Cultural Competence in Health Promotion and Experienced by the Kurdish Women in Finland

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For people who come from other countries to live in Finland, the impact of settlement and acculturation varies widely depending on their experience and situation. There are many determinants of health and well-being from outside of the health system. Finland is becoming more responsive to the needs of people from diverse backgrounds. This research explains in general the plight of the Kurdish women having immigrated into Finland. A woman's position in this society is slow to change. These women have experienced various factors in their everyday lives such as patriarchy, political issues, different environments, different languages and cultures. In this research I have shown that those factors directly and indirectly influence the Kurdish woman in Finland's health situation. I have likewise proposed a project plan in order to solve these problems.

Data were collected using individual interviews derived from three discrete groups in three cities in Finland. The interview group consisted of 12 Kurdish immigrant women aged 30 to 52 years. Each has lived in Finland for some time—either in Helsinki, Turku or Tampere. The research is based on interviews. The research method in this study was qualitative. Data collection was conducted in the form of individual theme interviews. The results were analyzed by qualitative method based on interview analysis. The result of this study shows that health promotion among Kurdish immigrant women is important and should be taken into account when planning further health promotion programs in Finland. Most of the Kurdish immigrant women have language problems and poor understanding of health care promotion and the health care system.

The findings of this research study could be used for planning of the methods in the health promotion project, developing personal health promotion skills of the Central Council for Health Education and Promotion for Kurdish immigrant women.

Keywords: Cultural competence, awareness, sensitivity, knowledge, Kurdish immigrant, Kurdish women

Culture has been defined as an integral part of learned beliefs and behaviors that can be shared among different groups of people. It naturally includes styles of communicating, ways of interacting, views on roles and relationships, values, customs and religion. Culture is influenced by various factors such as race, ethnicity, nationality, language, and gender, but it also extends to socio-

economic status, physical and mental ability, sexual orientation and occupation among other factors. To understand cultural competence, it is important to grasp the full meaning of the word "culture" first. According to Chamberlain (2005, 195–211) culture represents "the values, norms, and traditions that affect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world". According to research studies, no universal definition for cultural competence in health care exists. In general, it is skills that allow someone to increase their awareness of culture competency including: country of origin, language, education, spiritual traditions, family traditions, diet and nutrition, traditional medical practices, attitudes about illnesses and death and migration experiences (Donini 2000, 241–45).

Health literacy has become a keyword in the global discussion on health promotion and participation. The WHO (1998) defines health literacy as a cognitive and social skill which determines the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health.

Cultural competence in health care has emerged to contribute to racial/ethnic disparities in health care. Cultural competence in health care describes the ability of system´s needs. Understanding and being culturally competent is important, because unfortunately health care is not equal for everyone. (Malin and Gissler 2009.)

According to a recent survey conducted through a THL (2002) research study, many mental and physical problems as well as physical disabilities are left untreated amongst the immigrants. Information research appears to lack awareness of the complex needs of immigrants.

The target group in this thesis is Kurdish women who have been living in Finland for a while, but who still know little about health care, health promotion, and health services available to them. According to this research study, Kurdish women in need of health promotion can be divided into two categories: integration into Finnish society and joined to multicultural society. Health promotion among Kurdish immigrant women is a top priority of Finnish health care in this research. Based on this explanation, the research questions are: What are the health promotion problems among Kurdish immigrant women living in Finland? What are the causes of these problems? What are the health promotion activities that can lead to a solution to these problems? How effective has solving these health problems been?

I chose Kurdish women because I am Kurdish and belong to this population, and also to reach Kurdish women with preventive and health promoting activities and health education measures, specific communication patterns and health care services. In Finland, the Kurds have so far been studied primarily in the context of immigration policy and perspective. Wahlback (2000) and Lehtonen (2004) studied the Kurdish population in Turku, Finland in their doctoral and master's theses, respectively. Health promotion creates social change through community education. This education tells women what is best for them. Education develops women's health and supports them to express their health needs, and provides their needed information in a way that makes sense to them.

