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Islamic Values in Elderly Care in Finland: The Perspective of Muslim Women Caregivers

Shahnaj Begum¹ and Marjaana Seppänen²

Abstract

In recent decades, care-providing services in Finland have engaged care professionals with diverse cultural backgrounds, including Islamic cultures. Muslim women who adhere strictly to Islamic values in such work sometimes find it difficult to cope with the practices at care service institutions. In this article, we consider the experiences of Muslim women care professionals in such work, an environment that entails multiple interactions at different levels, among themselves and with care receivers.

Keywords: Muslim, Islamic Values, Culture, Care Professionals, Elderly Care Services, Finland

Introduction

Finland has traditionally had an ethnically homogenous population, but in recent decades, the country has experienced an increase in the number of immigrants. In 2012, the number of foreigners resident in the country was 195,000, accounting for 3.6 percent of the population (Väestöliitto, 2014). The immigrant population includes persons from predominantly Muslim countries.

Also on the rise in Finland, is the elderly population, a trend to be seen in the other Scandinavian countries and many societies across the Western world. The Finnish population is ageing faster than that in other European Union countries (Salin, 2013). Today, 17.5 percent of the population is over 65 years of age (Statistics Finland, 2014), and the figure is growing rapidly, increasing demand for elderly care in coming years.

Finland is described as a Nordic welfare state, characterised by the state's strong role (Greve, 2007), particularly so in the case of elderly care. However, analyses of recent developments show signs of marketisation and the emerging privatisation of care; another trend is the integration of informal family care into the formal care system (Anttonen and Häikiö, 2011; Kröger and Leinonen, 2012; Yeandle et al., 2013). Regardless of the way care is organised, it is evident that, in keeping with demographic changes, the need for care is increasing (Hunt et al., 2014), sparking a concomitant increase in the demand for women workers in elderly care (Castle, 2008; Donoghue, 2010; Kash, Naufal, Cortés, & Johnson, 2010). It follows that the number of immigrant women care-givers will rise accordingly, some of whom will be from countries of Islamic origin, such as Afghanistan, Albania, Iraq, Indonesia, Bangladesh, Gambia, Somalia, Syria, Turkey, Nigeria and the former Yugoslavia. The number of Muslims in Finland, a country of some five million, is estimated to be 60,000 persons (Kern, 2011).

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The increasing share of immigrant caregivers is a relatively new phenomenon in Finland, whereas in many European countries, and in many other parts of the world, the role of such workers has been widely discussed in recent policy and research (Spencer et al., 2010; Welsh and O'Shea, 2010).

Some Finnish immigrant caregivers have lived in the country for several years and have a care-related educational qualification obtained in Finland; the country has also actively recruited educated care professionals from abroad (Laurén and Wrede, 2011). Consequently, at present, in the care environment, one sees an unprecedented degree of interaction between individuals from different cultures and cultural backgrounds. An understanding of such interactions (Aranda & Knight, 1997) is of increasing importance in the society. Within this context and in this light, we focus in this article on the perspective of Islamic women caregivers who for the most part encounter Finnish clients and colleagues in their work.

While one can see a significant movement towards promoting theoretical understanding and the advancement of research in the care sector to recognise culture and incorporate it into health services (Sagar, 2012), to date relatively little effort has been made to understand the implications of cultural changes in the workforce and the experiences of immigrant carers (Walsh and O'Shea, 2010). Our practical knowledge of cultural interaction among care professionals from a variety of cultures (Aranda & Knight, 1997) remains relatively limited. Such knowledge would be important for a diverse range of needs and practices, and would increase understanding of the culture of both healthcare professionals and clients in care institutions. This is the case in Finland, where the growing number of caregivers and care receivers from multicultural backgrounds in elderly care institutions and hospitals.

