to receive social and health care services due to the economic recession of the 1990s which was followed by significant policy changes. These policy changes have usually meant cutting back services that are intended to meet the needs of the society's most vulnerable groups, asylum seekers among them. Based on the principles of the UN Declaration of Human Rights it is difficult to find justification for denying asylum seekers their right to seek a place to live where their basic rights are recognised. Indeed, they have fled their own native countries precisely because they did not have those rights

Still, there have been some positive changes in Finnish society as well. An effort has been made to provide asylum seekers with the opportunity of living a more normal life through some means, however limited, of creating job and study opportunities for them. The government has been active through the mass media to broaden Finns' knowledge of foreigners and their value in Finnish society which has also had a positive impact on the lives of asylum seekers. Moreover, the majority of Finnish people has more cultural awareness and experiences in general with people from different cultures, and hence the everyday encounters of Finnish people and non-Finns is more natural and less biased. This, in return, makes the asylum seekers feel less out of place and more in touch with normal life.

I find myself floating between two cultures. I am Iranian by origin, spent my childhood and youth in Iran, and hence my entire being was shaped strongly by Iranian culture. Now, as I grow older, I notice once again a shift in me towards that very Iranian culture that I once so strongly criticised. After living in Finland for more than twelve years, through the observations of others and my own self-realization, I can see more clearly the strong influence of Finnish culture and the Finnish mentality in my personality. I feel happy when I notice how well I have adapted here and I feel sad when I feel my alienation towards my origin. I have not lost hope of finding at least one positive thing out of this ongoing struggle. Perhaps I am one of those who can understand both Finns and Iranians better than most. It is my deep wish that I am

able to develop this quality into a practical skill and resource that can benefit everybody.

13. References

IranMania search engine, (2002), <http://www.iranmania.com>, 4th of November 2002.

Iranian Refugees' Alliance, Inc. (Revised 2001), *Iran Ref. (Documentation Centre)* <http://www.irainc.org>, 4th of November 2002.

Ministry of Labour, (1999), *Act on the Integration of Immigrants and Reception of Asylum Seekers*, on <http://www.mol.fi/migration/act.pdf>, 4th of November 2002.

Ministry of Labour, (2002), *Number of Iranian Refugees*, <http://www.mol.fi> 4th of November 2002.

Monitori Magazine, 2/2002, Ministry of Labour, Helsinki.

Monitori Magazine, 4/2002, Ministry of Labour, Helsinki.

Pakolaiset Suomeassa, Turvapaikanhakijan asema Suomeassa, http://www.maailmanpakolaistilanne.net/ps_turvap_asema.html, 4th of November 2002

UNHCR, The UN Refugee Agency, Basic Facts <http://www.unhcr.ch/cgi-bin/texis/vtx/home>, 4th of November 2002.

UNHCR, The UN Refugee Agency, Asylum Seekers in Finland, <http://www.unhcr.ch/cgi-bin/texis/vtx/home/+GwwBmebEcs8wwwxwwwwwwwhFqnN0bItFqt5nwGqrAFqnN0bIcFqiW5Oc1Ma5nnAnG5a-oDcwDmMzmwwwwwwDzmwwwwwwdFqw1FqnN0bI>, 4th of November 2002.

Appendix 1

Interview Questions

I. Background information of the family:

1. How many people are there in your family? Please mention gender and the family relationship.
2. How old is each member of the family?
3. How long have you been in Finland?
4. What languages do you speak?
5. What education do you have?
6. What profession(s) do you have?
7. What jobs have you had?
8. To which social class do you think you belonged in Iran?
9. Can you work in Finland? Do you work at the moment? Where and in which job?
10. Can you study in Finland? Do you study at the moment? What?

II. Questions regarding the general background of the experiences of the interviewee with the subject:

1. How did you first get information about health care in Finland?
2. What about the usefulness of health care guidelines (manuals/ booklets) provided by health care centres? Did you find them useful and easy to understand?
3. What is your experience concerning language differences, on the one hand, and distribution of health information, on the other?
4. Do you know enough about the health care benefits you are entitled to?
5. How do you see the future concerning this topic?

III. Questions regarding interviewees' experiences with Finnish health care system:

1. What are your primary health care needs?
2. Are there differences between the genders in the Finnish health care system?
3. Are there any differences between adults and children?
4. Tell about the first health screening when you came to Finland?
5. What kinds of experiences have you had with Finnish health care system (including doctors, nurses, pharmacies, clinics, hospitals, dentists, laboratories, maternal/child clinics, psychologists, psychotherapists, family counsellors, etc)?
6. What are the positive things you can mention about this issue?
7. What matters need improvement?
8. How do you think it is possible to make improvements?
9. What can you do personally to make a positive change?
10. How do you see the future?

Russian and Estonian sex workers and the Prostitution Counselling Centre in Helsinki

Judit Strömpl

I would like to thank the staff members of the Pro-tukipiste Prostitute Counselling Centre in Helsinki who made it possible for me to implement this study.

1. Introduction

This article is based on a qualitative study of Russian and Estonian sex workers in Helsinki. The data collection took place at the Pro-tukipiste Prostitute Counselling Centre during April and May of 2002, and consists of eight in-depth interviews with ten female sex workers. My objective in conducting these interviews was to clarify Pro-tukipiste clients' attitudes towards health and preventive health care, as well as to find answers to the following questions:

- How do Estonian and Russian sex workers assess their position/situation in the Finnish public health care system (for instance, how do they construct their own position in it)?
- What are the expectations/needs of the interviewed informants towards the Finnish public health care system, and how are these expectations/needs met?

One of the goals of this study is to introduce new information on these issues from the perspective of actual sex workers themselves to complement the heated but very important debate surrounding the issue of the increase in mobile prostitution in Finland. By reconstructing the insider's perspective, I hope to expand the general understanding of the phenomenon and to represent the Russian and Estonian commercial sex worker to the reader as an ordinary human being who discusses her health care needs just like the rest of us.

2. The context of the study: Estonian and Russian prostitutes in Finland

Soon after the collapse of the USSR at the end of 1980s, two phenomena rapidly emerged in the western world: the so-called Russian mafia (organised crime) and Russian prostitution. In place of the Soviet regime, a new danger from the region appeared to pose a threat to the West. The iron curtain between East and West crumbled at the same time that increasingly intensive migration from former Soviet states towards western countries began. Amidst the escalation of political instability in many of the former Soviet states, financial volatility, economic crisis and social insecurity, trafficking and prostitution rapidly developed. The Baltic Sea region soon emerged as an arena for mobile prostitution in the 1990s.

Prostitution has traditionally been viewed as a social problem from the perspective of the Nordic welfare state, with public health authorities in Sweden and Norway taking initiatives to rehabilitate prostitutes and limit the social harm caused by sex work, which was conceived as inherently violent towards women (Randhers-Person 1999). Working with prostitutes was thus seen as harm reduction work, though there were few guidelines or methods because prostitution was not considered to be a major problem. Due to the tight restrictions on travel from the Soviet Union, there were very few foreign sex workers in the Nordic countries up until the 1980s. It is important to note, too, that foreign prostitutes come to the Nordic countries from Thailand, African and South American countries as well. However, for the purposes of this paper, the focus will be limited to Russian and Estonian commercial sex workers, which make up the vast majority of prostitutes.