The factors affecting Kurdish women's health in Finland

In Finland, Kurdish women live a normal life, including employment, education, and child-care leave. Women have built their lives in Finland; they are happy to live in Finland, as here they can feel free as women. Kurdish cultural values are important to them, and they want to bring up their children according to their own cultural values. Most of the Kurds living in Finland had first moved to a different country, whether as quota refugees or asylum seekers; they are not coming from the Kurdistan area. The reasons why the Kurds have fled from Kurdistan as refugees are many and varied. (Kanervo and Saarinen 2005.)

The Kurds are an ethnic group, united by language, religion, origin and the contiguous geographical area of Kurdistan. Kurdistan is not an independent state, but is divided into several state areas. Contemporary use of Kurdistan refers to parts of eastern Turkey (Turkish Kurdistan), northern Iraq (Iraqi Kurdistan), northwestern Iran (Iranian Kurdistan) and northern Syria inhabited mainly by

Kurds. Kurdistan roughly encompasses the northwestern Zagros and the eastern Taurus mountain ranges, and covers small portions of Armenia. (Columbia Encyclopedia 2005.)

Kurd's population in the world totals about 35 to 40 million. Throughout history, women in Kurdistan have been socially and politically active. They have strong family lives. The Islamic culture is shown in Kurdish men and women's relationships, gender roles and the division of labor. Women's and girls' main task is to take care of home and children, they do not often go to school, and thus the illiteracy rate for women is higher than- that for men. (Kanervo and Saarinen 2007, 60.)

Some Kurds have arrived in Finland also on the basis of family ties. (Niemi 2006.) The Kurdish tribe, unlike many other Finnish tribes, is not one big umbrella organization including members from all of the countries with immigrant populations in Finland. But there are many small organizations. These organizations represent great ways to get in touch with the Kurds. They feel thankful towards Finland, and they have a good grasp of the Finnish culture. They also feel that they could have received more intensive language courses earlier as well as more information on the system. Many of them have received a good education in Finland, and they are an integral part of the labor force. Nowadays, a lot of work to promote women's and gender equality is carried out. Women are able to go to work and educate themselves. According to Moab's (2001a, 1–18) explanation, the number of Kurds living in Europe is approximately 700,000. According to Statistics Finland, at the end of 2010 there were 8,032 Kurdish people living in Finland. The Kurdish language was the seventh most widely spoken language in Finland. (Statistics 2010.)

The aim of the research

Most of the literature identified in this literature review pertains to the understanding of health promotion and health education among Kurdish immigrant women, also including those who have been living in Finland for a long time but still have need of health information and health knowledge. According to research studies in the UK diversity in Health and Social Care in 2004, lack of evidence-based transcultural nursing and research knowledge about cultural differences makes it difficult for providers to deliver, and for clients to experience, high-quality cost-effective care cultural competence. (Papadopoulos 2004, 108.)

Essential to the understanding of health promotion is the concept of health. Health has multiple definitions and meanings. The science and art of helping people change their lifestyle to move towards an optimal state of good health, which is a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences, which enhances awareness, increases motivation and builds good skills, and most importantly through creating supportive environments that provide opportunities for positive health practices. (O'Donnell 2009,5.)

The health promotion category expects nurses to have the knowledge to incorporate prevention and/or early detection of health problems and strategies, which will help clients and their family to achieve optimal health. The health of an individual, family, community and population-at-large is multidimensional. It includes the social, cultural, behavioral, economic and environmental influences on health. Those influences provide the basis for the development of policy and programs in preventive health care. The impact of preventive health care services or lack of such services in a community must be assessed. Such an assessment is within the purview of the professional registered nurse. (ANA 2001, 101.) Health promotion is the process that enables people to improve and have greater control over their health state. So the aim of health promotion is helping people improve their health to reach normal physical, mental and social health well-being states. Health education is a component of health promotion and for many is considered to be health promotion; however, health education differs from health promotion as it is specifically geared towards individual learning. The research is based on interviews. I have interviewed three groups of Kurdish women of different ages in three cities, and three group interviews with the key information. The key information was Kurdish women's health promotion in educating them about

health care promotion. I interviewed them separately in my place of residence and two other cities.