All societies have norms of care and behaviour based on age, lifestyle, gender and social values. However, the values, norms, ways of life and lived experiences of health professionals and elderly people, including immigrants and non-immigrants, differ. It has been argued that Islamic culture includes certain values that may make it difficult for Muslim women workers to provide care services in Western/European cultures (Siddiqui, 2012; Odeh Yosef, 2008). Therefore, providing services to the elderly and others in Finland could prove challenging for Muslim immigrant women engaged in care-providing tasks. For those who adhere to Islamic values and culture most strongly, the situation can create conflict and dissatisfaction. However, experiences may differ, as not all Muslim women care professionals observe Islamic norms and values in the same way.

Several studies have found that clients' sociocultural background influences their perspectives, values, beliefs and behaviours regarding health and wellbeing (Joseph et al., 2014). There is also evidence that different sociocultural backgrounds influence the encounters between caregiver and care receiver where decision-making and interaction are concerned (Eisenberg, 1979). In addition, clear indications have been presented that clients' satisfaction, commitment to care and health outcomes are related to their communication with health professionals. It has been argued that the quality of care may be insufficient if the healthcare professionals fail to recognise and understand sociocultural differences between their clients and themselves (Betancourt et al., 1999). The field of cross-cultural care research focuses on care workers' ability to communicate effectively and provide healthcare of good quality to clients/patients from diverse sociocultural backgrounds. However, research-based knowledge of cross-cultural care and interaction from the immigrant caregivers' point of view is scarce. It is required not only in care settings, but also in the field of education for example. It has been reported that efforts to educate healthcare

professionals in cross-cultural care improve their knowledge, and there is sound evidence that such training also improves their attitudes and skills (Joseph et al., 2014; Beach et al., 2005).

The purpose of this study is to provide information regarding the experiences of Muslim women healthcare professionals who adhere to their religious values while working at service centres and hospitals providing care for older adults in Finland. In this article, we explore how Muslim women care professionals (doctors and nurses) experience the practice of their cultural and religious values in their everyday work. This experience includes not only everyday interaction between them and their clients, but also interaction with their colleagues in the working environment. The pertinent questions we present are: 1) what kinds of values do Muslim women health professionals consider important while working at nursing homes and hospitals, and 2) what is their experience of practicing Islamic values at work?

Researching Islamic Culture

The definition of culture may vary in different disciplines and in different contexts, but a relatively common understanding is that culture is a system of beliefs, values, rules or ways of life. These elements are shared by groups, generally transmitted intergenerationally and influence one's way of thinking (Leininger and McFarland, 2006). Values form the norms and customs that individuals use to select and rationalise their activities. Values and norms have also been used to assess people and their actions (Schwartz, 1992). Any nation or subgroup in a nation may be characterised by a distinctive cultural value outline or cultural standard (Spering, 2001).

Within Islamic culture, Muslims have their own ways of life, beliefs, rules, values, patterns and particular traditions that are distinctive from those of other cultures. In the context of health behaviour, culture is established as “unique shared values, beliefs and practices that are directly associated with a health-related behaviour, indirectly associated with a behaviour, or influence acceptance and adaptation of the health education message” (Pasick et al., 1994).

The best way to research culture depends on the specific goals of a particular discipline. Triandis (2000) defines three different major perspectives on the study of culture: indigenous, cultural and cross-cultural. The indigenous approach places emphasis on the meaning of key concepts and categories widely used within a culture. It also focuses on the relationships among these central concepts. In the cultural approach, ethnographic methodologies are applied with the main goal of advancing understanding of the individual in a sociocultural context (Adamopolous and Lonner, 2001). In this approach, researchers focus on the ways in which individuals communicate and build relationships with each other (Greenfield, 2000). The approach also emphasises the importance of culture in understanding individuals' behaviour (Aneas and Sandín, 2009); it focuses on emic methods,³ such as ethnographic techniques. Finally, the cross-cultural approach involves obtaining data from two or more cultures with the aim of providing knowledge about culture-specific and universal phenomena (Brisling et al., 1973; Triandis, 2000; Adamopolous and Lonner, 2001; Aneas and Sandín, 2009) and understanding similarities and differences across cultures (Tanaka-Matsumi, 2001). Spering (2001) sees culture as the man-made part of the environment that consists of both subjective and objective elements and resides in the mind of individuals as well as in their environmental context.