It has been estimated that there were only about 100 prostitutes working in Helsinki in the 1980s. After the collapse of the Soviet Union the volume of prostitution grew dramatically. The first sex club opened in Helsinki in 1994, and by 1996 there were 13 of them (Markkanen 2000). Since 1994, the Helsinki police have reported a sharp increase in the inflow of prostitutes from Russia and the Baltic States (Trafficking of Women 1996). Jari Leskinen of the National Bureau of Investigation has stated in an interview with the largest Finnish daily newspaper, *Helsingin Sanomat* that the exact number of women coming to Finland for sex work is not known, but he believes their number should be counted in thousands. Foreign sex workers in Finland come largely

from Russia and Estonia, and their activities appear to be organised by Estonian and Russian organised criminal gangs (Harju 2002; Markkanen 2002; Lehti and Aromaa 2002; Lahdenmäki 2002). According to newspaper reports, there are an estimated 4000 to 6000 prostitutes working in Finland annually, though it is impossible to know an accurate figure (Markkonen 2002). Statistics Finland estimates that the prostitution business in this country is worth between 100 and 200 million Euro (Markkanen 2000).

It is very difficult to collect statistics on sex work in Finland due to the illicit nature of the work. Furthermore, there has been little academic research into the subject until recently. However, findings by the Programme for the Prevention of Prostitution and Violence against Women (1998 – 2002), a large-scale project directed by the Finnish National Research and Development Centre for Welfare and Health [STAKES], in the STOP I Report notes:

According to official records, 50,000 women move abroad [from Russia] permanently each year, and hundreds of thousands emigrate to find short-term employment. Every week about 400-500 Russian prostitutes enter Finland. Some of the women are recruited into the sex trade on a more permanent basis, while others work on a temporary basis as so-called 'mobile' prostitutes. Most of the brothel owners, both in St. Petersburg and Tallinn, are involved in organising prostitutes to Finland. (STOP I Report 1999, 43)

Hence many of the traditional Nordic public health perspectives on prostitution as a social problem, which were based on national welfare states, face new, globalised challenges with the emergence of trafficking and international organised crime.

The STOP I Report further characterises foreign sex workers in Finland:

- Most of the women have been working in the field for more than two years (45.5 % of the women).
- More than one third of the women (34.1 %) have been in the field for over five years.
- The educational level of the women varies: 22.9 % of the women have a university degree, and 39.7 % have gone to vocational school. However, more than one-fifth (21.8 %) lack any vocational training, and 15.6 % of the secondary school graduates are still continuing their studies.

The fact that an increasing number of prostitutes are from outside of the European Union means that they have may no rights in the Finnish social and health care system, unless they possess a permanent residence permit.

Most of the studies and newspaper articles that are used as sources for this article attempt to answer the question of why prostitution in Finland has grown so rapidly in recent years. They associate it directly with the economic situation in Russia and other Eastern European states (Trafficking in Women 2001; Nurmi 2002a, 175-7; Nurmi 2002b, 38-9). Most studies attempt to describe women involved in prostitution and assign socio-demographic characteristics to them (STOP I Report 1999; Okólski 2001; Saar et al. 2001; Zariõa 2001; Tureikyte and Sipaviëiene 2001; Sipaviciene 2002). They also examine the connection between prostitution and organised crime and the legal ramifications of prostitution (Askola 2001; Harju 2002; Lehti and Aromaa 2002; Trafficking in Women 1996, 2002). Nearly all of the above-mentioned materials also discuss the question of how to solve the problems that evolve with trafficking of human beings and prostitution, especially those written in connection with preventive programmes. The issue of prostitution has also been analysed in connection with rising consumerism (Jacobson 2002, 22-25) and as part of the growing global sex trade (STOP II Report 2000).

Studies of commercial sex work are obstructed by the lack of systematic sources of information and statistics, which is tied to the hidden character of the phenomenon (Lehti & Aromaa 2002). For this reason the available data must be considered as a provisional estimate.

In my research, however, I take a much more limited view: I attempt to open a window to sex workers' own views about their position in the Finnish public health care system by discussing common human issues such as health, health risks and responsibility.

3. Why me as the researcher of this issue?

There are several answers to this question. First of all, my research interests, teaching and professional experience is tied with the sociology of deviance. In the past decade,

I have conducted several research projects on young people's deviant behaviour and the development of social problems. I recently completed my doctoral dissertation on the subject of the management of troublesome young girls in Estonia. This is also an important point with regard to the issue of prostitution: It is evident that prostitution poses a very tangible danger to young girls with other social problems (Strömpl et al. 1999; Strömpl 2000, 2002).

Secondly, my fluency in Estonian, Russian and English, as well as familiarity with Russian and Estonian cultures, made me a suitable candidate to conduct interviews with Estonian and Russian prostitutes. Since I am very familiar with both Estonian and Russian cultures, I can perhaps also detect hidden meanings and more subtle nuances in the data, and untangle them for an international audience.

Finally, I have some personal interests and reasons to study the phenomenon of Eastern prostitution in Finland. This I see as giving me the final motivation for accepting the task of conducting this research.

As a private person, I had my own experience of observing the everyday life of a prostitute at close quarters. For a short period of time, the flat next door was owned by a woman who was considered to be very disorderly and scandalous in the neighbourhood. She was a Russian woman of 30-40 years with a defiant look and outlandish behaviour. She had a young son who spent most of his time either sitting in the stairwell of the house or at the nearby home of a friend because he was unable to return home due to the constant flow of visitors to his mother. The noisy parties carried on around the clock. From time to time the woman disappeared for a few days, but when she reappeared the parties continued again. Sometimes the woman was beaten up, and once her apartment was robbed.

It was the most unpleasant time I had ever experienced living in the house, and I started seriously considering moving elsewhere. There was talk among the neighbours that she earned money in Germany as a sex worker and therefore had the money to buy the flat, furnish it nicely and afford all of the best household appliances. When she moved in she wore expensive clothes, fur coats and even owned a car. However, she did not stay for long: within eight months all of the money was gone and she had

to sell everything she had, including the flat which by then was in a dreadful condition. Finally, the other residents could take a deep breath and sleep well at night again.

I observed all this as an ordinary social actor; a neighbour. I saw prostitution as a lifestyle that invades the entire sphere of an individual's life. This awareness produced very mixed feelings. On the one hand, I felt anger for the lack of consideration to the other people living in the house; and, on the other hand, I felt deeply sad for her circumstances and humiliating position in the neighbourhood which she concealed by behaving loudly and demonstrating how much she enjoyed her life.

There is another issue concerning prostitution that is tightly bound to my own deep personal emotions. When I attended the post-graduate seminar at the University of Tampere to complete my doctoral dissertation, I frequently travelled between Estonia and Finland. As a woman from the post-Soviet Estonia who crossed the Finnish border on a regular basis, I was subjected to the suspicions of the border guards and their questioning about the reason and destiny of my travel, the duration of my stay, the place and names of the people I stayed with, and my financial situation. The border guards considered me to be a potential danger for the Finnish society. However well I can understand the reasons for such an attitude, the feeling of being subjected to such treatment was always very unpleasant. My usual reaction to this situation was anger; it was hard to understand why an ordinary woman had to constantly undergo such humiliations. When I talked to Russian-speaking Ingrians I knew in Tampere, I found similar attitudes. In their eyes, Finns believed that all Russians are either criminals or prostitutes. This gave me the extra incentive to want to learn more about the phenomenon of Eastern prostitution in Finland: What kind of women are we talking about here, what are their own thoughts about the issue, and how do they see themselves as posing a danger to Finnish civil society?