This study is based on information gathered from interviews, articles, books, the THL research report of 2012 and the Internet. Qualitative research, which is descriptive, interpretive, and reflexive, was useful in minimizing my biases and highlighting new issues and perspectives. Interviews were well suited to give the researcher a better understanding of deeper perspectives. Interviews can be conducted as open-ended questions in which the researcher has the opportunity to get more detailed answers. The aim is to obtain women's opinions, feelings, experiences, knowledge and emotions related to health care promotion. (Denscombe 2007, 174–175.)

I asked for the interviewee's consents. I explained that I was recording my research only for the purposes of my thesis work. The secondary sources include newspapers, journals, magazines, human-right reports from the WHO homepage and Internet research. My familiarity with the Kurdish women's society, competence of the native language and the time I spent in the field helped me to build trust and establish rapport, which is of the highest importance for an interviewer. The research method in this study was qualitative. Data collection was conducted in the form of individual theme interviews with three different groups of Kurdish women, each of which of a different city in Finland all members of which having experienced the Finnish health care system. The following responses were given in the interviews:

"I suffer from emotional and mental distress. I've been seeing a psychotherapist regularly and after several years of the psychotherapy I got a prescription for medications which I use daily. I meet a psychotherapist three times a month. I made an agreement with my doctor to not change my translator during my treatment. Doctors have counseling treatments for me and I participate in these counseling."

52 years old, Helsinki

"Health system in Finland should be developed in a way that nurses and doctors could be more familiar with immigrant cultures. We ran away from our homelands because it wasn't safe for us to live there anymore. Finland accepted us as citizens so they should also make an effort and take care of us. Make it easier for us to live and understand. Teach us how to survive. For some of us it is hard to learn the language. Also it would help us so much if there would be health information in our language or in simple Finnish language."

38 years old, Tampere

"The biggest problem is that foreigner women don't have enough knowledge. They should be given more information about health and wellness. Health centers should think of good strategies how to make us more aware."

42 years old, Turku

"In my opinion culture is very important and people need Culturalization. The culture of the people should be considered because it is very important for us. The language is very important to obtain information. For example notes and contracts are very difficult and hard to read. If the information was written in our language, it would solve many problems. If they can't do this at least the written Finnish language should be easier to understand. It would make everything easier if monthly data would be sent to our home in our language".

38 years old, Tampere

The results were analyzed by qualitative content analysis

My interviewees were women experienced in trying to change the health care promotion situation. The researcher must try to identify what element can affect or undermine the reliability and validity of the data. It is often argued that the "interview on a sensitive topic exposes the researcher to bias". (Cohen 2003,121.)

Ensuring the confidentiality, reflexivity, safety, and the protection of the informant's privacy can enhance valid and reliable data. I am a Kurdish Muslim female, born and raised in the east of Kurdistan. In this respect I am part of the Kurdish women society. My field of research is Cultural Competence in Health Promotion and Nursing Care among Kurdish

Immigrant Women in Finland. My research purpose led to a greater understanding of health promotion, and filled a gap in current knowledge and built trust and cooperative relationships with information. During the process of choosing a research topic, collecting data, and the writing process itself, I was always reflecting on my own position.

I am from Kurdistan and speak the Kurdish language fluently. I chose to use a qualitative method and individual interviews for two reasons: first, I desired the viewpoint of one person to be unaffected by others; and second, interviews can be conducted in-person by creating a virtual face-to-face interview. Women studies are a very important and rapidly developing field of research in Finland Bergman (2002, 317-331) and Tuori and Silius (2002, 69-121). Even though there are many academic and official studies conducted on immigrants in Finland, studies on women immigrants are relatively few. According to Zechner (2002, 447-485), research on migration in Finland can be divided into three main branches: immigration, emigration, and ethnic minorities. Immigration, immigrants and their integration into Finnish society have been the most investigated. Immigration to Finland changed those women's lives either in a good way or in a bad way.

This research study was the beginning of these interviews and allowed me to meet these women via telephone. I reached these women by phone in three cities in Finland, and I travelled to these cities on two different days. It was not that easy to find these Kurdish women for interviews, because I did not know these Kurdish women's addresses and phone numbers. I had to contact a Kurdish women's organization in Finland to help me find them.