In our study, we have largely applied the cultural approach to identify and understand how Muslim women health professionals exhibit cultural beliefs regarding Islamic values and what

³ Emic knowledge and interpretations are those that already exist within a culture. Local customs, meanings and beliefs are the indicators that best describe a 'native' of the culture.

cultural values they consider important when working in the sociocultural context of care institutions. However, we have also adopted elements from the indigenous and cross-cultural approaches in our research.

Each individual learns culture from both his or her family and the wider community, and Muslims are no exception. Essential to Islamic culture is how Muslims live their everyday life; for example, how they dress and the food they eat. When Muslims move to other countries with different cultures, their cultural practices may change as part of their adapting to the new culture (Balquis and Mineh, 2012). However, it has been suggested that immigrants often become more sensitive to religion in their host country than in their country of origin (William, 1988). In Germany, for example, Muslims are found to be less integrated than Christians (Constant, 2006; Ozyurt, 2009), and religious practices are strongly rooted amongst them. Therefore, in care institutions, for example, it is important to know clients' ethnic identity, core values and behaviours, as these may affect their relationship with the professionals caring for them (Basil et al., 2010). Our assertion in this regard is that it is important to not only identify the clients' core values, but also to understand how the culture is embedded in the professional life of the care workers.

People, including Muslims, perceive cultural norms and values differently, regardless of their religion, given that the society in which they live is constructed on different values (Spering, 2001). For example, Muslims from an Arabic culture do not share similar values in practice with Muslims from other parts of the world, such as those from South Asia (Liu & Yu, 1985). Hence, Islamic culture also differs based on a person's geographic location, language, traditions, behaviours, perceptions, beliefs and other relevant issues. The definition of family, the importance of family (Iecovich, 2008), attitudes and gender-related issues will differ according to a person's cultural perspective.

The core meaning of Islam includes a belief in God, both oral acknowledgement and internal faith. Thereafter, the other fundamental aspects include *Salat*, *Ramadan*, *Hajj* and *Zakat*. The practice of Islam mandates that Muslim people should pray (*salat*) five times a day, with obligatory praying performed at dawn, noon, mid-afternoon, sunset and late at night. It should also be noted that Muslims ritually wash (*wuzu*) before their daily prayers, which includes washing the arms, face, mouth, ears and feet each time. Fasting during the month of *Ramadan* is also one of the 'pillars' of the Islamic faith, and is declared an obligatory duty (*fard*). All Muslims should travel to Mecca at least once in their lifetime if capable of such a pilgrimage. Depending on a person's financial situation, he or she may be required to pay *zakat* – a form of Islamic tax – to benefit the poorest or those in need.

Most Muslim women, following the practice in their country of origin, cover their head (*hijab*) and body in different ways. Regarding the *hijab*, for example, Hammoud et al. (2005) state:

“Islam commands both sexes to dress modestly, to maintain a moral social order and to protect a person's honour – so the basic requirement for Muslim women is that clothes are neither transparent nor shape-revealing and that hair, arms and legs are covered, especially in the presence of any adult male who is not in the woman's direct lineage.”

The use of the *hijab* often plays an important role in shaping the experiences of Muslim women, as a veiled woman is subjected to prejudice and stereotypes (Siddiqui, 2012). In addition, the family culture in Islam is both vital and significant, and related to the *hijab*, as Muslim women, in

theory, are not allowed to touch or shake hands with males, including elders, who are not relatives (Hammoud et al., 2005). In strict Islamic society, relatives take care of the elderly, and normally a member of the family will take care of the family's seniors and elderly parents. This cultural tradition is encouraged in instructions given by the Prophet of Islam in the following two verses: "He is not one of us who is not merciful to our youngsters and does not respect and honour our elders" (Al Tirmidhi); "He, who is not merciful to our youngsters and does not fulfil the rights of our elderly, is not one of us" (Abu Dawud).

One other important aspect of Muslim culture is maintaining the particular custom of eating only *halal* food. By general practice, Muslims do not eat pork, anything that contains pork or the meat of other animals not slaughtered in a manner prescribed by religious rules. Drinking alcohol is also prohibited in Islam.