4. The research process

Because the aim of this work was to learn about the phenomenon in depth, I planned to conduct the research as a phenomenological study. Since I knew little about the respondents and had my own quite negative attitude to the phenomenon initially, I

intended to carry out focus group interviews. I hoped to learn more about the respondents by having them talk more to each other, and placing myself in the position of an observer. Moreover, by doing this I hoped to create a comfortable setting for free conversation between people who knew each other. Later on, when I spent more time in the prostitution counselling centre and observed women sitting in the lounge, I repeatedly heard them discuss health issues. However, these extremely valuable conversations were not tape recorded, and when I asked the same women to step into a private room and continue the discussion as a group interview, they usually backed out by using different excuses. Because I had never before encountered sex workers as subjects of a study, I could not foresee what difficulties I might face during the data collection period. I had imagined that the main problem would be the refusal to participate in any way. This fear was confirmed by the workers of the Pro-Tukipiste Counselling Centre. They characterised their clients as very suspicious and cautious.

At first, I planned to carry out unstructured interviews. Because I wanted to properly inform the participants about the research, I prepared interview questions which were available to the participants before the interviews.

My aim was to talk with people in pleasant and informal situations. I wanted to make sure not to alarm or offend the respondents. The interview questions were constructed to be as neutral as possible. I did not want to compromise the clients' trust in the centre and its staff. Perhaps as a consequence of this very general and neutral character of the interview questions, some of the responses I received from the interviewees were also rather vague and general in character. However, during the interviews I referred to the actual interview questions quite freely and let the interviewees talk about whatever they wished in association with the general topics I had introduced, and created new questions in the process as the discussions took new turns.

The interview questions prepared in advance were grouped around two main topics: health in general, and health and risky behaviour in particular (see Appendix 1).

The data was produced in April - May 2002 in Helsinki at the Pro-Tukipiste Counselling Centre for sex-workers. The clients are mostly Russian and Estonian women. The data of the research consists of 8 tape recorded interviews with 10 sex workers (6 individual interviews and two in pairs) and several free conversations.

The focus group interviews that I initially planned to conduct did not succeed. It was not possible to gather enough women to participate at the same time to form a focus group. Women tended to drop in briefly and leave again. They came to the centre for different reasons, such as appointments with a physician or other medical reasons, or to talk to a social worker. It also seemed that meeting each other and talking together was a very important part of visiting the centre. The women shared a lot of valuable information with each other, and the centre was a natural meeting place for them. The data I produced by observing these informal conversations add important information to the research data, and complement the general picture I formed from the centre and its clients.

When there were two friends who came to the centre together, they were more willing to be interviewed also together. In my opinion, the data obtained from such a pair interviews is richer in content than that of individual interviews. The respondents evidently felt secure being interviewed together, and spoke more freely about their activities as sex workers and the risks involved in it. In individual interviews, respondents were more reluctant and often gave mechanical and restricted answers to the questions. It sometimes happened in the pair interviews that the respondents got engaged in a discussion of the issues at hand with each other, and opened up new topics and revealed details of their work that were totally new to me. I also noticed that in pair interviews the women were more comfortable and willing to discuss their roles as sex workers and the problems tied to prostitution. Health in general was an important aspect of the lives of the respondents.

All the interviews were conducted in the premises of the Pro-Tukipiste Counselling Centre during opening hours. The staff of the centre in general, and the medical nurse and the social worker in particular, played a substantial role in the process of data collection. In the beginning, they introduced me and my research topic to the women, and encouraged them to participate in the study. After the introduction I spoke briefly

about the objectives and the possible outcome of the research. From the very beginning, I together with the staff emphasised that the topic of the study was clearly restricted to the health issues that concerned the clients. It was strongly underlined that the goal here was not to discuss the reasons for prostitution or any other details of the clients' lives, and that they could feel secure. We also emphasised that the general character of the research was going to be neutral and impartial. The women were welcome to go and read the interview questions that were available on the table.

However, not all women were willing to participate in the study. Many women agreed to talk about the health issues there and then, but when they were asked to come and be interviewed in a specially arranged room, they became nervous and began to leave. They often explained that they had no time to talk to me that particular day, perhaps someone was waiting for them, or they had another excuse.¹³ This is why I tried not to put any pressure on them and encouraged them to speak freely without having a tape recorder on. On these occasions I made mental notes of the conversations and wrote them down later. This kind of data I use as additional information to the tape recorded interviews. I also rechecked it often against the information I obtained in the actual interviews. One of the topics the women would only talk about informally was the use of condoms, as well as the wish of the customers to have unprotected sex.

Many women also explained their refusal to be interviewed by saying that they could not speak with a tape recorder running; either because their opinions about things were not valuable enough to be recorded or they were quite afraid. Even those who agreed to be interviewed were at first very nervous.

5. The location: Pro-Tukipiste Prostitute Counselling Centre, Helsinki

This study was carried out in the premises of the Pro-Tukipiste Prostitute Counselling Centre in Helsinki. Pro-Tukipiste was founded as a registered and independent non-governmental organisation in 1996 to continue the work with prostitutes started by the

¹³ When giving reasons for not participating in interviews, women gave information about their daily schedules: they got up in the early afternoon, did their laundry, went to swimming and had sauna. Another woman, while telling me about her appreciation of the centre, mentioned that the staff makes soup for the women on Thursdays, but it feels funny to eat it for breakfast: "*2 p.m. is just morning for us*".

Helsinki Deaconess Institute in 1990. The centre is largely funded by the Finnish Slot Machine Association. It is also active in international and national networks that concern commercial sex work, sexually transmitted infections, and intravenous drug use.

Pro-Tukipiste Prostitute Counselling Centre has a low threshold for services and also does outreach work in sex bars and on the streets. According to its mission statement:

Pro-Tukipiste offers support services to anyone who has or is involved in selling sexual services. This help can also be extended to the relatives and friends of those involved. The purpose of the association is to promote sex workers' health, well being, safety and cooperation. It seeks to reduce and prevent the disadvantages and problems which are caused by the commercial sex activities. This also applies to sex workers, their relatives as well as society as a whole. The main principles of the work with prostitutes are empowerment and harm reduction. The starting point for the activities are to respect human dignity, the right to self-determination and individuality. The wish to stop prostitution is not a condition to receive services. Services are completely confidential, anonymous and free of charge. (Pro-Tukipiste 2002)

Pro-Tukipiste has a helpline, offers individual counselling, and consultation with a physician.

Before I started collecting the data, I visited the centre once in January of 2002 to gather preliminary information and an impression of the place itself, its activities and clients.

The centre was located in downtown Helsinki on the fifth floor of an old building. The rooms of the counselling centre were comfortable and well suited to the centre's activities. There were offices for a gynaecologist, a medical nurse and other personnel, as well as a kitchen and a lounge. The lounge was a large room where there were two tables surrounded with comfortable armchairs and sofas covered with multi-coloured cushions. Potted plants, posters, pictures and mirrors on the walls and other miscellaneous decorations created a cosy atmosphere. A side table with shelves had stacks of brochures, other information material, advertisements and free condoms available to clients or other visitors.

The Pro-Tukipiste Prostitute Counselling Centre is open to clients twice a week. During opening hours, free coffee, tea and cookies are available, and on Thursdays the staff make soup for the clients. I collected all my data during the opening hours of the centre.

During the interviews I asked the women how they had found their way to Pro-Tukipiste. Most of the respondents told me about their fears and how they needed to muster all the courage they had to come and place their trust in the centre. They also talked a lot about their gratitude for all the support they received from the staff. Every respondent emphasised the psychological support that they felt they were given as the most valuable service. It was the one place where they could feel safe and secure, where nobody was taking advantage of or abusing them. The reaction to any form of potential abuse evoked an extremely negative reaction from the women. One of them once asked me in an aggressive way if I my aim was only to benefit from the women by collecting data for my own doctoral dissertation. I could well understand her feelings. As is discussed later in this study, many of the women had higher education but could not find work in their own countries. Most of the women cited financial reasons as the reason they were involved in the commercial sex work industry. Particularly in the beginning of the interviews, discussing this fact made all of the women feel very uncomfortable.