Methods and materials

In this research study the interview method was selected because interviewing is an invaluable tool for the qualitative researcher. The Interview method according to Kvale (2007, 12) provides both the theoretical background and the practical aspects of the interview process, incorporating discussion of the wide variety of methods in interview-based research and the different approaches to reading the data. The qualitative research interview seeks to describe the meanings of central themes in the life world of the subjects. The main task in interviewing is to understand what the interviewees say. (Kvale 2007,12.)

The qualitative method is based on interviews chosen for this study. The respondents live in the cities of Turku, Tampere and Helsinki.

Questions were asked in the Kurdish language and answers were then translated into English. Interviewees answered the questions with confidence. They expressed their contentment to participate in this research. This research study was organized for 12 women in three different cities in Finland. The interviews were undertaken according to an interview guide explaining the purpose of this research study to interviewees and giving some practical information.

The questions were made as simple as possible because interviewees had different educational backgrounds. In the structured in-depth interviews, the women were asked about their health care, health care promotion and health care services. The interviews lasted from 60 minutes up to 90 minutes and were conducted in the respondents' mother tongue. The interviews were transcribed and then translated into English. I have used this model to introduce the report. In this study, the average interviewee age was 40.5 years. The youngest woman to participate in the study was 30 years old, and the oldest 52 years old.

Health promotion needs of Kurdish immigrant women

'Culture shock' describes the process of coming to terms with the otherness of a different society. It affects even those refugees with a positive attitude to being in a new country and who want to build a new life for themselves. Refugees may suffer from identity problems associated with losing their home, family and country they used to live in. (Papadopoulos 1998.)

According to research studies, immigrant and refugee populations often experience extensive post-migration stressors, including distressing life events and poor physical health. Research shows that stressful life events experienced by older resi-

dents in a new country, such as financial crisis and separation from someone close, contribute to depression. (Gellis and Taguchi 2004, 23–38; Mui and Kang 2006, 243–255.)

New research literature, of THL (2012), describes the basic steps a refugee suffering from trauma or other psychological distress needs to go through as part of rebuilding their lives. The research approach needs to be based on:

- Empowerment
- Cultural appropriateness
- Education (THL 2012)

Displacement is difficult for all refugees, but women are often the most seriously affected. (Ferron 2000). The illiteracy of women forms one of the important changes in the social fabric in Kurdistan. The social environment affects both the women's individual freedom to the extent of withholding them from public life, as well as their humane security. This warrants the creation of development and empowerment opportunities for women to expand available choices, build their capacity, and provide them with a humane environment marked with justice and fairness, and the empowerment of vulnerable groups, providing them with alternative opportunities to integrate in the society, and providing the necessary care to help them play positive roles in the development process that can be used to affect women's freedom and humane security in a positive way. (Social services sector 2012.)

Discussion on the results

Growing evidence has been presented that there is an independent risk factor associated with poor health care promotion information and knowledge among Kurdish immigrant women. Research studies of Kurdish immigrant women have identified elements such as feelings of loss of social status and social isolation arising from language which have a negative consequence on their health condition (Hatter, Pollara, and Meleis 1995, 5.) A qualitative research study shows that the experience of immigrant women is an important determinant of health care promotion influenced by cultural competence (Sundquist and Johansson 1997, 36–156.) Kurdish immigrant women are suffering from health issues, and they have limited access to healthcare. Kurdish immigrant women in Finland suffer from psychological and physical health problems created by their experiences. This research study dealt with the ability of Kurdish immigrant women in Finland to handle and integrate experiences of poor health in order to understand health care promotion and the health care system in Finland. In this issue cultural competence context is important. Cultural competence is a tool for the development of modern thinking in Kurdish immigrant women in Finland. A Kurdish immigrant woman can create by developing and recognizing her womanhood, by making use of her own knowledge and worth in health care promotion experiences.

Cultural competence in health care promotion is seen in different dimensions of uniqueness, context, culture, and universality. The world is becoming more multicultural, and the Nordic countries are having more patients from different countries with different cultures and languages. Kurdish women actively participate in giving the nursing information needed to increase their cultural competence. They also suggested that cultural minorities in Finland need to add a nursing education program to facilitate health care promotion. It is important in the health care system and health care education for caregivers at all levels to be aware of the structural context of caring, meeting and treating to access the cultural competency of Kurdish immigrant women in Finland. The awareness is also needed at the societal level to elucidate the structure contradiction in Finnish society that influences our lives.