Traditional Islamic practice maintains a highly conservative lifestyle. Muslims generally live following their own traditions and *Quranic* instructions. However, previous developments suggest that Islam has been influenced by different factors such as cultural practices and innovations in healthcare sectors supported by Islamic law (Nayer, 2008). It has also been asserted that the Prophet of Islam encourages patients to seek proper treatment in times of illness, saying, "Taking proper care of one's health is the right of the body" *Bukhari as-Sawm 55, an-Nikah 89, Muslim as-siyam 183, 193, Nisai* (Nayer, 2008). As a result, Muslims have gradually become open to accepting the professional practices found in health sectors in different traditions, including those in non-Muslims cultures. However, gender preference is common among Muslim clients who accept healthcare services. In the case of Muslim women care professionals, experiences are shaped by of the role of the family in Islamic culture, which teaches them how to care for their elderly (Siddiqui, 2012).

Because of the fundamental Islamic values, rooted in their cultural practices, even in a foreign society, the integration of cultural practices in care services has been considered important. In his research on health beliefs and practices of the Arab Muslim population in the United States, Odeh Yosef (2008) states that individuals' religion and cultural background influence their beliefs, behaviours and attitudes toward health and illness. In his view, Muslim healthcare professionals in the Western world, especially women, face potential challenges related to work practices. He suggests that Muslim women who have been involved in healthcare professions should clarify the precise cultural and religious obligations that they want to preserve, and stresses the importance of creating a culturally competent care environment (Odeh Yosef, 2008; Kulwicki et al., 2008) in the care sector for both caregivers and care receivers. Other scholars have noted that "Islam works within a holistic framework for healthcare in which physical, social, spiritual and environmental needs" of the care receivers are taken into consideration (Fonte and Horton-Deutsch, 2005). However, less emphasis has been placed on the significance of caregivers' perspective; despite this, it has been noted that Muslim women healthcare professionals, especially those who wear a veil, encounter negative attitudes in Western cultures (Haldenby, 2007). In Finland, Laurèn and Wrede (2008) have suggested that applications for jobs as practical nurses were rejected in some cases because the women applicants disclosed that they exercise religious practices.

In the following section, we describe the processes of data collection and analysis that underpin the subsequent discussion.

Methodological Framework

Data Collection Process

We used an ethnographic method (Atkinson and Hammersley, 1994) in this research, involving several informal discussions and interviews. Most of the data was gathered through interviews. The informants were immigrant Muslim women care professionals, who we selectively chose in Helsinki through personal connections and using the snowball technique. First, we selected some known informants in Helsinki, and they then provided information about other Muslim women immigrants working with the elderly in relevant institutions and hospitals. We carried out data collection between October 2013 and June 2014, during which time we interviewed eight care professionals (practical nurses and doctors) with an average of more than three years experience of working in elderly nursing homes and hospitals. All participants were females who had lived in Finland for between five and twenty-five years. Six of the participants still worked in elderly care institutions, while two had previous experience of such work. The practical nurses had generally completed their studies in Finland, whereas the doctors we interviewed had earned their professional degrees in their native countries. All of the informants had taken language courses and completed other relevant studies in Finland. Each interview lasted between 60 and 90 minutes. The participants were between 25 and 45 years of age. We do not use their real names in this article.

In ethnographic research, there is not usually an exact research design; rather, the design changes throughout the study, based on the way in which the research is carried out; in other words, the ultimate design cannot be predicted (Goldbart and Hustler, 2006). However, we had a preliminary plan to begin with informal discussions before proceeding to the thematic interviews, and we followed this, for the most part. During the discussions and interviews, we maintained a diary and noted the important themes in field notes (Heikkilä, 2004). The focus of the interviews was to investigate the practice of cultural values (Cox & Monk, 1990) in workplaces, reactions to interviewees' desire to practice such values and the coping strategies adopted in the care institutions. We asked for the informants' experiences as care professionals using open-ended questions that gave them space to express their thoughts freely and to provide a variety of in-depth information. We tape-recorded and transcribed each interview. At the same time, we used the informal discussions to establish a general picture of the kinds of Islamic values identified by the immigrant (Muslim women) professionals, and how they experience and interact with each other (immigrant and non-immigrant colleagues and elderly) in institution-based elderly services and hospitals. We also asked informants what their expectations were for care-related institutional services.