The most important goal that the Pro-Tukipiste Prostitute Counselling Centre has achieved since its founding is gaining the trust of its clients. It became evident to me through the research process that sex work is a hidden phenomenon in society, and the people involved in it were very distrusting and wary of outsiders.

6. The target group

During my first visit, the nurse gave me general information about the clients. She also told me that the staff does not ask their clients to give any background information when they come in, such as place of origin, name, or family relationships. However, she thought that most of the clients were Russian-speaking women from Estonia. The others were mostly Russian, Estonian and Russian-speaking people from

Lithuania and Latvia. It seemed to her that the sex work business was well organised from above, and that there were women who received and initiated newcomers into the work. The majority of clients only came to Finland to work for a short periods of time ranging from a few days up to three months. The ordinary tourist visa allows visitors to stay in the country for three months at a time. Only a few women had permanent residence permits. The age of the clients varied between 20 and 60 years.

The main incentive to get the women to visit the centre was access to free condoms. The nurse told me that the women were very afraid of being recognised as prostitutes if they came to the centre, and that was why the threshold for the first visit was high. Even regular clients tried to come and go as discreetly as possible.

When I was outlining the interview questions, I faced different kinds of problems. First of all, I had no idea about who these women were -- these prostitutes -- whom I should talk to. My initial understanding of the identity of women who, in contemporary terms, sell sexual favours, came largely from reading literature. Between Dostoyevsky's heroine Sonya Marmeladova, who becomes the personification of female goodness and humanity through self-sacrifice and Douglas' (1984) proud sex workers there is a huge variety of interpretations, definitions and categorisations about prostitution given both by society at large and prostitutes themselves.

As was emphasised before, the topic of the interviews and conversations with the clients of the Pro-Tukipiste Prostitute Counselling Centre was not to be the women's sexual activities, but the construction of the health of the interviewees by themselves. However, it was obviously their very sexual activity that was the reason to study their attitudes towards health. The fact that the women I interviewed were clients of the Pro-Tukipiste provided the basis for assuming that they were sex workers.

I had the opportunity to conduct tape recorded interviews with six individuals and two pairs of women during three different days. All of the interviewees were women; nine of them came from Russia and one from Estonia. The youngest interviewee was 20 years old, and the oldest 46. Most of the respondents came from Russia with limited visas, or as "tourists", as they said themselves. Most of the Russian women had either

completed a higher educational degree or had studied at university for some time but dropped out for different reasons, such as having a child.

If I compare the socio-demographic characteristics of my data with other available data, the women I interviewed were generally older than those, for instance, in Nurmi's work (2002a, 179). One reason could be that it was mostly the older clients of the centre that were willing to be interviewed. However, my subjective impression of the average age of the clients was about 30-40 years.

In spite of the fact that the interview questions did not include any inquiries about the women's background information and family history, most of the respondents spoke quite freely about their families. They liked talking about their children and elderly parents for whom they were responsible and provided care. Most of the interviewees were divorced or single mothers. Some respondents also talked about their husbands or boyfriends. However, only one woman had a long-term relationship with a Finnish man. All of the women talked warmly about their friends at home, while they referred to the Russian people they knew in Finland as 'acquaintances' rather than friends.

The Estonian interviewee differed from the Russian interviewees. She was quite young and had only a primary education. She spoke about not being able to continue her studies and the lack of any family to support her. The only person she mentioned was an Estonian man friend who took care of her in Helsinki. However, this was an isolated case and could not be seen as a general difference between Russian and Estonian sex workers.

On the basis of the interviews, it was difficult to get an overall picture of the respondents' situation in working life; particularly who came from Russia for only a short time. Two of the women who had a residence permit in Finland were unemployed at the time of the interviews, but both planned to find a job in the near future. It was also difficult to get a comprehensive picture of the women's legal status in Finland. The two women who had a permanent residence permit in Finland were the only ones who were well aware of their own legal status and could explain it in a comprehensive way.

It appeared that those women who had stayed in Finland for a long time were more self-confident and were aware of their rights. One of the women had lived in Finland already for 13 years. Those women also did not hesitate to refuse to be interviewed if they did not want to. On the other hand, I had the impression that the women who stayed in Finland on a temporary basis felt more dependent on the services of the centre, and when the staff asked them to participate in my research did not want to disappoint them. They also talked more about the great need for such services for sex workers, and often expressed their gratitude towards the centre. The women who lived in Finland on a more permanent basis seemed to accept the existence of the centre more as a self-evident thing. However, they certainly appreciated the services and the centre was an important part of their lives.

The Russian-speaking Estonian women are a large client group of the Pro-Tukipiste Prostitute Counselling Centre, but unfortunately all of them refused to participate in the research. I had the opportunity to talk to these women only informally.

The lack of Finnish language skills was a common and a significant problem for all of the interviewees; those who were in Finland on a short-term basis in particular. Consequently, the women had no access to sources of information about the structures and services of the society other than the closed informal group of acquaintances and colleagues. The Pro-Tukipiste Prostitute Counselling Centre is extremely important for the women in terms of access to and distribution of correct, wide-ranging information tailored specifically for the needs of sex workers.

7. The interviewees

The interviews were conducted anonymously, and all the names used here have been changed. There were 10 interviewees:

- Asja
- Nina
- Katja
- Marina
- Julia
- Nadia
- Tanja

- Malle
- Dasha
- Masha

Asja

The first interviewee was a 42 year-old woman from St. Petersburg. Asja agreed to be interviewed after she had spoken to the nurse, who told her that this was a good opportunity to explain about her own health problems and talk about her access to the public health care system in Finland. Asja looked lovely; she had beautiful clothes and was tastefully made up. Obviously she took good care of herself. Asja was very articulate. She had studied in the university, but had not yet completed her degree. She was divorced and had an adult daughter.

From the very beginning of the interview, Asja focused on health issues and her own health problems. She had been in a car accident and was not fully recovered yet, and she seemed quite concerned about her own state of health.

Throughout the interview, Asja avoided the issue of being a sex worker in Helsinki. She said that she had been coming to Finland for years as *“a tourist, I mean, not a tourist but I just came to Helsinki...”* After some time, she had met and married a wealthy Finnish man who could afford private health care for her. At the time of the interview they had already divorced, and Asja complained that her ex-husband tried to make it hard for her to get a resident permit in Finland. After the divorce, she had stayed in the country illegally for a while, but was now about to receive her permanent residence permit. I tried to clarify her legal status in Finland in more detail, but she would only repeat that she was in the process of getting her residence permit.

Nina

Nina was a corpulent 39 year-old woman from Saint Petersburg, who was modestly dressed and wore no make-up. She had higher education, but gave no information about her family background.

Nina was having a lively conversation with other women in the lounge of the centre when the social worker asked her to participate in the research. She agreed after

talking to the other woman for a while longer. When she came to the interview room, she sat close to me and her manner and way of answering my questions reminded me of a teacher explaining things to a young pupil.

Before the interview, Nina first carefully read the interview questions. Throughout the entire interview she kept the sheet of questions in her hand, glanced at it from time to time and kept the conversation focused on the health questions. Nina's response to the questions was rather general and abstract. She gave no real-life examples and talked in an objective and impersonal way. Nina also did not refer to her activities as a sex worker in Finland.