According to the interviews, the Kurdish immigrant women need health knowledge, health literacy and health education. Therefore, they try to use Internet and native TV-channels as a source. They do not have any resources to learn about the Finnish health care system in their own language. Problems among Kurdish women differ, because some learn just by hearing or listening; they are unable to read or write. Others have a good ability and education background; they actively participate in health education by schools or universities. Kurdish immigrant women have acknowledged the need for help in health care issues. Their knowledge about the health care in Finland is quite limited. Language has been cited as a barrier to Kurdish immigrants´

women gaining health care knowledge in the Finnish language.

A lack of health information and knowledge for women has adverse health consequences for them for their future in Finnish society too. Development in health education is necessary since educational programs promote "healthy living". Group education provides opportunities and gives them chances for better learning and lifestyles. They can have regular lectures regarding healthcare once a week. The place can be a women's center or AKK center´s facility (Turku Adult Education Centre). Programs can start with discussion, the watching of healthcare videos, short health documents, making health posters with each other, preparing health information notebook with each other, or exchanging information with one another.

Most of the women in Kurdistan are left untreated in their mental health. When they moved to their new host country, the mental problems appeared due to new circumstances. Kurdish women are suffering from many mental health problems such as depression and loneliness. There are big gaps in securing treatment because of literacy, language barriers and communication problems.

Food is very important to the health of the Kurds. They consume healthy foods. Many vegetables and fruits are used. Kurdistan has good weather in which various vegetables are grown. During spring and summer in the mountains of Kurdistan, a nice scented green grows that it is consumed for use. They eat healthy foods and enjoy them with family and friends outdoors. Halal food is very important to all the Kurdish people. Family ties are very close therefore there is a lot of common talk amongst the family members. Elders and those with experience are always in a special place. Looking to all of those interviewed by their parents and other family members is a good source of learning.

Conclusion and discussion based on the results

A large number of research studies emphasize the need of women, in quantitative data on the health status of ethnic minority women and more qualitative information on their health experience, with their own perceptions of their health concerning the most important influences on their wellbeing in their family. (Avotri 2001). Research studies emphasize the misdiagnosis, lack of cultural understanding, inability to communicate or communication difficulties on the part of care providers, socio-demographic differences and difference of attitudes among immigrant women. (Bruxner 1997, 4) Based on my research study, Kurdish immigrant women have language problems that lead to communication difficulties between a doctor and nurse. They always need a third person, the interpreter, to solve the health problems. They fill lots of gaps with health care centers in Finland.

Cultural competence is very important for Kurdish immigrant women. Understanding other people's culture increases health care organization effectiveness in meeting their needs. Understanding the context of the Kurdish immigrant women and their experience, physical and emotional needs, and addressing geographic, linguistic, economic, and cultural barriers are problematic elements for Kurdish women. Background knowledge of Kurdish immigrant women's perceptions of health, illness, and health care needs allows, culturally competent health care providers to effectively helps to enrich the communities in which they live, study and work.

Cultural competence has a potential aim of improving the quality of health care and well-being among people with different cultures and backgrounds. Kurdish immigrant women have different backgrounds with many health problems that affect their health condition. According to research interviews they are suffering from many mental health problems which affect their daily lives too.

Communication and language skills provide optimal care by increasing aptitudes in communicating with Kurdish immigrant women from diverse cultures and backgrounds.

Cultural competence is the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviors, and needs. Cultural competence is both a process and an output, and results from the synthesis of knowledge and skills. Cultural competence requires the synthesis of previously gained awareness, knowledge and sensitivity, and its application in the assessment of clients'

needs, clinical diagnosis and other caring skills. The aim of this scientific study is to find knowledge to alleviate suffering and to serve life and healthcare promotion among Kurdish women living in Finland.

This research study found that they need interpreter services, but they do not trust those services because most of them used family members or friends as an interpreter when needed. Based on the research interview across cultural barriers, we need to understand what cultural competence is and what raises our own cultural self-awareness in health care education and health literacy.