Data Analysis

We based the data analysis on a dialogue between our conceptual framework and our empirical data, and used thematic analysis that drew mainly on concepts relevant for gaining insight and knowledge from the data gathered (Boyatzis, 1998). This knowledge helps to develop a better understanding of the group (Muslim women care professionals), in a specifically researched context (a care sector). The themes we selected, which emerged from the interview data, were analysed inductively. Our aim was to develop new knowledge based on the findings. However, the conceptual and theoretical framework guided us in extracting and articulating the knowledge (Hsieh and Shannon, 2005) and in applying the concepts in the context in which our informants worked (Braun and Clarke, 2006).

In analysing the data, we used an ethnographic approach, which generally provides a description of people and their culture (Altheide, 1987; Leininger, 1997). To understand the concepts and engage with the data collected, we repeatedly read the diary notes and listened to the recorded interviews. As the knowledge gleaned from the research is based on inductive data analysis, the themes we have selected derive from the information freely generated from the interviews, which we considered in relation to the objectives of our study.

Findings

Cultural Competence

As regards to experiences, all eight informants mentioned a lack of awareness of other cultures and a lack of respect for Muslim culture in the workplaces. In their view, there is a lack of understanding of Islamic values and culture, which becomes evident in the context of the multidimensional interactions occurring in care institutions. We also asked informants about their expectations that such knowledge gaps would be reduced. They highlighted their duty of the care as professionals to communicate their values more modestly to their non-Muslim colleagues and clients, in order for them to respect these values. For example, one participant, Fatema, who has around 10 years of experience in the care service (nursing home and day care), stated:

“Nowadays, the acceptance of Muslim values and culture are positively recognised by many if I compare the present situation to the earlier one. I must, however, mention that in every culture there are both positive and negative sides. We should not be distracted by negative examples only; we should also value the positive ones. Promotion of this understanding will certainly offer a better understanding amongst the professionals who are from a different culture by origin.”

Gender Preference in the Professional Environment

Muslim women generally adhere to some of the fundamental values more strongly than men do. For example, women prefer to follow certain strict rules with regard to the opposite sex. The interview findings suggest that amongst Muslim female care professionals, practical nurses prefer to care for same-gender clients, whereas doctors are exceptional, in that gender is not an important issue to them. In this regard, Diba, a medical doctor educated in a country with a Muslim majority, noted:

“We were taught to treat clients by merely considering them as patients, regardless of gender. The teaching helps me to see my professional duty as gender neutral. As for working with male colleagues, I basically have not found it as challenging, probably because I am more open than the others. I know a Muslim woman doctor working in our hospital, who was educated in and originating from a European Muslim country, refused to share an office with her male colleague.”

However, we could not make the generalisation that doctors are more gender neutral than practical nurses, as in the course of the interviews we found that there are other practical reasons at work. Doctors' duties are, for example, more formally set: they do not have to take care of the patients in the same way as the practical nurses. Practical nurses in Finland are generally required to deliver

a wide range of practical care, such as giving baths to patients, washing them in the sauna, dressing them and so on, and the variety of services may lead to a variety of opinions. In addition, the formal education, which doctors have received, could also be a reason why they are more open minded than other health professionals.

One problematic facet of care work for Muslim women, in particular, practical nurses, is that they are not comfortable with the aspects of their job that bring shame on them in their cultural community; examples being bathing male care receivers or washing them in saunas at care institutions. Most of the informants acknowledged this fact, and mentioned that they are ashamed of talking about their job responsibilities (in the elderly care institutions and home care services) within their own cultural community because Muslim women taking care of men is not regarded favourably within that community.