Katja and Marina

If the interview with Nina remained very formal, then the next one succeeded very well. The following interview was done with two friends -- Katja and Marina -- from St. Petersburg. Katja was 26 and Marina 34 years old. Both of them dressed very simply. They were relaxed and friendly. They felt more free than Asja and Nina to speak about their work as prostitutes in Helsinki, as well as about problems connected with it.

Marina had completed higher education, and Katja had studied on higher level but had not finished her degree. Both of them had small children and emphasised that their life at home in Russia differed substantially from that in Finland. They told openly about their activity in Finland and time to time came back to explanations as to why they were working as prostitutes. For both of them, the only reason for doing sex work was financial. Having no income in Russia they had to earn money to somehow bring up their children. Both of them emphasised how hard the work was and that they did not do it as professionals. Marina even complained that during that particular visit to Finland, she could not bring herself to start work because of an internal barrier that she was not able to cross. She spoke about resentment she felt when men were watching her on the streets; even during the day when she was just doing her errands as an ordinary woman. Marina had been in Helsinki already for ten days, she had run out of money but still she could not start working. She also talked about how shameful it was to "behave like a prostitute".

Marina: For instance I stay here with a young girl, (to Katja:) you know her. She dresses very provocatively on purpose, and everything to give a sign 'here I go tra-la-la a prostitute' and the men who want her can know that she is there for them and they can come on to her. I cannot behave like that.

Katja: Me neither.

Katja was trying to explain the difficulties of the work to Marina and advised her just to think about her child whom she had to bring up, and that she had nobody who could help her. That's why she had to do this work. Katja also suggested that perhaps the fact that it had been a long time since Marina's last visit was another problem: *"Because at home we don't do this. There we have a totally different life, family, children..."* This information strongly contradicted with general the understanding of prostitution as a lifestyle.

Julia

The fifth interviewee was Julia - a former gymnast and aerobics instructor in her late forties. She wore sporty clothes and was very optimistic and jovial. Her daughter - a young adult woman - had studied and worked in Finland for four years and now she, the mother, had also decided to come to live in Finland.

When Julia came to the centre, she said that she only came to see how people here live. She was immediately quite willing to talk about health, and turned out to be a very talkative lady. During the interview, she kept talking with hardly a pause in between, and did not wait for me to ask any questions. During her monologue she jumped from one topic to another. She began with health, which in her views depended solely on how much exercise the person had, gymnastics in particular, and fluently moved on to speak about emotions which are especially important for women. She was planning to open a club for women where she wanted to be an aerobics instructor. To myself, I called Julia an 'example of femininity'. She spoke very much about the gender differences and about the needs of a woman. Typical gender stereotypes resounded throughout her talk: women are sensitive, they need care, emotions and love, while men are different; they want competition, combat, and

they need to feel strong and take care about women. Women need presents and surprises, they are like children. It is for men to provide those presents. It is not nice when a woman pays her own bill in a cafe or restaurant. It offends a real man. Sometimes it is difficult to understand what men need, Julia said. However, she wasn't very interested in the issue of men's needs; her sole interest was in what women needed. She told about the place where she grew up in the South, where traditionally men were men and women – women.

Nadia

The fifth interviewee was Nadia, a 38 year-old woman who had lived in Finland for five years. She had come to Finland through marriage with a Finnish man who was seriously ill and permanently institutionalised in a hospital. Her grandfather was also a Finn. Nadia had a 15 year-old daughter about whom she spoke very much and of whom she was very proud.

Nadia was very critical towards herself: she blamed herself for being stupid and weak. She had higher education and spoke Finnish well. The main reason for all the self-blame was that she had not been able to find a proper job yet. Nadia spoke a lot of being old and tired. She felt it was impossible to live now the way she had lived some years earlier. She blamed herself for sex work and the only explanation was that otherwise there was too little money to support a daughter, a cat and a dog. Nadia repeated many times how she always thought first of other people, and how she sacrificed herself for others. Her sex work was also a sacrifice, because she only did it to cope with the financial needs of her family. She spoke in detail about the official income she got, as well as her expenses, but did not mention the income she got from sex work. Nadia was very depressed and spoke about the deep discontent she felt about herself. She had a plan to find a job the following autumn. Nadia tried to explain why she had not found work even though she spoke Finnish, but all her explanations circled back to blaming herself.

Tanja

Tanja was a 46 year-old economist from St Petersburg. She read the interview questions and told me that she was an expert in health questions because at the moment she was very involved with BAA (biologically active food additions). She was married and had three adult sons in St. Petersburg. She did not speak at all about her sex work, but the sole topic of our conversation was her own health problems from early childhood up until the time when she started to use BAA. As a matter of fact, the interview consisted of her life story starting from before the collapse of the Soviet Union when she was still working as an economist and bringing up her children, and how afterwards she worked as a vendor in a marketplace. At the moment she sold BAA.

Tanja was staying in Finland for a short period of time and did not speak any Finnish.

Malle

Malle was the only Estonian woman who agreed to participate in the research. She differed from other respondents in three different aspects. Firstly, she was the only one who was not Russian; secondly she was only 20 years old; and thirdly, she was the only interviewee who had only primary education. Malle agreed to the interview because the nurse asked her to do that. She was very simply dressed in a black skirt and a blouse. Malle appeared very calm and was not particularly talkative, but just simply answered questions. She did not avoid discussing her work as a prostitute but mentioned it in passing when she was talking about a possible job opportunity in Estonia: *"If I'll get a job in Estonia, normal work, I mean..."* She was the only one who mentioned that she had a venereal disease when she first came to the centre. She had heard about the counselling centre from a friend who urged to go and find help there.

Dasha and Masha

The last two women, interviewed together, were Dasha and Masha. They came from a large Russian city. Both of them were around 40. Even though they had agreed to participate in the research, they were very nervous and seemed scared in the

beginning. Once, when Dasha accidentally spoke to Masha using her real name – which, anyhow, was one of the most common Russian names - Masha was visibly startled. Masha didn't take her eyes from the tape-recorder during the entire interview. Neither was willing to say from which city they came from. In the beginning, both spoke very nervously and only about health issues without giving much information about their own real situation. In their opinion, the lack of information about health was a big problem particularly for young people. They would have liked to see much more information available for how to keep healthy and lead a healthy life style.

As the interview progressed, both Masha's and Dasha's initial behaviour changed: they visibly relaxed and became much more open and willing to talk about different topics. After the 'official' part of the interview was done we continued the conversation for over an hour without the tape recorder. This interview-turned-conversation ended up being the longest and most interesting of them all. Both women were happy to communicate this way, and spoke about a great variety of issues. They explained their involvement in sex work as a result of all the changes that took place in Russia after the Soviet Union collapse: *"We are here not because of trying to find a happy life. Life in Russia is very hard. It changed very much. If you have children, you have to give them education, but that is very expensive in Russia now, and if you don't have a job, what to do?"*

8. Findings

After the interviews were made, I transcribed them into computer files in the original language that was used. I added my own observations and the information I wrote down from the free (not taped) conversations to the data. Then I coded the data according to the most important topics.

8.1 Health as a general notion

The health issue was understood by the respondents as a general topic about health or as personal health of the interviewee.

One opinion was shared by all the respondents: Health was the most important single matter in the life of a human being. To be healthy, people had to have an actively healthy lifestyle. When asked what a healthy lifestyle meant, many interviewees mentioned physical exercise as the most important thing. Then came a regular daily routine; good nutrition and enough sleep.