Health literacy has been defined as the cognitive and social skill which determines the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. According to Nutbeam (2000, 259–267), health literacy is a public health goal and challenge for contemporary health education and communication strategies in the 21st century as a health promotion international. The concept of culturalization of race in the expression of these developments is considerable evidence of an increasing intensity of that among Kurdish immigrant women in Finland (Castles 2000, 228). Improvements of the health care promotion of Kurdish immigrant women are based on understanding their needs and cultural availability. Cultural competence in health care and the health care system is needed to develop educational diversity in expanding its focus to include social and cultural groups for getting good information in this field. Clearly marginalization and oppression are also complex social processes that are found along many axes of social difference. Establish central of the culture diversity under name of multicultural umbrella. The health care system in Finland and it is practitioners must function effectively in transcultural interactions because Finland is moving towards a multicultural society.

Cultural competence in health care promotion is seen in different dimensions of uniqueness, context, culture, and universality. The world is becoming more multicultural and the Nordic countries have more patients from different countries with different cultures and languages. According to Wikberg and Eriksson (2008, 485–496.) in culture studies, types of learned but dynamic values and beliefs gives meaning to experience and influence the thoughts and actions of individuals of an ethnic group. Kurdish women actively participate in promulgating nursing information needed to increase their cultural competence. They also suggest that cultural minorities in Finland need to add a nursing education program to facilitate health care promotion. It is important in the health care system and health care education for caregivers at all levels to be aware of the structural context of caring, meeting and treating to know the cultural competency of Kurdish immigrant women in Finland. The awareness is also needed at the societal level to elucidate the structure contradiction in Finland's society that influences our lives.

Many of the Kurdish immigrant women suffer depression, insomnia and stressful lives in Finland because it is difficult to find correct treatment owing to language and communication often posing a problem. The awareness level and health knowledge and health care promotion are low. I discovered by interviewing Kurdish immigrants' women that migratory grief is a significant predictor of depressive symptoms among them. Kurdish immigrants' women need to access acculturation, because acculturation decreases the risk of psychological distress and is the best way to adapt to a new culture.

Further research and development proposals

It is important that Kurdish immigrant women forms be changed in the society of Finland. The social environment affects both the women's individual freedom to the extent of withholding them from public life, as well as their humane security in Finland. This urges the creation of development and empowerment opportunities for women in order to expand available choices, build their capacity, and provide them with a humane environment marked with justice and fairness, and the empowering of vulnerable groups, providing them with alternative opportunities to integrate in the Finnish society, and providing the necessary care to help them play positive roles in the development process in this society.

They must be able to get jobs that satisfy the needs of their families and insure them a decent so-

cial status. Health awareness should develop personal skills, providing information and education for health. Therefore, health promotion creates social change through community education. Healthcare promotion education tells women what is best for them. Education develops women's healthcare promotion and supports to express their health needs and provides the information for them in ways that makes sense to them. Integrating in a new society with immigrant backgrounds seems to be of vital importance, and is based on the caregiver's cultural differences, (WHO/1998, 4.)

Health literacy is a person's ability to obtain, understand, and act on health information, and a provider's capacity to communicate clearly, educate about health, and empower them. According to the Institute of Medicine, low health literacy impacts a person's health status more than any other factor, including education, income, employment, or race. Today within changing demographics, the world is more diverse than ever in terms of race, ethnicity, gender, sexual identity, language, acculturation, socioeconomic level and education. (Dorsett, 2006; Nielsen 2004.)

Communicating health information is more difficult today than ever due to patients bringing forward individual learning needs such as limited literacy or language skills, cultural differences, age-related physical and cognitive changes, disabilities, and emotions that affect listening, learning, and remembering. The World Health Organization at (2001) the World Assembly stated that improved health literacy is necessary for all people to increase control over their health and for better management of disease, risk and their health. It is imperative that healthcare providers become aware of health literacy and change their written and verbal communication style to one of 'plain language' so that patients will be better able to understand and manage their health problems. Health literacy has to do with patient safety and better health results. Health literacy is improving the readability of information flow between health professional and the health system for health care customers. Health literacy needs to be in plain language for written and oral information to be of easy comprehension. Language is an important tool for improving health literacy. It facilitates the communication between healthcare users and healthcare professionals such that, they are able to understand the first time they read or hear it, what they need to understand or what is indicated, and act correctly to so that they might understand each other. (U.S, 2001.)