Some other issues, such as handshaking, which is a normal practice in Finland, are difficult to come to terms with for some relatively conservative Muslim women care professionals. Some of the interviewees expressed their discomfort with this, and some even said that handshaking was not a hygienic or healthy practice regardless of whether it involved males or females.

Muslim/Halal Food

Eating habits are very important for most Muslims, including those living in a foreign country. While interviewing, we found almost all of our respondents to be of the same opinion concerning their restricted behaviour surrounding pork products, non-*halal* food and alcohol. However, some participants viewed *halalness* in a different way. Diba suggested:

“Freshness of food is important to me. Where eating meats is concerned, although an animal is not slaughtered in an Islamic way, I find no problem in eating the meat, as I consider meats sold in a supermarket to be healthy and fresh. However, I don’t eat pork and don’t drink alcohol, as they are strictly forbidden in the *Quran*.”

For the others, *halal* food, including permitted animal meats slaughtered in an Islamic way, was extremely important. *Halal* food is slowly becoming more available in Finland’s big cities. However, there is no access to such food in care institutions, which led the interviewees to express their concerns. For example, Diba does not feel comfortable when somebody disrespects her religion while discussing food habits in the workplace. She, herself, does not bring the discussion round to food habits at work, fearing that this might cause colleagues to form a negative attitude towards her and she brings her own food to work. Four of the informants were of the opinion that the staff in their workplace cafeteria knew of their food habits, which meant they had not encountered any negative attitudes towards their choice of food. Despite this, they stated that if they were to live in the same kind of institutions in their old age they would prefer more food options. In this regard, Sabiha made an interesting point:

“When we (including other Muslim colleagues) say that we want *halal* food, representing the food that Muslims want, then we can see that the reactions/impressions of non-Muslim colleagues are not always positive; but if we use the terminology “vegetarian food”, then it seems pretty acceptable.”

Prayer

Praying five times a day is one of the core practices for Muslims, although not all adhere to it strictly or equally. However, in order to perform prayers, one requires clean dress and a quiet and clean place. Health professionals working seven to eight hours a day must pray at least twice during their working day. The professionals who had worked in hospitals mentioned difficulties in following prayer times in the workplace because suitable places for prayer were not available. Praying in their offices was not always possible because they usually shared these offices with other male colleagues. In addition, prayer times were not officially set in the workplace, and the interviewees could not find their own time to pray, given the small number of doctors in relation to patients. However, one of the respondents found that not performing prayers did not always make her feel bad. According to her, she provides worthwhile services that improve the wellbeing of the clients, making her feel good about delivering her services. She believes that as long as she complies with good practices, ones not contrary to God's instruction, she does not regret not praying. On the other hand, during the interviews, most of the practical nurses expressed satisfaction that their colleagues now understand them better and help them to pray during working hours. However, two of them detailed some negative experiences concerning workplace prayers. These two were both professionals, one at a nursing home and the other at a daycare centre, and in some cases, they were refused permission to allocate extra time for prayers when they requested it. For example, the respondent Santa complained:

“When I have mentioned specifically that I need time for prayer, I was refused. But my co-workers go outside quite often to smoke, and that wasn't forbidden. Isn't it unfair and unequal?”

Family

As mentioned, the importance of family in Islamic culture is vital, and all the informants emphasised its significance. Of the eight informants, six had school-going children. They mentioned that twice a year they have their major religious festivals, which are regarded as equivalents to the Christmas celebration in Western culture. However, to the detriment of their family, they usually do not have any holiday time from work, during their festivals, to celebrate. While mentioning the importance of family and its connection to religious events, Aysha stated:

“Even though the events for Muslim celebration are easily traceable from the calendar, in Finland there is no common holiday. Some of us can manage a day off from work, though, but that does not work equally for all. Moreover, as there is no common holiday for celebration, children of school age may not have a chance to spend time with their family, as they may have important lessons or examinations at school.”