It is interesting that some women saw not smoking and drinking¹⁴ as the first step towards a healthy lifestyle. They also mentioned the importance of safe sex (the exact meaning of safe sex is discussed later). The respondents indicated that their own lifestyle is not very healthy because of smoking and irregular sleeping habits. Those with whom I spoke said that they had no alcohol problems. However, they were worried about potential future alcoholism. Because of the nature of their work, the women drank to help them relax and lose their inhibitions. The nurse at the centre also told me that the women often complained that they could not work without drinking. However, most of my interviewees emphasised that alcohol and drugs were very dangerous in their line of work: *“If one starts to drink, it is the end. It is the first step in your downfall.”*

During the time I spent at the centre I only once met a woman who was slightly drunk. She also explained her inability to participate in the study because of being hung over.

In general, it was very important to the respondents to have control over their own health.

8.2 Fears concerning health

The women's biggest fear regarding their health was the risk of being infected with either HIV or other sexually transmitted infections. However, they did not discuss the issue of risky behaviour directly in connection with sex work. The women spoke about safe sex as something self-evident. Only one interviewee mentioned that using

¹⁴ It is interesting to compare this with my study in a reformatory school for troublesome girls where the residents of the school defined 'normal' parents and other members of their families as people who do not drink and smoke. (Strömpl, 2002)

protection during sex is only about 90%. The health risks of sex work was a difficult issue to discuss. One interviewee said: *“This is risky, but there is nothing to do. There is no other choice for earning money.”*

Those women who did not have a problem identifying themselves as sex workers were very critical towards young Finnish drug users who worked as prostitutes and were not concerned about safe sex. The interviewees saw prostitutes with a drug or an alcohol problem as very dangerous. They were more likely to give in if the client insisted on not using a condom, and this posed a threat for others who may share the same clients. The respondents talked about clients who were regular visitors in sex bars: *“They come there as we go to work. The only difference is that we earn money and they spend it.”*

8.3 Finnish health care

Most of the respondents were surprised when I asked them to describe Finnish health care. They didn't know much about it. They didn't associate the activities of the Pro-Tukipiste so much with health care as such, but saw it rather as social care.

The general opinion among the Pro-Tukipiste clients was that getting health care in Finland was very expensive. Those who had had some personal experience with Finnish health care providers assessed it positively except for the fees. The positive aspects included highly professional staff, good facilities and equipment, and fast diagnosis. *“Everything is very comfortable and human-centred.”* They saw the Finnish system as a high-quality state system particularly in terms of high technology. However, it was designed only to serve Finnish people and left non-residents out.

8.4 Expectations towards Finnish health care system

When the interviewees were asked about their expectations towards the Finnish health care system, they were all taken by surprise. They felt strongly that they were not included in the system but were outsiders, and hence could have no expectations. However, all of the interviewees mentioned that there was a need for more information about services in Russian. When I mentioned that the Pro-Tukipiste

Prostitute Counselling Centre could also be seen as part of the general system, they spoke enthusiastically about how needed and effective the centre was and that they would like to know that its activities would continue. *“As we are, and as we are needed in Finnish society, it would be very important to have this centre also in the future.”* (On the concept of Russian sex workers’ being needed in Finnish society further details later.)

Some interviewees also felt that they should be provided with less expensive accommodation for staying in Finland for sex work. This would make them less dependent upon pimps, who currently provide the women with places to stay and benefit from their work by charging high, tax-free rents.

Most of the interviewees did not speak about their sex work activities during the individual interviews. There were only two exceptions. Nadia spoke very frankly about the problems she had working as a prostitute. She mentioned often how she wanted to quit, and about the self-hatred she felt for not being able to do so. She saw herself as weak and incapable of keeping the promises she made to herself.

The other interviewee, Julia, did not directly talk about sex work as such, but she spoke elaborately about women’s needs and what they had to do to keep healthy. She essentially presented a general stereotype of women and men: the two sexes were different with different needs. Women were fundamentally emotional beings, and their health was directly connected with satisfying their emotional needs. Julia mentioned that she grew up in the Caucasus where the gender roles are traditional and, in her eyes, correct. Julia criticised her own daughter for being far too emancipated.

Russian sex workers saw themselves as completely outside of the Finnish health care system and thus had no expectations of it. The health risks of sex work were thus conceptualised as a personal health issue, not a structural health problem.

9. How Russian sex workers see their role in Finnish society

9.1 On Finnish women

The interviewees who spoke about their work as prostitutes gave different justifications for doing this work. The one reason that was common to all of the women was financial need. However, many interviewees felt that there was a need for Russian prostitutes in Finnish society. This was directly tied to notions of gender roles and the particular feminine quality of Russian women:

“Marina: Finnish women are too emancipated.

Katja: Yes, men want just to relax, to take a moment to relax in peace, but with Finnish women it is not possible.

Marina: Only with us they can feel as normal men. ... When you write your report please write about that. That the Finnish women with their behaviour repel men.

Katja: Of course, not all the Finnish women are like that but many are, and especially young women.

Marina: And we in Russia have also such young women, I mean who are aggressive, but there it is more an exception but here in Finland more as a rule.

Katja: The men should be men and the women - women. ... Many Finnish men talk about, and I know that they could get sex without paying for it. Because there are Finnish women who are also looking for one-night stands, and they don't expect any payment. But why then the men come to us? I mean they could get sex free. It means there is something absent with their women. It means they cannot feel free and relaxed, they cannot get what they need.”

To the question of what they thought about gender emancipation both of them answered that in Russia men and women are equal. They have the same rights, they can speak with each other as equals. Gender equality does not mean that women should be as aggressive and physically as strong as men are. Females should not behave as males do.

9.2 On Finnish men

I had promised the interviewees that I would not ask them directly about their work as prostitutes. In the individual interviews the topic of risky behaviour in connection to sex work came up only in passing. However, in the two pair interviews I conducted the women spoke freely about sex work in terms of its health risks. In the informal conversations I participated in the topic was frequently discussed. The clients were

very critical towards Finnish men, who, in their opinion, behaved irresponsibly. The main issue was the use of condoms:

“Finnish men are very reckless. They think that they cannot get sick. They don’t care. They want to have sex without a condom.”

“I had an older man, he tried to take off the condom behind my back. Maybe he thinks he has lived long enough and doesn’t care if he gets ill and dies. I don’t know what they think.”

How Finnish people relate to non-Finns

The common opinion among the interviewees was that Finns in general did not like Russians. This could be seen as an implicit part of their narratives. Asja, for example, told about the history she learned in school about the relationship between Finland and the Soviet Union was very different from the history her Finnish husband thought to be the truth. She did agree that the Soviet version was only partially true, but she also considered Finns to be *“very nationalistic. My husband believed the Finnish doctor I saw even though I myself didn’t. He thinks that everything in Finland is the best possible.”*

Other respondents also emphasised the same opinion about Finnish patriotism and about a specific xenophobia towards Russians. However, none of the interviewees gave a personal example of experiencing discrimination as Russians. On the contrary, they spoke about the benevolence of Finnish people in their personal relationships with foreigners. It was interesting that some of the interviewees saw Finnish women as caring, while others saw men this way.

10. Conclusion

The main findings of the research were the following:

First, the sex work industry in Helsinki includes a large group of women of very different backgrounds in terms of age, educational level, family background and other issues. With the exception of Malle, all of the Pro-Tukipiste clients that were interviewed for this study were well-educated women. They were all adults, and were

involved in the sex work industry voluntarily. Malle, who was also the youngest interviewee, did not give any clear indication about her route to work in Helsinki as a prostitute, and also appeared to be more dependent on her personal friends than the others. For all the women, the main and often single reason for prostitution was their poor financial situation.