Cultural competency can contribute to health literacy to help healthcare professionals. According to the Department of Health and Human Services in US (2001), cultural competence is the ability of health organizations and health careers to recognize the cultural beliefs, values, attitudes, traditions, language, health needed for diverse populations to use that knowledge to produce positive health results. Understanding various cultures helps to recognize how others interpret and navigate their environments. Health care providers should begin to familiarize themselves with these differences to improve treatment results and patient satisfaction. (Kaiser 2001.)

References

American Nurses Association (ANA). 2001. P. 101. Code of ethics for nurses with interpretative statements. [Online] Available at: <http://nursingworld.org/default.aspx> [Accessed 28 July 2012].

Avotri, J., and Walters, V. 2001. We women worry a lot about our husbands: Ghanian women talking about their health and their relationship with men. Journal of Gender Studies 10(2).

Bergman, Max. 2002. Reliability and Validity in Interpretative Research During the Conception of the Research Topic and Data Collection. 2, 317–331.

Bruxner, G. Burvill, P. Fazio, S. and Febbo, S. 1997. Aspects of psychiatric admissions of migrants to hospital in Peth Western Australia. Aust N Z J psychiatry, 31(4).

Castles, S. 2000. Ethnicity and globalization: from migrant worker to transnational citizen. London, Sage publication 228 p. (Ubit:304.8 Cas).

Chamberlain, S. P. 2005. Recognizing and responding to cultural differences in the education of culturally and linguistically diverse learners. Intervention in School and Clinic, 40(4).

Cohen, Louis, Manion, Lawrence and Morrison, Keith. 2003. Research Methods in Education. 5th Ed. London and New York: Rutledge Falmer, p 121.

Denscombe, Martyn. 2007. The Good Research Guide for Small Scale Social Research Projects. Third Ed. New York: Open University Press. p 174–5.

Donini-Lenhoff, F., G. and H., L. Hedrick. 2000. Increasing Awareness and Implementation of Cultural Competence Principles in Health Professions Education, Journal of Allied Health 29: 241–45.

Dorsett, B. 2006. Live well, live long: Health promotion and disease prevention for older adults. American Society on Aging. [Online] Available at: <http://www.asaging.org/cdc/issue_briefs/Issue_brief_4.pdf> [Accessed 12 January 2012].

Ferron, S. Morgan, J. and O'Reilly, M. 2000. Hygiene promotion a practical manual for relief and development. London: CARE International and Intermediate Technology Publications.

Gellis, Z., D. & Taguchi, A. 2004. Depression and health status among community dwelling Japanese American elderly. Clinical Gerontologist, 27(3), 23–38.

Hattar-Pollara, M. and Meleis, A. L. 1995. The stress of immigration and the daily lived experiences of Jordanian immigrant women in the United States. Western Journal of Nursing Research, 17 (5).

Kaiser, Permanente. 2001. National Diversity Council and Kaiser Permanente Nation Diversity Department. A provider's handbook on culturally competent care: Latino population. 2nd edition.

Kanervo, Sari and Saarinen, Tiina. 2005. Cultures among us. Educational material produced by the international meeting point of the city of Turku. [Online] Available at: <www05.turku.fi/kulttuurikeskus/kvk/kulttuurit> [Accessed 10 March 2012].

Kanervo, Sari ja Saarinen, Tiina. 2007. Kulttuurit keskuudessamme. Opas kulttuurien kohtaamiseen. S. 60.[Online] Available at: <http://www.kuopio.fi/ > [Accessed 17 May 2012].

Kvale, S. 2007. Doing Interviews. Thousand Oaks, California: Sage Publications.

Lehtonen, Elina. 2004. Kurdit Turussa. Yhteisöllisyyden rakentuminen diasporassa. Pro gradu –tutkielma. Sosiologia. Turun yliopisto.

Malin, Maili and Gissler, Mika. 2009. Maternal care and birth outcomes among ethnic minority women in Finland [Online] Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2674879/citedby/ > [Accessed 12 August 2012].

Mui, A., C, and Kang, S., Y. 2006. Acculturation stress and depression among Asian immigrant elders. Social Work, 51, 243–255.