The respondents suggested the importance of flexible and alternative arrangements in workplaces, and also demanded corresponding schedules for their school-going children so that school authorities could avoid scheduling important exams during the celebration events. They also mentioned difficulties in performing physical work during *Ramadan* (the fasting month); they believe that if their *vuosiloma* (annual holiday) is adjusted to accommodate the month of fasting, they will be able to engage in their religious practices more easily, which will help them to have a

family environment better in tune with cultural norms and values. A better family atmosphere was viewed as contributing to better performance at work.

Discussion

In our study, we found that the women care workers we interviewed have encountered a lack of awareness of Muslim culture, which in turn has presented them with different kinds of challenges in their role as care workers. The extent to which they wanted to adhere to the rules of Muslim culture varied, but some practices were important to them all. Praying five times a day was a practice often difficult to exercise at work. However, experiencing understanding in the workplace made the work easier, and receiving support from colleagues brought satisfaction. Some of the informants experienced a lack of respect for their prayer practices, and reported that they were denied time for prayers. At the same time, other employees were allowed breaks to smoke was allowed, which created feelings of unfairness.

The other important value for the care workers interviewed was the behaviour connected to food, including eating *halal* food and fasting during *Ramadan*. An understanding of what *halal* food is seemed to vary among colleagues and workplace cafeteria staff, and sometimes it was easier to express the needs using concepts more common in Finnish culture, for example, vegetarian food. There were also difficulties during *Ramadan*, especially when it occurred during the Finnish summer, when the dark time of day is very short due to the northern location; then, eating only during darkness required extra persistence and coping with work duties became more difficult. The other religious festivals also created challenges, as in Finnish working life and public schools the common religious holidays are defined according to Christianity. This question was especially pressing for families with children.

In Finnish culture, the professional care and support provided by, for example, a nurse or social worker, plays a vital role in the lives of older people, as in the Nordic welfare model public services take on an important position. At present, professional elderly care lies mostly in the hands of women, and because of the growing number of immigrant women (including Muslim) caregivers, cross-cultural interaction is rapidly increasing (although there are great variations between different regions in Finland). The gender issue is a multifaceted one that seems to figure prominently in daily working life. In Finnish culture, there is no possibility of selecting clients by gender, which poses difficulties especially for the practical nurses whose tasks include intimate procedures such as bathing a client of the opposite gender. The informants exhibited feelings of shame when talking about these issues.

The overall interpretation of the experiences of the women care workers was that they face difficulties when practicing their Muslim culture and religion, but that the atmosphere is slowly changing as the exchange of information and encounters between different cultures are steadily increasing. However, there is a great variation in how organisations and individual colleagues encounter the Muslim women care workers. Co-workers' negative impressions of religious practices clearly caused some frustration, which can sometimes lead to an unhealthy work atmosphere. On the contrary, respect from co-workers for Muslim cultural practices was reported to contribute to motivation and wellbeing in the workplace.

When people engage in a practice of understanding of and tolerance towards each other's cultural practices, it not only brings cultural elements into discussions, but also creates room for the implementation of prayers, eating habits, gender preferences, respect for family values and so on. Acquiring knowledge of cultural factors, such as values, attitudes, beliefs and behaviour, and

understanding the differences in the values held by others, enables people to achieve greater cultural competence. Enhancing “cultural competence” among health professionals, by integrating cross-cultural values, should become a norm in order to promote better management in the care system and reduce inequalities in the health sector (Van and Bruijnzeels, 2002; Hartley and Hamid, 2002). Detailed knowledge and deeper understanding of other cultures provide better healthcare (Siddiqui, 2012). However, achieving these goals requires extra effort to ensure an environment where care professionals in institutions designed for the elderly may perform their cultural practices in a balanced manner (Nayer, 2008). For example, arranging a time and place for prayers, ensuring a supply of acceptable food and maintaining gender preferences in care services, which are all common Islamic practices, may create challenges.

We believe that in societies with a growing variety of cultures and religions, knowledge, such as our research findings, can help to mitigate workplace challenges. A number of proactive steps, such as accommodating some cultural norms in the workplace, promotion of education and training programmes on intercultural communication and overall reformation of care-providing practices in a multicultural environment, will promote better services for the elderly in care institutions and hospitals.

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