Second, all the respondents felt uncomfortable because of their activity and tried to justify it with many different kinds of reasons. On the one hand, they had to earn money by any means possible; this was particularly for taking care of their families rather than for their own needs. On the other hand, they found there was a need for sex work in Finnish society. Russian prostitutes were needed to alleviate problems in the Finnish gender relationships that had veered away from the traditional gender roles.

Third, when talking about the topic of health the respondents, on the one hand, approached it as something very abstract, general and impersonal and addressed it in a formal way. On the other hand, they spoke about their own health problems, but these health problems were not directly tied with sex work. The issue about the health risks connected with sex work was the most sensitive area, and only few women were willing to discuss it. The interviewees saw other prostitutes who were not concerned about safe sex as the biggest source of danger to them, and the use of alcohol and drugs also posed a threat both in terms of health per se and as a cause of risky behaviour. All of the respondents were aware about the importance of safe sex and were much concerned about it. It is important to emphasise that in spite of the awareness about risky behaviour, the respondents pointed out that the most important means to take care of one's personal health was to regularly visit a doctor and get tested.

Fourth, in their assessment of the Finnish health care system the respondents seemed to accept the fact that they were out of its sphere, and did not even expect any support from the Finnish public sector. At the same time they were extremely grateful to the staff of the Pro-Tukipiste where they were received and respected as dignified human beings, treated well and provided real help. The Pro-Tukipiste Prostitute Counselling

Centre provided a haven for the women where they could have a break from the frustration and everyday life difficulties that they had to face nearly everywhere else.

Fifth, when they were comparing the Finnish and Russian health care systems, the interviewees expressed both nationalistic Russian attitudes and criticism of the Russian system. They saw the health care system in a welfare state as something ideal. However, even though they seemed to generally prefer a health care system such as in Finland, almost all the Russian interviewees emphasised that the care they received from Russian physicians was of high professional quality, mainly due to the opinion that Russian professionals were treating their patient as a human being in a more holistic way, whereas in Finland doctors relied more on hard scientific facts and treated only the actual diagnosis. However, with the exception of one person, the respondents had had few contacts with Finnish doctors because of the high fees. The Russian sex workers also preferred seeing a Russian doctor due to the language barrier.

Sixth, not having Finnish language skills presented a continuous and big problem for the Russian sex workers. They felt there was not enough information available in their own language, and hence had little general knowledge about the Finnish society and how it worked. The fact that the Pro-Tukipiste Counselling Centre provided services, health material and other kind of help also in Russian and Estonian languages was much appreciated.

Seventh, I did not meet one person among the interviewees who could be defined as “the proud prostitute” in Douglas’ (1984) terms. The staff of the centre emphasised that their clients were not full-time, professional prostitutes.

Finally, for me personally the most important knowledge I gained during the research process was that the Pro-Tukipiste clients I interviewed were driven to prostitution by their poor economic situation and only did it sporadically or temporarily. All the women I met had families and lives of their own totally separate from their sex work activities in Finland. My earlier assumptions of prostitution as a lifestyle were thus reversed.

I see it as extremely important to support these women and help them find other opportunities to earn money, while there is still time before they have to accept prostitution as the only way to live.

11. References

- Askola, H. (2001) Part I. Trafficking In Women In The Baltic States: Legal Aspects. *Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects*. Helsinki: IOM. <http://www.iom.int/>: 13-92.
- Douglas, J.D.(1984) The Fundamental Process of Becoming Deviant: Becoming a Proud Whore and Seduction on the Nude Beach. Douglas, J.D.(ed.). *The Sociology of Deviance*. Boston: Allyn and Bacon, Inc.
- Harju, J. (2002) Russian and Estonian criminal gangs divide Finnish prostitution market amongst themselves. *Helsingin Sanomat*. <http://www.helsinki-hs.net/news.asp?id=20020611IE10>
- Jacobson, M. (2002) Why do men buy sex? *NIKK magazine*. Nordic Institute for Women's Studies and Gender Research. No.1:22-25.
- Khodyreva, N. (2002) How women in prostitution see themselves and explain their motivations. *NIKK magazine*. Nordic Institute for Women's Studies and Gender Research.No.1:26-29.
- Lahdenmäki, A. (2002) Organised prostitution leagues amicably divide Finland into zones. High profits and lax punishment fuel cross-border vice business. *Helsingin Sanomat*. <http://www.helsinki-hs.net/news.asp?id=20021029IE17>
- Lehti, M. & Aromaa, K. (2002) Naiskauppa, laitton siirtolaisuus ja Suomi. Nykytilanne, lainsäädäntö ja tutkimuslähteet. Helsinki: Oikeuspoliittinen tutkimuslaitos.
- Markkanen, K. (2002) BACKGROUND: A festival's worth of customers every week. *Helsingin Sanomat*. <http://www.helsinki-hs.net/news.asp?id=20021112IE17>
- Nurmi, R. (2002a) Prostitution at the limits of risk. *Being Positive. Perspectives on HIV/AIDS in the EU's Northern Dimension and Finland's Neighbouring Areas*. STAKES. Saarijärvi, Gummerus Printing: 175-185.
- Nurmi, R. (2002b) A vicious circle of abuse of minors in the sex trade. *NIKK magazine*. Nordic Institute for Women's Studies and Gender Research.No.1:37-39.
- Okólski, M. (2001) Trafficking in women in the Baltic states: Sociological module. *Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects*. Helsinki: IOM. <http://www.focus-on-trafficking.net/pdf/Trafficking%20Book.pdf> :93-153.
- Pro-Tukipiste Counselling Centre (2002) Website. Available at: (<http://www.pro-tukipiste.fi/sivut/index.html>)

Randers-Perhson, Arne (1999) [with Liv Jessen] *Northern Regional Report*. European Network for HIV/STD Prevention in Prostitution. Available at: http://www.europap.net/regional/northern_regional.htm

Resource Book for Working Against Trafficking in Women and Girls Baltic Sea Region. By Kvinnoforum, Stockholm February 2002. 3rd Edition.

Saar, J., Annist, A. and Ahven, A. (2001) Trafficking in women in Estonia: social aspects. *Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects*. Helsinki: IOM. <http://www.focus-on-trafficking.net/pdf/Trafficking%20Book.pdf> : 156-197.

Sipaviciene, A. (2002) You will be sold like a doll. *NIKK magazine*. Nordic Institute for Women's Studies and Gender Research.No.1:11-15.

STOP I Report (1999) *Building up a Network for Monitoring, Analysing, and Combating Trafficking in Women and Children*. European Commission STOP Project. Available at: <http://www.stakes.fi/sexviolence/stop/stop1report.pdf>

STOP II Report (2000) *An Incentive and Exchange Programme for Persons Responsible for Combating Trade in Human Beings and the Sexual Exploitation of Children*. European Commission STOP Project. Available at: http://europa.eu.int/comm/justice_home/project/stop_prov_en.htm

Strömpl, J. (2002) *The K. School. Residential Management of Troublesome Girls in Transition-time Estonia*. Tartu: Tartu University Press.

Strömpl, J.(2000). The Transition in Estonian society and its' impact on a girls' reformatory school. *European Journal of Social Work*. Vol. 3, No.1, pp. 29-42

Strömpl, J., Jedomskihh, J., Kadajane, T., Markina, A.(1999). *Alaerialiste kriminaalset karjääri mõjutavad sotsiaalsed faktorid* [Social determinants of juvenile criminal career] Tallinn: Ministry of Social Affairs.