Nielsen-Bohlman, Lynn, Panzer, Allison, Kindig, David (2004, editors): Health Literacy. A Prescription to End Confusion. Institute of Medicine of the National Academies. The National Academic Press, Washington, D.C.

Niemi, Hannele. 2006. Helsingin yliopiston syrjinnän vastainen suunnitelma. Helsingin yliopiston hallinnon julkaisua 16/2006. Helsinki.

Nutbeam, D. 2000. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Promotion International, 15, 259–267.

O'Donnell, M. 2009. Definitions of health promotion: Part III: Expanding the Definition. American Journal of Health Promotion, 3(5).

Papadopoulos, Irena. 2004. Promoting cultural competence in health care through a research based intervention in the UK. Professor of Transcultural Health and Nursing. Research Centre for Transcultural Studies in Health Middlesex University London N19 5LWp. 108.

Papadopoulos, R. K. 1998. Destructiveness, atrocities and healing: epistemological and clinical reflections. Journal of Analytical Psychology Development Goals [Online] Available at: <www.developmentgoals.org > [Accessed 17 July 2012].

Social services sector. 2012. Ministry of Planning / Kurdistan. [Online] Available at: <http://www.mop krg.org/index.jsp?sid=1&id=288&pid=274> [Accessed 14 July 2012].

Statistics Finland. 2010. Suomen suurimmat vieraskieliset ryhmät 2001, 2011. Helsinki: Tilastokeskus.[Online] Available at: <http://www.stat.fi/til/vaerak/2011/vaerak_2011_20120316_kuv_002_fi.html>[Accessed 12 June 2012].

Sundquist, Jan and Johansson, Sven-Erik. 1997. Self-reported poor health and low education level predictors for mortality: a population –based follow –up study of 36–156 people in Sweden. Journal of Epidemiol Community Health 51(1).

The Columbia Encyclopedia, Sixth Edition. 2005. Kurdistan, Britannica Concise.[Online] Available at: <:http://en.wikipedia.org/wiki/Kurdistan >[Accessed 17. May.2012].

THL, Research report. 2012. [Online] Available at: <http://www.turku.fi/public/default.aspx?contentid=364226&nodeid=9382 >[Accessed 15 November 2012].

Tuori, Salla & Silius, Harriet. 2002. Background Data Report: Finland. In: Gabriele Griffin (ed.) Women's Employment, Women's Studies, and Equal Opportunities 1945–2001. Reports from nine European Countries. The University of Hull, 69–121.

U.S. Department of Health and Human Services. 2001. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Washington, DC: Office of Minority Health.

Wikberg, A. and Eriksson, K. 2008. Intercultural caring – an abductive model. Scandinavian Journal of Caring Science, 22(3), 485–496.

World Health Organization. 1998. Health Promotion Glossar. World Health Organization [Online] Available at: <http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf >[Accessed 22 February 2012].

Wahlbeck, O. (2000) Kurdish Diasporas: A Comparative Study of Kurdish Refugee Communities. London: Macmillan.

Zechner, K., 2002. Automatic Summarization of Open-Domain Multiparty Dialogues in Diverse Genres. Computational Linguistics 28(4), pp. 447–485, December, Special Issue on Summarization.

Did you know? Helsingfors in Argentina

(Helsinki is called Helsingfors in Swedish)

At the beginning of the 20th century, a group of Scandinavians were captivated by the landscape in the beautiful glacier area on the coast of Viedma Lake in Patagonia, Argentina. One of them, Alfred Ramstrom arrived in Argentina in 1907 after fleeing away from Finland, his homeland, which was going through a difficult situation under the Russian Regime.

He started working at a lumber-yard in the Oberá area, in the Province of Misiones. In 1912, he was employed by a French Company for the building of a large shed on the premises of "La Primera" Ranch, in the area of El Chaltén. He was fascinated by the marvelous views and started breeding horses, which were sold for the acquisition of land for his new ranch in 1917. He gave it the name of "Helsingfors" (Helsinki).

Since 1996, Helsingfors welcomes visitors from all over the world and allows them to discover its past, its great beauty and enjoy Patagonia in a unique way.

Read the whole story at: http://www.helsingfors.com.ar/

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