Zariņa, I. (2001) Trafficking in women: a perspective from Latvia. *Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects*. Helsinki: IOM. <http://www.focus-on-trafficking.net/pdf/Trafficking%20Book.pdf> : 201-276.

Tureikyte, D. & Sipaviciene, A. (2001) Trafficking in women in Lithuania: magnitude, mechanism and actors. *Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects*. <http://www.focus-on-trafficking.net/pdf/Trafficking%20Book.pdf> : 277-348.

Trafficking in Women and Prostitution in the Baltic States: Social and Legal Aspects (2001). Helsinki: IOM. <http://www.focus-on-trafficking.net/pdf/Trafficking%20Book.pdf>

Trafficking of Women to the European Union: Characteristics, Trends and Policy Issues, European Conference on Trafficking in Women, (June 1996), IOM, 7 May 1996). <http://www.uri.edu/artsci/wms/hughes/htm>

Appendix 1

Interview questions

I. Topic: health

1. The word 'health' is quite well known by everyone. Nevertheless, if we ask people what exactly this word means, we can find that different people have different understanding of it. I would like to discuss today with you how you understand the meaning of word. How do you use it? What does 'health' and 'being healthy' mean for you?
2. What are your personal experiences, when (in which conditions, concerning what) your attention focuses on your health?
3. As a rule, the notion 'health' goes together with its opposite – illness. Sometimes people start to think about health when it is gone, when one becomes ill. What does it mean to you 'to be ill'?
4. What does a human being's well-being mean? What are those circumstances that can influence people's health?
5. Who should care about human health?
6. Where is the border between the personal responsibility of an individual, other people and the state health care system? What is your opinion of when an individual has responsibility for his/her own health, when do other people have the responsibility, and when does the state health care system bear the responsibility?

II. Topic: Risky behaviour and health

1. There are particular professions, human activities, which are more threatening to the health of a person. Such activities are, for example, being medical service workers, miner, fireman, etc. Where do you locate your (professional) activity in this regard? Which are your professional risks and how should they be taken care of?
2. Please, take some examples, when you can tell that a person takes care about his or her health, or when he or she does not do it.

3. In which circumstances or conditions a person can forget about his or her responsibility to take care about his/her health? Can you take some example of such circumstances or conditions? (It may not be your own personal experiences, but those of someone else that you have met.)
4. What, in your opinion, are the state's duties to take care of people's health and well-being? What are the main functions of national health care?
5. What do you think about the Finnish health care system, how it should take care of your health? Why is it important?
6. What are the differences between your national health care system and Finland's?
7. Is there anything important that you think the Finnish health care system authorities should know to improve the system of health care? Please, tell me what is your opinion?

Thank you for your cooperation.

Summary and recommendations

Kris Clarke

This chapter briefly describes the significant findings of the migrant community health research project and puts forward recommendations for Finnish social and health care policy makers and practitioners to consider in their work with migrants.

1. The aims and methods of the project

The aim of the migrant community health project was to examine how migrants experience the Finnish health care system through two primary research questions:

- How do these respondents assess their position/situation in the Finnish health care system?
- What expectations/needs do these respondents have regarding the Finnish health care system?

By utilising migrants as experts on their own communities, this project sought to develop an empowerment-oriented evaluation framework for needs assessment based from the perspective of insiders (see de la Cancela et al. 1998). Health was viewed from a holistic perspective in these studies therefore a great emphasis was placed on the sense of well being in Finnish society as an issue of special relevance to the study.

Each researcher used a qualitative research method that involved between 5-10 semi-structured interviews. Each study focuses on a particular aspect of health care: the maternity and child health clinics of African mothers, health care services for Iranian asylum seeking families, and outreach services for Russian and Estonian sex workers.

2. Policy recommendations

Structural level:

- *Identification of the health needs of migrant communities*: more needs assessments should to be implemented in migrant communities to better understand the needs and effectiveness of Finnish health care delivery as well as health promotion, information and prevention efforts.
- *Further research from the perspective of migrant communities*: defining the research agenda from a migrant perspective adds rich and more complex dimensions to analysing the effectiveness of health and welfare services in migrant communities. An empowerment-oriented evaluation method provides essential information for designing effective health and welfare strategies and interventions for migrant communities.
- *Prioritising social and health concerns specific to migrant communities*: based on needs assessment findings in migrant communities, greater priority needs to be placed on the specific needs of migrant communities in social and health care policymaking as part and parcel of a policy of equality in health care provision.
- *Increased focus on preventing factors that produce negative social and health outcomes amongst migrants*: prevention work based on analyses of social and health care provision from a migrant perspective needs to be emphasised as the best means to reducing social and health care costs as well as decreasing human suffering and promoting well being in migrant communities.
- *Engaging migrant communities as stakeholders in the process of developing services*: members of migrant communities should be included in policy planning discussions. This would add the important voice of diverse service users and raise important issues that may not be obvious to mainstream policy planners.
- *Community capacity building*: engaging with migrant communities and helping them to develop support networks can be one of the most significant ways to reduce social isolation and promote mutual support.
- *Resource provision*: migrant health issues should receive appropriate resources.

Organisational level

- *Developing culturally appropriate health interventions as an essential strategy*: based on migrant community research and empowerment-oriented needs assessments, culturally appropriate health interventions should be implemented that are suited to the local community.
- *Cultural competence training for staff*: appropriate in-service training and extended education in cultural competence should be a priority of all health service organisations.
- *Use of culturally competent interpreters who are proficient in health care terminology*: interpreters should be available when needed and trained to be culturally competent and understand medical terminology.
- *Better culturally and linguistically appropriate information*: more information should be available in a multitude of languages to further health promotion, information and prevention efforts.

- *Employing migrants in the field:* agencies should hire qualified migrant personnel as workers in the field. This would not only benefit migrant patients but also co-workers who would benefit from a multicultural health perspective. Equal opportunity policies should be put in place on a local level.

3. Concluding remarks

Quality health care is one of the most important challenges of our time. It is indeed a major political issue in most western societies which are facing myriad health issues due to changing demographics at the same time that an ever-diminishing amount of public resources is devoted to health promotion and disease prevention. Finland has a comprehensive national health service that provides cradle-to-grave care. However, many of the ideas that have contributed to social constructions of equality in service provision and information dissemination are coming under challenge as the population of Finland becomes more culturally diverse.

It has long been established that effective health promotion and disease prevention work is one of the keys to a healthy society. For health promotion and disease prevention work to be effective, however, there must be adequate information about the needs, socio-economic realities and cultural worldview of the target group. As Finland becomes increasingly culturally diverse there is a crying need for migrant community research to improve and develop health promotion and disease prevention efforts. Very little information is actually available about the needs and realities of migrants from the perspective of migrants themselves. In the long run, the development of empowerment-oriented evaluations of social and health care in Finland will prove to be a valuable prevention strategy. An empowerment-oriented evaluation strategy will also help improve the quality of service delivery to culturally diverse communities.

The studies in this collection clearly demonstrate that migrants can effectively produce significant research on health and welfare issues in Finland. The recommendations outlined in these reports can be implemented at a relatively low cost. The advantages in terms of improved health and well being, however, cannot be counted and will ultimately benefit all of Finnish society.

4. Reference

de la Cancela, Victor; Chin, Jean Lau and Jenkins, Yvonne (1998) *Community Health Psychology: Empowerment for Diverse Communities*. New York: Routledge.

Contributors

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